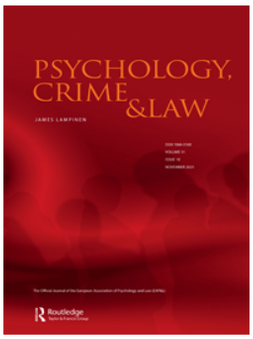

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Unmet needs: analysing the Fixated Threat Assessment Centre's fulfilment of the public health approach, and its value for violence prevention

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ABSTRACT

The Fixated Threat Assessment Centre (FTAC) operates with a public health approach, through catalysing mental health treatment for those with mental health needs unidentified, untreated, or sub-optimally managed by mainstream services. While much literature examines mental illness's role in fixated threats, *unmet* mental health needs garner less attention. This paper evaluates the value and fulfilment of safeguarding within FTAC, through analysing whether (1) FTAC identifies and successfully refers into treatment those with unmet needs, and (2) unmet needs are related to concerning behaviours. Two measures of unmet needs are analysed: disengagement from mental health services, and unidentified mental illness. Data comprise FTAC referrals from 2012 to 2016, and methods include chi-squared tests and logistic regressions. Results indicate FTAC does safeguard individuals referred. Over a quarter of referrals (where previous mental healthcare information is available) have unmet needs, predominantly psychotic illnesses. These are directed to (mental) health-based interventions, reducing concern levels. Safeguarding is useful for violence prevention, as unmet needs isolate a subgroup exhibiting disproportionately concerning behaviours (approach, problematic approach, breaching security barriers). Findings imply unmet mental health needs should be given more attention in research as a variable, and in threat assessment as a risk indicator for assessments of levels of concern.

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Threat assessment; fixated threats; mental illness and violence risk; public figures; public health approach to violence prevention

Introduction

Fixated individuals are pathologically preoccupied with a person or cause. For public figures, the variety of concerning approaches and communications emanating from fixated individuals is well documented (Every-Palmer et al., 2015; James, Farnham et al.,

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2016; Phillips et al., 2023), and often causes psychological harm, disruption, and significant use of resources (James, Sukhwal et al., 2016; Wilson et al., 2021). Decades of research has established that among fixated individuals there is a high prevalence of mental illness and psychotic disorders (Barry-Walsh et al., 2020; James et al., 2007). Often, the individual has a need for treatment that is insufficiently met by mainstream mental health services (Barry-Walsh et al., 2020): an unmet mental health need.

Although unmet needs are a central concept both within fixated threat research and practice more generally, they have been understudied empirically. To further validate and evaluate the public health approach taken by these threat assessment units, unmet mental health needs should be examined more closely through being treated as a variable in their own right, and their relationship with concerning or violent outcomes should be interrogated. This paper addresses this gap through an empirical analysis of Fixated Threat Assessment Centre (FTAC) data.

FTAC is a joint NHS and police unit, whose aim is to mitigate the threat posed by fixated lone individuals to public figures, particularly the British Royal Family and politicians. FTAC's purpose is to assess the level of concern of individuals who come to their attention, and then catalyse a multi-agency collaboration of supportive interventions. Cases come to FTAC's attention from various bodies including royal households, communications offices, and the Houses of Parliament (James & Farnham, 2016). These are generally prompted by a communication or approach towards a politician, royal, or symbolic building. Around half are quickly regarded as low concern and not taken on by FTAC, with advice and conclusions provided back to the referrer (Wilson et al., 2021). The remaining half deemed moderate or high concern require further assessment or action.

FTAC's objective is to treat underlying problems which might be causing or manifesting in concerning behaviours (James, Kerrigan et al., 2010). These are often unmet mental health, social, or material needs. Through this, FTAC aims to both manage risk of violence to targets of fixation or the general public, and safeguard by improving outcomes for individuals referred regarding health, wellbeing, quality of life, social relationships, and involvement with the criminal justice system (Barry-Walsh et al., 2020). FTAC is a multidisciplinary hub that does not carry out in-house interventions but instead facilitates multi-agency support. Hence, interventions are diverse. Most cases are provided a health or mental health based intervention, including engagement with community mental health teams, GPs, and psychiatric services, as well as admission to hospital (James, Kerrigan et al., 2010). A small percentage have police-based interventions, including arrest and prosecution (Wilson et al., 2021; James, Kerrigan et al., 2010) and further still have no further action taken, or other interventions including home visits or telephone interviews.

Literature review

Unmet mental health needs

Studies consistently show that while many perpetrators of concerning fixated behaviours had previous involvement with mental health services, many of these were not under mental health care at the time of the referral or concerning behaviour (Meloy et al., 2004; Pathé, 2017). Early US studies interpreted this as a non-issue. Fein and Vossekuil (1999) found that while over 60% of attackers and near-lethal approachers of US public

figures had historic mental health treatment and 38% previous psychiatric hospitalisation, only 23% were in contact with services in the preceding year, concluding their mental health issue had been sufficiently treated. However, it is more likely because they were unsuitable for or noncompliant with mainstream services (Mullen et al., 2009).

This is now consistently seen in caseloads of existing threat assessment units. Scalora and Zimmerman (2015) find over 40% of US Capitol Police's Threat Assessment Section cases have serious mental illness, commenting this is often due to not taking medication. James, Kerrigan et al. (2010) conclude a large proportion of FTAC's first 100 high or moderate concern referrals had either disengaged from treatment or never had treatment, yet suffered from disorders proving problematic. 81% had been previously seen by psychiatric services but only 60% of these remained in care at the time of referral. Of those, 61% had stopped taking medication and 59% had no contact with mental health teams. Overall, 67% of those previously in services had disengaged. Similarly, in the Queensland Fixated Threat Assessment Centre's (QFTAC's) first year, 75% of those with a serious mental illness had either disengaged from or were otherwise unknown to services at the time of referral (Pathé et al., 2015). For 2013–2016 only 22% of those with severe mental illnesses were under care of public mental health services (Pathé et al., 2016). Riddle et al. (2019) find similar for the Australian Federal Police's unit: only 35% of those with mental disorders at the time of referral were being managed by mental health services. More recently, Gray et al.'s (2024) examination of cases aged 14–25 in the Victorian lone actor grievance-fuelled violence FTAC (VFTAC) finds almost half those diagnosed with Autism Spectrum Disorder (ASD) by the VFTAC had not been previously formally diagnosed.

There are many reasons for needs being unmet. Individuals may not have (yet) been identified or treated by services due to oversubscription, delays in processing or treatment, or cases failing to meet criteria for acceptance. Those with diagnosed or suspected mental illnesses can also be challenging to engage. The individual may be non-compliant, or their disorder may be considered untreatable (Meloy et al., 2004). They may have other complex needs alongside mental health (substance abuse, homelessness, or poor social relationships, for example) which inhibit treatment engagement. Even for those with an identified mental illness and service engagement, clinicians may be unaware of concerning fixated behaviours displayed elsewhere, inhibiting treatment effectiveness (James, Kerrigan et al., 2010). There are also systemic issues with UK mental healthcare infrastructure uniquely preventing those with psychosis from accessing suitable treatment, including only taking referrals from family doctors, where there is patient consent, or where the patient responds to an 'opt in' letter (Wilson et al., 2019).

FTAC stands out due to its explicit focus on untreated mental illness in the context of threats to public figures (Barry-Walsh et al., 2020). In FTAC's case, unmet needs are often due to failure to meet criteria, and inaccessible or unavailable services (James et al., 2013; MacKenzie & James, 2011; McEwan et al., 2013; McEwan & Darjee, 2021; Phillips, 2008). In their referrals cohort there is a high prevalence of delusional disorders (Wilson et al., 2019). These are often missed by mainstream services due to a lack of expertise and a perception they are rare and untreatable (Wilson et al., 2019; 2021). Such individuals often fail to meet mainstream services' criteria due to high rates of encapsulated delusional disorder where they appear to function effectively (James, Kerrigan et al., 2010; Wilson et al., 2018). Delusional disorders also cause individuals to be particularly paranoid and resistant to intervention (Dietz & Martell, 1989; James, Kerrigan et al., 2010).

Despite the conceptual and empirically implied significance of unmet needs, they are only explicitly analysed by van der Meer et al. (2012) and Gray et al. (2024). van der Meer et al. (2012) examine non-engagement in psychiatric treatment and its relationship with outcomes of concern. Non-engagement is defined as either medical noncompliance or involuntary commitment and comprises 43% of their sample. They found successful breachers were not only disproportionately severely mentally ill and/or had grandiose delusions, but had not engaged in recommended treatment. Further, non-engagement was higher among those who both communicated and approached than those limited to either one, implying it may be a risk factor for approach. Gray et al. (2024) examine LAGFV cases aged 14–25 in the VFTAC, where they find those with previously undiagnosed ASD receive more mental health service interventions upon contact with the VFTAC. Together, these two studies provide preliminary indications that those with unmet needs exhibit disproportionately risky or concerning behaviours, and that they are appropriately directed towards mental health interventions. Both of these avenues will be explored in this study.

Correlate risk factors for concerning behaviours

While unmet needs have been understudied, other risk factors for various concerning behaviours and proxy measures for violence have been extensively researched. For the likelihood of making a concerning approach, while there are some disputed cases, generally similar factors emerge in deductive and inductive work on different datasets (Clemmow et al., 2021; Gill et al., 2021; Meloy, 2014; Meloy et al., 2010). Beside serious mental illness, approach is related to: help-seeking or personal rather than policy grievance-based motivations; a lack of direct threats or hateful, abusive, or angry language; a criminal record and/or history of violence; higher frequency or intensity of communications; multiple methods of communication; and target dispersion (Clemmow et al., 2021; Dietz et al., 1991; Dietz & Martell, 1989; Gill et al., 2021; James et al., 2007; James et al., 2010; Scalora et al., 2002; Scalora et al., 2002; Scalora et al., 2003; Schoeneman et al., 2011; van der Meer et al., 2012).

While few studies examine breaching of security barriers, among those that do, the factors found more than once to distinguish between attempted, failed, and successful breaches are: delusions of royal identity; hostile, aggressive, or abusive language; previous hospital admission for mental health; delusions and grandiosity; feelings of persecution; querulant motivations; chaotic motivations; and counselling motivations (Gill et al., 2021; James et al., 2009; 2011; van der Meer et al., 2012).

Given the empirical consensus for these correlates for approach and breaching of security barriers, they will be used as control variables in this study's analysis of unmet needs as a potential additional correlate.

Evaluations of safeguarding in threat assessment

There have generally been two forms of attempts to evaluate fixated threat assessment units: evaluating violence prevention (outcomes for the general public or specific targets) and evaluating safeguarding practices (outcomes for individuals referred).

Evaluating violence prevention is challenging due to the lack of a counterfactual, and the infeasibility of a randomised controlled trial (Hutson, 2022). Some studies find implied prevention by reductions in judged level of concern from high or moderate to low after some time in the unit (James, Kerrigan et al., 2010; Pathé et al., 2015; 2016; Riddle et al., 2019). FTAC, for example, has shown that it can reduce levels of concern and effect outcomes for individuals, but these are insufficient to prove FTAC's impact on violence or concerning behaviours (James & Farnham, 2016). Others, therefore, opt for quasi-experimental designs. James and Farnham (2016) conducted a mirrored study comparing the 12 months and 2 years before and after FTAC intervention, finding reductions in concerning approaches, communications, and police call outs. Sizoo and van Nobelen (2021) applied this to the Netherlands police's threat management team, finding reduced frequency and volume of callouts, concerning approaches, and communications. Overall, these imply threat assessment units can reduce concerning behaviours and therefore justify their use of funds in saving police or healthcare resources elsewhere.

Regarding safeguarding evaluations, in the realm of school violence a significant quantity of research shows improved outcomes for individuals referred in schools using the Comprehensive School Threat Assessment Guidelines, in descriptive, correlational, retrospective, quasi-experimental, and randomised controlled studies (Cornell et al., 2004; Cornell et al., 2004; Cornell et al., 2009; 2011; 2012; 2015; 2018; Cornell & Lovegrove, 2013; Nekvasil & Cornell, 2015; Strong & Cornell, 2008). In fixated threats, evaluations of outcomes for individuals referred are limited to merely descriptively reporting interventions. James, Kerrigan et al. (2010) state outcomes for the first 100 individuals referred to FTAC and find FTAC had direct engagement with community mental health teams in 70% and direct liaison with GPs in 46% of cases. This resulted in 57% of individuals being admitted to hospital for psychiatric treatment (voluntarily or otherwise), and a further 26% taken on by local community psychiatric teams. Similar studies demonstrate QFTAC's (Pathé et al., 2015; 2016) and the Australian Federal Police fixated threat assessment team's (Riddle et al., 2019) successful catalysing of (mental) health services. So, aside from whether they successfully prevented harm to public figures, fixated threat assessment units successfully mobilised resources that should improve the wellbeing of these individuals and ensured they received more sufficient care.

These studies are overwhelmingly descriptive and do not comment on the statistical significance of any proportions or subgroups they mention. For example, it is unknown whether beneficial health outcomes disproportionately affect a certain subgroup, or whether reductions in levels of concern are disproportionately for those receiving these interventions – with the exception of Gray et al.'s (2024) examination of ASD in the VFTAC. Relatedly, existing studies also limit attention to referrals of high or moderate concern as these are accepted for assessment and intervention (James, Kerrigan et al., 2010). To examine relationships between unmet needs and proxy violence measures or judged concern levels, we include all referrals in our time period.

Study aims

This paper examines safeguarding within FTAC, and particularly the role of unmet mental health needs, resulting from both a lack of contact with mainstream mental health

services at all, and by insufficient treatment reflected in individuals disengaging from services.

The first aim of this study is to examine FTAC's fulfilment of safeguarding in the public health approach, by analysing how FTAC identifies individuals of concern with unmet needs and refers them into treatment. This involves the following questions:

(1) Does FTAC identify individuals with unmet mental health needs?
(2) Are there specific disorders in FTAC referrals that are not being sufficiently addressed by mainstream services?
(3) What benefits do FTAC provide for individuals with unmet needs? Are there any changes in levels of concern as a result?

The second aim is to examine the value of safeguarding in a violence prevention unit, by analysing whether unmet needs are relevant to violence prevention for FTAC. This involves the following questions.

(2) Are unmet mental health needs related to FTAC's judgement of the individual's level of concern at referral, either overall or for specific problematic behaviours?
(3) Are unmet needs related to various concerning behaviours and proxy measures for violence?

Materials & Methods

Data

Data were 1,914 referrals to FTAC from 2012 to 2016. Ethics approval was granted by the University College London Department of Security and Crime Science Ethics Committee and the European Research Council Executive Agency Research Ethics Committee.

FTAC maintains a case management database to record client information, facilitate research, and improve future service provision and risk management. Data were recorded in this system by trained and experienced FTAC staff (police, forensic psychiatrists and psychologists, and other mental health practitioners). These represent expert judgements and descriptions made by staff working in small multidisciplinary teams, and thus inter-rater reliability information is not available (Clemmow et al., 2021). Data were then coded by researchers directly from FTAC's case management database with no changes made, beyond de-identification (Clemmow et al., 2021; Gill et al., 2021).

Variables in this database pertain to all main stages of referral (Wilson et al., 2021), and all used in this study are fully listed with descriptive statistics in the tables in the results section. Referrals to FTAC are prompted by inappropriate or concerning communications or approaches towards relevant public figures (Gill et al., 2021). Therefore, initial data recorded includes details of the communication (e.g. linguistic content, frequency, method of communication) or approach (e.g. level of violence, weapons in possession, any attempts to breach security barriers), and the recipient or target of either. When a referral is received, teams of police and clinicians make judgements of overall concern and concerns for specific behaviours (Gill et al., 2021), which are recorded. Background information is then collated on the individual. For example, variables describe prior

criminal history from police systems FTAC staff can access (e.g. Police National Computer records, violent history, details of weapons). Clinicians code various aspects of mental illness from their own assessments alongside prior information from GP, psychiatric, and hospitalisation records (Gill et al., 2021). Finally, interventions taken by FTAC and resulting outcomes for the client are recorded, along with the final level of concern.

Procedure

The original dataset was the full 2,866 referrals in 2012–2016. However, for the purposes of this study some cases were removed. Cases with missing data on key valuables necessary for analysis (e.g. prior contact with mental health services) were removed as this would have prevented analysis. For example, given our focus on unmet needs relies on information regarding contact with mental health services either previously or at referral, 672 cases were removed for individuals where *both* were missing/unknown. These cases were mostly low concern, where FTAC has not needed to ascertain this information. As this represents a very large proportion of cases with a complete lack of information on mental healthcare, including them would significantly inflate the figures for unidentified mental illness (clear in the differences in percentages in Table 1) and thus skew core analysis. Similarly, 271 cases were removed as they were marked as international, resulting in missing/unknown data on a significant number of variables (particularly those regarding previous contact with mental health services) and causing complications due to the different (mental) healthcare infrastructures outside the UK. Finally, 9 cases were removed where the concerning behaviour prompting referral (approach and/or communication) was either missing or recorded as 'none (absconsion/intel request)'. For transparency, descriptive statistics in Tables 1, 2, 4, 6, 8 show frequencies and percentages for relevant variables for both the full cohort of 2,866 referrals, and the subsample of 1,914 relevant to this study. All statistical analysis applies only to this remaining subsample.

Definitions of unmet mental health needs

To analyse unmet needs, two new variables were created from existing data:

Unidentified mental illness = individuals with no confirmed contact with mental health services both previously and at time of referral, but upon assessment by FTAC, clinicians judged them to have either a specific mental disorder or general evidence of an overt mental disorder

Disengaged from mental health services = individuals known to mental health services either previously or at time of referral, but recorded as having a history of noncompliance with services.[1]

Table 1. Descriptive statistics for unmet mental health needs variables.

	All referrals		Study subsample	
	Frequency	%	Frequency	%
Known to MH services previously	1677	58.51	1,609	84.06
Known to MH services at time of referral	1032	36.01	1,000	52.25
Unidentified mental illness	412	14.38	101	5.28
Disengaged	424	14.79	410	21.42
Unmet mental health needs (either unidentified illness or disengaged)	836	29.17	511	26.70

Table 2. Descriptive statistics for mental illness variables.

	All referrals		Study subsample	
	Frequency	%	Frequency	%
Mental disorders				
Any mental disorder	1,385	48.33	1,205	62.96
Bipolar disorder	95	3.31	86	4.49
Delusional disorder	149	5.20	126	6.58
Depression	36	1.26	25	1.31
Learning difficulties	13	0.45	12	0.63
Psychosis	103	3.59	89	4.65
Personality disorder	93	3.24	86	4.49
Schizophrenia	823	28.72	717	37.46
Other mental disorder	73	2.55	64	3.34
Other presenting issues related to mental illness				
Evidence of overt mental disorder	1,453	50.70	1,180	61.65
Delusions	1,361	47.49	1,056	55.17
Grandiosity	446	15.56	332	17.35
Substance use problems	136	4.75	128	6.69

Analysis structure and statistical methods

Bivariate chi-squared analysis

Bivariate analysis was used to examine the relationship between the two unmet needs variables and each correlate variable.

Multivariate logistic regressions

For analysis of concerning behaviours and proxies for violence only, multivariate logistic regressions were used to validate bivariate findings, only when (a) a significant relationship was found in bivariate analysis, and (b) there is sufficient previous literature on fixated threats and similar threat assessment units to support including a specific set of control variables alongside unmet needs (from 'correlate risk factors for concerning behaviours' in the literature review). This only applies to approach and breach behaviours, where control variables (where available in the dataset) from the literature review were included in regressions.

Results

Does FTAC identify individuals with unmet mental health needs?

Table 1 displays the scale of unmet needs in FTAC referrals from 2012 to 2016 for whom there is sufficient information regarding contact with services. There is a clear mental health need, as 84.06% had previous contact with a mental health service. However, only 52.25% were in contact with mental health services at the time of referral or concerning behaviour. The discrepancy in these figures may indicate that some subjects had been sufficiently treated and were therefore no longer in active contact with mental health services for this reason. However, 21.42% of the full sample had contact with services at some point but were recorded as being noncompliant ('Disengaged'). Individuals referred to FTAC commonly have psychotic illnesses which inherently feature a lack of awareness of their illness, meaning they are difficult for services to manage, often managed poorly, and resultingly often drop out of care, hence referred to as 'disengagement'. Further, while 62.96%

have a specific mental disorder and 61.65% presented with general evidence of an overt mental disorder at referral, 5.28% have either a disorder or overt illness identified by FTAC which, before FTAC involvement, had never been identified by professionals as they had never been in contact with mental health services ('Unidentified mental illness'). Altogether, a total of 26.70% of the sample have one of these two forms of unmet needs.

Are there specific disorders in FTAC referrals that are not being sufficiently addressed by mainstream services?

Table 2 reports descriptive statistics regarding the different forms of mental illness present in FTAC's cohort of referrals. This shows that around half of this study's cohort experience delusions, with the most prevalent disorder overwhelmingly being schizophrenia.

Table 3 shows the relationship between unmet needs and mental illness variables. If a referral has an unmet need, they are around twice as likely to have evidence of an overt mental disorder (disengaged: odds ratio (OR) = 2.17, unidentified illness: OR = 1.82). More specifically, unmet needs disproportionately affect those with delusions (disengaged: OR = 1.93, unidentified: OR = 2.13). Further, those disengaged from services disproportionately have a mental disorder (OR = 7.72), grandiosity (OR = 1.66), and substance abuse issues (OR = 1.52). Unidentified mental illnesses are disproportionately delusional disorders (OR = 3.12). While FTAC identifies a high level of schizophrenia, this differs among unmet needs measures. Disengaged cases are more likely to have schizophrenia (OR = 1.57), but schizophrenia is less likely to be an unidentified illness (OR = 0.49). Overall, FTAC is identifying unmet needs which disproportionately affect certain (delusional) disorders.

What benefits does FTAC provide for individuals with unmet needs? Are there any changes in levels of concern as a result?

Table 4 provides descriptive statistics for the interventions provided by FTAC, and the changes in concern level between referral and case closure. This shows that most referrals are directed to at least one (mental) health-based intervention. Around half of referrals have their level of concern reduced at closure, while another half have no change to level of concern.

Table 3. Bivariate tests of association between unmet needs and mental illness.

	Disengaged		Unidentified mental illness	
	$\chi 2$	*V*	$\chi 2$	*V*
Any mental disorder	**26.725*****	**.143*****	N/A	.010
Bipolar disorder[a]	0.077	.008	N/A	.010
Delusional disorder[a]	0.891	.026	**12.911*****	**.099*****
Depression[a]	2.791	.046	N/A	.026
Learning difficulties[a]	N/A	.040	N/A	.020
Psychosis[a]	0.844	.025	N/A	.049
Personality disorder[a]	0.281	.015	N/A	.010
Schizophrenia[a]	**12.481*****	**.098*****	6.448*	.070*
Other mental disorder[a]	1.373	.032	N/A	.030
Overt mental disorder[b]	**30.334*****	**.134*****	**5.435***	**.057***
Delusions[c]	**26.761*****	**.126*****	**9.759****	**.076****
Grandiosity[b]	**13.897*****	**.091*****	1.290	.028
Substance problems[c]	**4.371***	**.051***	0.032	.004

Note: *$p < .05$, **$p < .01$, ***$p < .001$, [a]N = 1307, [b]N – 1682, [c]N = 1683. N/A = Fisher's Exact Test conducted between two binary variables, so no test statistic given. Where relationship between two binary variables is significant, bold represents a positive association and underlined represents a negative association.

Table 4. Descriptive statistics for variables relating to FTAC interventions and resulting change in level of concern.

	All referrals		Study subsample	
	Frequency	%	Frequency	%
FTAC intervention types[2]				
No further action/no intervention recorded	521	18.18	189	9.87
At least one (mental) health-based intervention	1,854	64.69	1,546	80.77
Police or criminal justice-based intervention only	468	16.33	170	8.88
Other intervention only	23	0.80	9	0.47
Resulting change in concern level				
Reduction in judged level of concern	1,202	41.94	981	51.25
No change in judged level of concern	1,617	56.42	900	47.02
Increase in judged level of concern	10	0.35	6	0.31

Table 5. Bivariate tests of association between unmet needs and FTAC interventions and resulting levels of concern.

	Disengaged		Unidentified mental illness	
	$\chi 2$		$\chi 2$	V
FTAC intervention[a]	21.558***	.106***	3.674 [z]	.040
Change in judged level of concern[b]	16.972*** [z]	.094***	7.727* [z]	.061*

Note: *$p < .05$, **$p < .01$, ***$p < .001$, [a]N = 1914, [b]N = 1887, [z]Fisher-Freeman-Halton exact test. Where relationship between two binary variables is significant, bold represents a positive association and underlined represents a negative association.

Table 5 shows the relationship between unmet needs and the intervention catalysed by FTAC, along with the resulting change in judged level of concern during time as an FTAC referral. Disengagement from services is related to intervention type. Examination of adjusted standardised residuals reveals this is driven by disengaged cases being disproportionately unlikely to have no action taken or recorded (adjusted standardised residual < -1.96), likely to have some form of (mental) health-based action (>1.96), and unlikely to have police or criminal justice-based action alone (<-1.96). Both forms of unmet needs are related to the resulting change in level of concern. For both, residuals indicate that for those with unmet needs, level of concern is disproportionately likely to decrease and unlikely to be unchanged. Overall, FTAC is disproportionately providing (mental) health-based interventions for disengaged individuals, and judging that these interventions result in reduced levels of concern for future problematic behaviour.

Are unmet mental health needs related to FTAC's judgement of the individual's level of concern at referral or concern for specific problematic behaviours?

Table 6 displays descriptive statistics for the overall level of concern at referral, and then judgements regarding whether there is concern for specific concerning or problematic behaviours. This shows that the most common judgements of concern are not for violence, but instead for embarrassment to both the public figure and to police, time consumption, and psychological distress to FTAC staff.

Table 7 displays the associations between unmet needs and FTAC's judgement of initial level and type of concern. Both forms of unmet needs are related to the individual's level of concern. Residuals imply those with unmet needs are disproportionately unlikely to be of low concern, and likely to be of moderate concern.

Table 6. Descriptive statistics for judgements of level and type of concern.[3]

	All referrals		Study subsample	
	Frequency	%	Frequency	%
Initial concern				
Low	1,616	56.39	896	46.81
Moderate	1,123	39.18	916	47.86
High	127	4.43	102	5.33
Type of concern				
Any concerns evoked	1,954	68.18	1,445	75.50
Violence to principal	137	4.78	107	5.59
Violence to police	133	4.64	105	5.49
Embarrassment to principal	623	21.74	431	22.52
Embarrassment to police	652	22.75	483	25.24
Psychological harm to principal, short of physical violence	192	6.70	161	8.41
Disruption of events	262	9.14	196	10.24
Wasting of resources	336	11.72	228	11.91
Time consumption	706	24.63	527	27.53
High risk	293	10.22	243	12.70
Psychological distress to FTAC staff, short of psychological harm	559	19.50	418	21.84
Distress to principal	46	1.61	32	1.67

Regarding the type of concern posed, disengaged individuals are more likely to present some form of concern (OR = 1.44), and specifically violence towards police (OR = 1.61). Those with unidentified mental illness are likely to be of concern for embarrassment to the public figure (OR = 1.76). Beyond these, those with unmet needs are no more or less likely to be judged by FTAC as of concern for any particular outcome.

Are unmet needs related to various concerning behaviours and proxy measures for violence?

Having established unmet needs are largely unrelated to judged concern for specific outcomes, we now turn to their relationship with concerning behaviours that are objectively exhibited.

Table 7. Bivariate tests of association between unmet needs and judged level and type of concern.

	Disengaged		Unidentified mental illness	
	$\chi 2$		$\chi 2$	*V*
Level of concern[a]	17.141***	.095***	7.820*	.064*
Any concerns evoked[a]	**7.027****	**.061****	0.597	.440
Violence to principal[b]	0.101	.008	0.493	.018
Violence to police[b]	**4.838***	**.055***	0.042	.005
Embarrassment to principal[b]	0.888	.024	**5.995***	**.062***
Embarrassment to police[b]	0.024	.004	0.051	.006
Psychological harm to principal, short of physical violence[c]	0.221	.012	0.375	.015
Disruption of events[b]	0.069	.007	0.004	.002
Wasting of Resources[b]	0.001	.001	0.840	.023
Time Consumption[b]	0.435	.017	0.108	.008
High risk[b]	3.201	.045	0.014	.003
Psychological distress to FTAC staff, short of psychological harm[b]	0.917	.024	2.153	.037
Distress to principal[b]	1.948	.035	N/A	.007

Note: *$p < .05$, **$p < .01$, ***$p < .001$, [a]N = 1914, [b]N = 1579, [c]N = 1578. N/A = Fisher's Exact Test conducted between two binary variables, so no test statistic given. Where relationship between two binary variables is significant, bold represents a positive association and underlined represents a negative association.

Given the rarity of attacks in this space, it is necessary to analyse proxy measures for violence that are likely to indicate other harms, including escalation to violence, distress, and resource requirement. Table 8 provides descriptive statistics for such measures used here. For example, to pose a risk of violence, an individual would have to approach, breach security barriers, gain access to the public figure, and have a weapon and/or homicidal ideation, meaning these measures are fitting proxies or prerequisites for violence (James et al., 2009; James et al., 2011). These and other variables (e.g. direct threats, angry or abusive content in communications) also represent factors that would cause distress to communications staff or targets of fixation. Others still represent actions that would require increased FTAC or police resources (e.g. high number of communications, problematic or violent approaches, breach attempts).

Table 9 reports relationships with unmet needs variables.

Disengaged individuals are more likely to engage in several concerning behaviours. They are less likely to communicate (OR = 0.59), more likely to approach (OR = 1.80), and more likely to do both (OR = 1.75). Of those that communicate, disengaged individuals are more likely to approach (OR = 2.10). Of those that approach, disengagement is related to the nature of that approach, where they are less likely to be concerning (the least severe form of approach) and more likely to be problematic (involving threatening language, intimidating behaviour, or talking about security procedures, but without violence).

None of these relationships hold for those with unidentified mental illness. However, among those who approach, unidentified illness is related to behaviour regarding breaching of security barriers. Residuals imply this is driven by these individuals being disproportionately unlikely to approach without attempting a breach (and therefore likely to attempt a breach), and likely to make a successful breach.

Notably, the effect of each unmet needs measure diverges for angry or abusive content in communications. While disengaged cases are more likely to produce such

Table 8. Descriptive statistics for variables relating to concerning behaviours and proxy measures for violence.

	All referrals		Study subsample	
	Frequency	%	Frequency	%
Homicidal ideation	101	3.52	85	4.44
Communication	2,133	74.42	1,377	71.94
Approach	819	28.58	603	31.50
Both communication and approach	98	3.42	66	3.45
Within all communicators:				
Approach	98	4.59	66	4.79
Direct threats	134	6.28	103	7.48
Angry or abusive content	513	24.05	365	26.51
High number of communications (>10)	244	11.44	167	12.13
Within all approachers:				
Communication	98	11.97	66	10.95
Concerning approach[4]	538	65.69	401	66.50
Problematic approach[5]	252	30.77	180	29.85
Violent approach[6]	22	2.69	16	2.65
Weapon possession	20	2.44	16	2.65
No breach attempt[7]	547	66.79	410	68.00
Failed breach attempt[8]	237	28.94	164	27.20
Successfully breach security barriers[8]	28	3.42	23	3.81

Table 9. Bivariate tests of association between unmet needs and concerning behaviours or proxy measures for violence.

	Disengaged		Unidentified mental illness	
	$\chi 2$	*V*	$\chi 2$	*V*
Any communications[a]	19.895***	.102***	0.283	.012
Any approach[a]	**26.387****	**.117****	0.067	.006
Communication and approach[a]	**4.390***	**.048***	N/A	**.045***
Homicidal ideation[b]	0.165	.010	N/A	.023
Of those that communicate:				
Approaches[c]	**7.682****	**.075****	N/A	.051
Direct threats[d]	0.204	.012	0.538	.020
Angry or abusive content[e]	**7.621****	**.075****	7.155**	.072**
More than 10 communications[f]	0.092	.008	0.107	.009
Of those that approach:				
Communications[g]	0.394	.026	N/A	.079
Nature of approach[h]	7.245*	.110*	4.962 [z]	.087
Weapon possession[h]	N/A	.012	N/A	.051
Breach behaviour[h]	1.729	.054	16.126***	.164***

Note: *$p < .05$, **$p < .01$, ***$p < .001$, [a]N = 1914, [b]N = 1684, [c]N = 1377, [d]N = 1373, [e]N = 1372, [f]N = 1376, [g]N = 603, [h]N = 597. N/A = Fisher's Exact Test conducted between two binary variables, so no test statistic given. Where relationship between two binary variables is significant, bold represents a positive association and underlined represents a negative association.

communications (OR = 1.51), those with unidentified illnesses are less likely (OR = 0.41). This is perhaps because their tendency to avoid angry or abusive communication in this and other aspects of life is a reason behind them having not been identified by mental health services in the past.

For both forms of unmet needs, there are no relationships with other forms of proxy measures for violence or behaviour likely to cause distress: homicidal ideation, direct threats in communications, excessive quantities of concerning communications, pre-approach communications, or weapon possession during approach.

Tables 10–14 display logistic regressions for the relationships found to be significant in Table 9's bivariate analysis, where there is sufficient prior literature to justify inclusion of other variables in multivariate analysis.

Binomial logistic regressions in Tables 10–13 verify the finding in bivariate analysis that disengaged cases are more likely to approach. While low values of R^2 reflect poor goodness-of-fit for these models, coefficients on disengagement are statistically significant. Disengaged individuals are less likely to communicate, more likely to approach, more likely to do both, and (of those who communicate) more likely to approach, even when

Table 10. Factors influencing the probability of making a concerning communication.[8]

		95% Confidence interval for odds ratio		
Included variable	B (SE)	Lower	Odds Ratio (Exp(B))	Upper
Constant	**1.118 (0.171)****		3.058	
Disengaged	−0.451 (0.126)***	0.498	0.637	0.815
Mental illness	−0.237 (0.172)	0.563	0.789	1.104
Help-seeking	**0.498 (0.129)****	1.278	1.646	2.120
UK police record	**0.339 (0.124)****	1.102	1.404	1.789
History of violence	−0.408 (0.119)***	0.527	0.665	0.839

Note: *$p < .05$, **$p < .01$, ***$p < .001$, $N = 1664$, $R2 = .031$ (Cox & Snell), .044 (Nagelkerke). Model $\chi 2$ (5, $N = 1664$) = 52.153, $p < .001$. AIC = 135.810, BIC = 168.312. Bold represents a positive association and underlined represents a negative association.

Table 11. Factors influencing the probability of making a concerning approach.[10]

		95% Confidence interval for odds ratio		
Included variable	B (SE)	Lower	Odds Ratio (Exp(B))	Upper
Constant	−0.869 (0.161)***		0.419	
Disengaged	**0.534 (0.123)***	1.342	1.707	2.170
Mental illness	0.120 (0.162)	0.820	1.128	1.550
Help-seeking	−0.614 (0.126)***	0.423	0.541	0.692
UK police record	−0.195 (0.118)	0.652	0.823	1.037
History of violence	**0.386 (0.116)***	1.172	1.471	1.845

Note: *p < .05, **p < .01, ***p < .001, N = 1664, R^2 = .037 (Cox & Snell), .051 (Nagelkerke). Model χ^2 (5, N = 1664) = 62.162, p < .001. AIC = 137.198, BIC = 169.700. Bold represents a positive association and underlined represents a negative association.

Table 12. Factors influencing the probability of making both a concerning communication and approach.[10]

		95% Confidence interval for odds ratio		
Included variable	B (SE)	Lower	Odds Ratio (Exp(B))	Upper
Constant	−3.059 (0.352)***		0.047	
Disengaged	**0.627 (0.286)***	1.068	1.872	3.279
Mental illness	−0.529 (0.354)	0.294	0.589	1.180
Help-seeking	−1.124 (0.408)**	0.146	0.325	0.723
UK police record	**0.666 (0.271)***	1.145	1.946	3.308
History of violence	0.005 (0.287)	0.573	1.005	1.762

Note: *p < .05, **p < .01, ***p < .001, N = 1664, R^2 = .013 (Cox & Snell), .050 (Nagelkerke). Model χ^2 (5, N = 1664) = 22.560, p < .001, AIC = 78.311, BIC = 110.813. Bold represents a positive association and underlined represents a negative association. This is an imperfect model: for 3.6% of cases the standardised residuals were greater than 3, and for 5 cases the leverage statistic was high (>5 times the expected leverage). We decided against removing any cases that might be having a disproportionate effect on the model given they would be true outliers, data quality was checked to ensure no measurement error, and this data is not a subsample of referrals but all relevant referrals in a time period.

Table 13. Of those who make a concerning communication, factors influencing the probability of also making a concerning approach.

		95% Confidence interval for odds ratio		
Included variable	B (SE)	Lower	Odds Ratio (Exp(B))	Upper
Constant	−2.891 (0.400)***		0.056	
Disengaged	**0.793 (0.313)***	1.196	2.211	4.086
Mental illness	−0.446 (0.380)	0.304	0.640	1.350
Help-seeking	−1.046 (0.419)*	0.155	0.351	0.798
Angry/abusive content	−0.232 (0.327)	0.417	0.793	1.505
UK police record	0.240 (0.301)	0.705	1.271	2.293
History of violence	0.181 (0.320)	0.640	1.198	2.242
>10 communications	**0.798 (0.349)***	1.122	2.221	4.397
>1 method of communication	0.213 (0.425)	0.538	1.237	2.846

Note: *p < .05, **p < .01, ***p < .001, N = 1132, R^2 = .021 (Cox & Snell), .069 (Nagelkerke). Model χ^2 (8, N = 1132) = 24.491, p = .002, AIC = 167.386, BIC = 212.671. Bold represents a positive association and underlined represents a negative association. Direct threats and multiple targets had to be removed due to >20% of cells having an expected frequency of below 5 in their crosstabulation with approach. This is an imperfect model: for 3.9% of cases the standardised residuals were greater than 3, and for 7 cases the leverage statistic was high (>5 times the expected leverage). We decided against removing any cases that might be having a disproportionate effect on the model given they would be true outliers, data quality was checked to ensure no measurement error, and this data is not a subsample of referrals but all relevant referrals in a time period.

controlling for other factors consistently found in prior literature to be related to approach. Further, help-seeking motivations, a prior criminal record, and a lack of history of violence predict likelihood of communication, while a criminal record, history

Table 14. Of those who make a concerning approach, factors influencing the probability of breach-related behaviours.

		95% Confidence interval for odds ratio		
Included variable	B (SE)	Lower	Odds Ratio (Exp(B))	Upper
Failed breachers vs no attempt				
Constant	−0.408 (0.632)			
Unidentified mental illness	0.851 (0.546)	0.803	2.342	6.849
Previous mental hospital admission	−0.771 (0.245)**	0.286	0.463	0.748
Delusions	0.338 (0.268)	0.829	1.403	2.370
Grandiosity	0.090 (0.274)	0.639	1.094	1.873
Chaotic motivations	−0.560 (0.245)*	0.353	0.571	0.923
Successful breachers vs no attempt				
Constant	**1.247 (1.212)*** **		0.056	
Unidentified mental illness	**3.285 (1.033)****	**3.521**	**27.027**	**200.000**
Previous mental hospital admission	1.166 (0.790)	0.682	3.205	15.152
Delusions	−0.298 (0.612)	0.224	0.742	2.463
Grandiosity	0.516 (0.622)	0.496	1.675	5.682
Chaotic motivations	0.692 (0.558)	0.669	2.000	5.952
Successful breachers vs failed breachers				
Constant	**1.656 (1.212)*** **			
Unidentified mental illness	**2.433 (1.009)***	**1.580**	**11.364**	**83.333**
Previous mental hospital admission	**1.937 (0.805)***	**1.433**	**6.944**	**33.333**
Delusions	−0.636 (0.634)	0.153	0.529	1.835
Grandiosity	0.426 (0.643)	0.434	1.531	5.405
Chaotic motivations	**1.252 (0.577)***	**1.127**	**3.497**	**10.870**

Note: *$p < .05$, **$p < .01$, ***$p < .001$, $N = 358$, $R^2 = .091$ (Cox & Snell), .114 (Nagelkerke). Likelihood ratio test: χ^2 (10, $N = 358$) = 34.040, $p < .001$. AIC = 121.639, BIC = 168.206. Bold represents a positive association and underlined represents a negative association. Variables for angry/abusive communications removed as only relevant to communications. Variables for perceived persecution and resentful agenda motivations removed due to unreasonable standard errors.

of violence, excessive quantities of communications, and lack of help-seeking motivations predict likelihood of approach.

Table 14 shows the results of a multinomial logistic regression of those individuals who made an approach. The dependent variable is breach behaviours, and unidentified mental illness is included as an independent variable. Again, low values of R^2 reflect weak effect sizes in this model. However, there is some evidence that the model quality is satisfactory. The likelihood ratio test has a statistically significant result (χ^2 (10, $N = 358$) = 34.040, $p < .001$), which shows that the model explains a significant amount of variability in the data. Further, nonsignificant results in both Pearson (χ^2 (32, $N = 358$) = 23.590, $p = .859$) and Deviance (χ^2 (32, $N = 358$) = 24.496, $p = .741$) goodness-of-fit tests show that the model's expected values are not significantly different from observed values.

Regarding each variable's individual contribution to the entire model in predicting breach activity, likelihood ratio tests show unidentified mental illness (χ^2 (2, $N = 358$) = 10.545, $p = .005$) was significant, alongside previous mental hospital admission (χ^2 (2, $N = 358$) = 14.170, $p < .001$) and chaotic motivations (χ^2 (2, $N = 358$) = 7.945, $p = .019$). Other included variables did not make significant contributions to the model.

Table 14 shows that for those with unidentified mental illness, the odds of being a successful breacher are over 27 times higher than making no breach, and 11 times higher than a failed attempt. Interestingly, individuals with previous admission or chaotic motivations are more likely to make no attempt than a failed attempt, but more likely to succeed than fail.

Overall, these logistic regressions validate findings in bivariate analysis that disengaged individuals are more likely to approach, and those with unidentified illness are more likely to successfully breach when they do approach.

Discussion

Summary of findings

Fulfilment of safeguarding in the public health approach: does FTAC identify and treat unmet needs in individuals of concern?

Findings imply FTAC is identifying a significant minority of individuals of concern with unmet mental health needs: over 25% of this subsample of domestic referrals with available information on mental healthcare. This was either due to disengagement with prior mental health services or mental illnesses being so far unidentified. This aligns with James et al.'s (2010) initial findings concerning FTAC's first years of operation. The literature has for years established that individuals fixated with public figures have a very high mental health need (Barry-Walsh et al., 2020; James et al., 2007; 2008; 2009; 2011; Meloy et al., 2008; Scalora, Baumgartner, Callaway et al., 2002; Scalora, Baumgartner, Zimmerman et al., 2002; Scalora et al., 2003; van der Meer et al., 2012). In this study we begin work showing that this is often a need that is *unmet*. While other studies merely note a discrepancy between those currently and previously involved in services (Pathé et al., 2015; 2016; Riddle et al., 2019), often interpreting this as meaning needs *have* been sufficiently met (Fein & Vossekuil, 1999), here we show that it is possible to investigate the unmet needs concept further.

Those with unmet needs disproportionately have psychotic illnesses (schizophrenia, delusions, delusional disorders, grandiosity). This aligns with clinical literature explaining that delusional disorders are often highly encapsulated, meaning individuals can function normally in daily life and do not present significant behavioural problems, and can therefore evade identification or judgements by professionals that treatment is necessary (James, Kerrigan et al., 2010; Wilson et al., 2018). Further, those with delusional disorders can be particularly difficult to engage in treatment (although just as likely to respond successfully when treated) because they are so certain there is nothing wrong with them (Munro, 1999), also explaining the disengagement relationship (Dietz & Martell, 1989; James, Kerrigan et al., 2010; Sizoo & van Nobelen, 2021).

Regarding interventions, those with unmet mental health needs are disproportionately directed towards mental health-based interventions, rather than police or criminal justice-based interventions. They also disproportionately have their judged concern level reduced following intervention. This implies that, in FTAC's judgement, these interventions are to some extent effective in reducing concern for problematic behaviours, as their risk stemmed from lack of treatment or contact with services. Altogether, this implies that FTAC is operating according to its stated public health approach. They are identifying a significant minority of individuals with unmet mental health needs (particularly psychotic illnesses), and catalysing appropriate mental health services to those who evaded sufficient treatment by mainstream services. Thus, they are meeting treatment needs for the individual's benefit while reducing risk of the overall group without predicting who would have gone on to commit violence (Barry-Walsh et al., 2020; James et al.,

2008; 2009; 2013; Wilson et al., 2021). Essentially, FTAC's violence prevention role is achieved through being a strong treatment advocate for people with psychosis who have fallen through the cracks in mainstream services.

Are unmet needs relevant to violence prevention?

Those with unmet needs are regarded by FTAC as being disproportionately of moderate concern. This aligns with their behaviour, as validated in bivariate and multivariate analysis. Disengaged individuals are more likely to approach, and when they do so exhibit threatening language, intimidating behaviour, or questioning of security procedures. Those with unidentified illnesses are more likely to successfully breach security barriers when approaching. Altogether, those with unmet needs represent a subgroup of referrals who are disproportionately disruptive and concerning for proxies for violent behaviour. This validates the many studies that argue for the need to disaggregate the 'risk of what' (Gill et al., 2021). It also largely aligns with the only comparable study that looks at unmet needs (van der Meer et al., 2012), which found that non-engagement with recommended treatment was linked to approach in addition to communication, and successful breaching of security barriers.

However, there is a slight mismatch between the concerning behaviours carried out and the judgements of concern. Those with unmet needs are not judged to be of particular concern for any specific outcomes except violence to the police and embarrassment to the public figure. Being likely to approach, exhibit concerning and threatening behaviour, and breach security barriers implies they should potentially be regarded as more concerning for outcomes reflective of this (disruption of events, psychological harm to principal, violence to principal, wasting resources, excessive time consumption, for example). Perhaps this highlights that, while FTAC is built on the public health approach, staff could appreciate further the disproportionate risk posed by this unmet needs subgroup.

Implications for practice and research

The main implications for practice are threefold. Firstly, the safeguarding of unmet mental health needs is a worthwhile endeavour in (fixated) threat assessment practice, given its isolation of a disproportionately disruptive and potentially violent subgroup often suffering from untreated psychosic illnesses. This aligns with previous findings of the reduction in violent crime associated with psychosis treatment (Fazel et al., 2014). Secondly, unmet needs are identified and treated with direction to (mental) health services. FTAC does disproportionately deliver (mental) health-based outcomes to those disproportionately in need of it, showing empirically how FTAC adheres to the public health approach and provides a beneficial service to individuals referred. Finally, unmet needs should perhaps be given *more* attention in practice when making judgements of level and type of concern for future problematic behaviour, to align with the concerning behaviours that are disproportionately exhibited by this subgroup.

Findings imply research should consider using unmet needs measures as a variable and potential risk factor. In many areas, decades of studies have attempted to understand the causal role or relevance of mental illness to violence risk, where there is a clear high

prevalence of mental illness in offenders. Research has posited mental illness should not be treated as a singular concept, and has, for example, found more validated relationships for either serious mental illness, specific disorders, or specific symptomatology (Schoeneman et al., 2011). Findings here highlight that it may not (only) be specific disorders that have isolated relationships with behaviour, but when these disorders are insufficiently treated by services. It is also clear that the concept of unmet needs itself is worth disaggregating, due to the different relationships found for those disengaged from services and those whose illnesses have never been identified. There is at least one more form of unmet need, which is an unknown in this dataset (Meloy et al., 2010): mentally ill individuals who have had contact with services, been engaged with and suitable for them, but where treatment has been ineffective or they have been non-responsive to treatment. This is an aspect that remains unstudied.

Limitations

This study overcomes the limitations of prior analysis of threat assessment units' operation, primarily due to the large sample size available. It also shares limitations with other studies using the same or similar data: outdated data, missing data, interrater reliability in coding of variables, and a bias in less information being collected on the cases that are low concern, as these are not progressed by FTAC (Clemmow et al., 2021; Meloy et al., 2010). Regarding the specific sample, there are some selection effects as findings are only reported for the subsample of referrals that were not international and for which there was information on either previous or at-time-of-referral mental healthcare, to enable analysis.

Other unique limitations affect these findings. There is no available counterfactual, meaning it remains undetermined what would have happened to referrals if they had not been referred to FTAC, as they feasibly could have gained access to necessary services and reaped resulting benefits without FTAC intervention. Some measures are underestimates; for example, FTAC only obtains mental health information for cases that are initially sufficiently high concern and therefore require thorough assessment. Measures of 'concern' used are not outcome behaviours or objective measures, but judgements of concern by FTAC professionals. These could be biased, for example in rating those who have disengaged as higher concern due to FTAC's foundational principle being meeting unmet needs. This analysis is therefore subject to the same limitation as others that use concern changes as an indication of effectiveness (James, Kerrigan et al., 2010; Pathé et al., 2015; Riddle et al., 2019). We do attempt to overcome this by examining objective concerning behaviours, and indeed find a discrepancy between judgments and behaviour. For reductions in concern following mental health treatment, there is again some subjectivity and bias. FTAC clinicians believing that untreated psychosis is driver of concerning behaviour are of course likely to record lower concern when they have got that individual into appropriate treatment. Overall, this subjectivity limitation means findings are unable to answer the question of whether interventions do reduce risk or concerning behaviours, which requires quasi-experimental analysis (James & Farnham, 2016; Sizoo & van Nobelen, 2021).

Most importantly, while findings show there is a relationship between unmet mental health needs and concerning behaviours, the causal link here is unclear. Mental illness

could be a cause of, result of, or unrelated to violence risk (Corner et al., 2018). It could be that mental illnesses being insufficiently treated causes individuals to act more inappropriately through enhancing motivations, capacity, or disinhibition, and therefore come to FTAC attention through more concerning behaviours. Or it may be that unmet needs are *caused* by involvement in concerning behaviours; preoccupation with delusional fixations on public figures may make individuals less likely to seek professional help or engage with services due to the time and resources committed to this, or due to this activity to some extent meeting their mental health need. Alternatively, there could be a confounding factor such as social isolation, homelessness, or socioeconomic problems that is associated with both unmet needs and concerning behaviours (Sizoo & van Nobelen, 2021). To understand a causal role would require future qualitative or case study-based work. However, there is substantial literature on the relationship between violence and psychosis with odds ratios in the region of 5 (Douglas et al., 2009; Large & Nielssen, 2011; Witt et al., 2013), and the FTAC cohort are predominantly a group of people with psychotic illnesses.

Overall, while findings from this exploratory study go some way to implying that safeguarding and attention to unmet mental health needs in threat assessment is both valuable for violence prevention and carried out in fulfilment of the public health approach, these findings are extremely limited. They apply only to fixated threats, where there is a uniquely high consensus for the role of severe mental illness in concerning behaviours, and only to FTAC, which places uniquely explicit attention on the public health approach and needs being insufficiently met by mainstream services. Future research should apply similar questions to other threat assessment units in operation, and of other offence types.

Conclusions

Although a necessary part of justifying safeguarding's role in violence prevention, and to ensure interventions benefit individuals referred, analysis of threat assessment safeguarding practices is lacking. For fixated threats in particular, there is insufficient attention given to unmet mental health needs and insufficient rigorous analysis of outcomes for individuals. This study begins exploratory work into these questions, analysing the value and fulfilment of FTAC's public health approach through examining the concept of unmet mental health needs.

The substantial minority of FTAC cases that have unmet needs are disproportionately directed to (mental) health-based interventions, which reduces their judged level of concern, and suggests support for FTAC's fulfilment of the public health approach. Unmet needs are also worthy of attention in threat assessment for violence prevention, as they isolate a disproportionately concerning and disruptive behavioural subgroup. Different forms of unmet needs are related to approach and, when approaching, problematic behaviour and breaching of security barriers.

These findings support the value and fulfilment of safeguarding within fixated threat assessment. Measures of unmet needs have potential as a risk factor for concerning behaviour in this space and should be given more attention in assessments of levels of concern. Future research should explicitly use unmet mental health needs as a variable, to validate these findings and examine their application to other offence types.

Notes

1. 'Disengagement' here is therefore most similar to the non-engagement variable used by van der Meer et al. (2012).
2. (Mental) health-based interventions include referral to community mental health team, referral to GP, referral to international medical team, sectioned under the mental health act by FTAC or other police, hospital detention, or voluntary admission to hospital. Police or criminal justice-based interventions include arrest, briefing note circulated amongst police/criminal intelligence, referral to international or UK police, information about individual circulated across PNC, referral to WICU, individual issued with an ASBO, or individual subject to criminal proceedings. Other interventions include FTAC staff attended a visit at the individual's home, FTAC staff convened a meeting with other service professionals to discuss individual, FTAC staff met individual in a public place such as a coffee shop, stalking risk assessment/FAST assessment conducted, police offered advice to individual, or individual referred to single access path.
3. Other judgements of concern present in the dataset included risk of persistence, escalation, violence, and disruption. These were not included in analysis due to extremely small frequencies.
4. Concerning approach: the person posed no problem and was not violent, but appeared bizarre or acted in a way which caused sufficient concern to bring them to police attention.
5. Problematic approach: the person used threatening language, behaved in an intimidating fashion, or talked about security procedures: but no actual violence or attempted violence occurred, and this was not simply a 'concerning approach'.
6. Violent approach: the person was involved in an attempted or actual assault on anyone.
7. Behaviour related to breaching of security barriers is treated as 3 subgroups (approach without breach attempt, failed breach, successful breach) as prior research indicates these are distinct subgroups, rather than there being a group that tends to attempt breaching, where some succeed and some fail (James et al., 2011).
8. As Tables 10–12 involve the full sample and not only those who communicate, control variables that apply only to communication behaviours (direct threats, angry/abusive content, number of communications, number of communication methods, and number of targets of communication) were excluded. Table 13 then limits attention to those who did communicate, so these variables are reintroduced.

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Data availability statement

Data cannot be made available due to security clearances associated with access to data.

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