Towards a national strategy for managing fixated persons in Australia

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Pathological fixations targeting public figures such as politicians can lead to harassment or stalking and result in distress, disruption and dignity issues, potentially placing public figures, their staff and their families at risk of serious harm. Fixated individuals often suffer from mental health issues and may cause harm to themselves and others if untreated. In both the United Kingdom (UK) and Queensland, Australia, units that assess, manage and mitigate threats posed by fixated individuals have successfully employed a joint approach between police and mental health professionals to identify individuals who raise significant concerns. The Australian Federal Police (AFP) set up a unit in 2016 with a national remit to assess and manage harassing behaviour towards Australian Commonwealth High Office Holders. The first year of operational outcomes shows that whilst such units can be effective at managing fixated behaviour, there are challenges in doing so across multiple health and policing jurisdictions.

Key words: fixation; politicians; public figure harassment; stalking; mental health; threat assessment; threat management; mental illness; early intervention; risk assessment.

Fixation and the threat to public figures

Fascination with public figures, whether they be royalty, celebrities or politicians, can sometimes become pathological. The concept of fixation – defined as an obsession or pre-occupation with a person or cause, pursued to an extreme or irrational degree (Mullen, Pathé, & Purcell, 2009) – arose from the stalking literature and is seen in those individuals who send harassing correspondence or otherwise intrude upon public figures. More often than not, individuals who make problematic contact with politicians are fixated on a personalised cause or grievance, rather than on the public figures themselves (James et al., 2007; Meloy, Mohandie, &

McGowan, 2008). The politician may be seen as a source of support, an avenue through which to address a grievance, an impediment towards achieving an outcome or the target of displaced anger and blame (Mullen et al., 2009).

Harassment and stalking behaviours are commonly experienced by public office holders. In their study of Queensland state politicians, Pathé, Phillips, Perdacher, and Heffernan (2013) found that 93% of respondents reported experiencing some form of harassment. In a study of New Zealand members of parliament (MPs), 87% reported experiencing some form of harassing behaviour from members of the public. Those surveyed

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commonly reported experiencing psychological harm and disruption as a result of the harassing behaviour (Every-Palmer, Barry-Walsh, & Pathé, 2015). However, previous research suggests that the family members and staff of public office holders are also targeted by fixated individuals (Every-Palmer et al., 2015; James et al., 2016; Lowry et al., 2015).

Historically, the risks associated with individuals who correspond with public figures have not been well recognised, as there were no systems in place to identify which of these individuals might be more likely to go on to approach or attack public figures. The risk of politicians being stalked and harassed is higher than that of the general population (Dietz et al., 1991; Mohandie, Meloy, Green-McGowan, & Williams, 2006) and of celebrity figures (Fein & Vossekuil, 1997; Hoffmann, Meloy, Guldinann, & Ermer, 2011; James, Farnham, & Wilson, 2014). Politicians are also at greater risk of being physically attacked (James et al., 2014). Lone, fixated individuals have been shown to pose the most risk of harm to Western politicians (James et al., 2011; Meloy et al., 2004; Mullen et al., 2009; Scalora et al., 2002).

Studies of attacks on public figures have established that at least half of those individuals who committed attacks demonstrated some prior warning behaviours (James et al., 2008, 2014). Although direct threats are uncommon antecedents in public figure attacks (James et al., 2007; Meloy & Amman, 2016; Meloy et al., 2004), other behaviours such as written correspondence, lone protests, statements of intent to others and approaches to the public figure are more common (Hoffmann et al., 2011; James et al., 2008; Meloy, Hoffmann, Guldinann, & James, 2012; Scalora et al., 2002; Schoeneman et al., 2011).

Attackers of public figures have also been shown to have relatively high rates of mental illness (Hoffmann et al., 2011; James et al., 2008) and many fixated individuals have fallen out of ongoing mental health care or treatment (James, Kerrigan, et al., 2010). Therefore, for

those individuals whose fixated behaviours are being driven by mental illness, appropriate mental health intervention may be the most effective way of reducing the threat posed to public office holders and their family and staff, the broader community, and the fixated individuals themselves (James et al., 2014). Consequently, having trained mental health professionals on hand to identify any signs and symptoms of mental illness that may be evident in individuals' correspondence and interactions with government agencies is essential. This allows for those mentally unwell individuals to be appropriately identified and referred for further mental health assessment and intervention, effectively enabling a multi-agency response to a health and security issue (James et al., 2014).

The Fixated Threat Assessment Centre (FTAC)

The Fixated Research Group (2006) reviewed 15 years' worth of correspondence sent to the British royal family and conducted an extensive review on the literature relating to public figure threats and attacks, particularly those on politicians and royalty. Findings from the research of James et al. (2007) showed that the main threat to public figures in Western countries is from lone individuals, most likely suffering from a mental illness, who are fixated on a personal grievance. The Fixated Threat Assessment Centre (FTAC) in the United Kingdom (UK) was then set up in 2006 as a joint initiative between the Metropolitan Police and the National Health Service (NHS). It was the first unit of its kind, incorporating police and mental health personnel to jointly assess and manage lone, fixated individuals who display an unusual or obsessive interest in the royal family and senior politicians (James, Kerrigan, et al., 2010). Building on the work of Scalora and colleagues (later published as Scalora, Zimmerman, & Wells, 2008), a risk aide-memoire was developed to assist in screening and managing these cases. Since the

British royal family receives thousands of letters every year, a screening tool assists in identifying and prioritising cases of concern. Given the high proportion of fixated individuals who had been found to be mentally ill in studies undertaken by the Fixated Research Group, a model was thus implemented by FTAC whereby psychiatrically unwell individuals could be identified and diverted into treatment prior to the occurrence of an adverse event.

The Queensland Fixated Threat Assessment Centre (QFTAC)

The Queensland Fixated Threat Assessment Centre (QFTAC) was established in Queensland, Australia in 2013. The unit was a joint initiative between the Queensland Police Service and the Queensland Forensic Mental Health Service. QFTAC was the first such unit in Australia, and utilises a similar methodology to that of FTAC. QFTAC accepted 145 referrals within its first year of operations, and has now expanded to assess and manage the threat of violence from lone, grievance-fuelled actors (Pathé et al., 2017).

The Australian Federal Police Fixated Threat Assessment Team (AFP FTAT)

The Australian Federal Police Fixated Threat Assessment Team (AFP FTAT) is organisationally situated within the AFP's protection operations as part of the national security framework. The core function of AFP FTAT is to reduce the risk of harm from fixated individuals who seek to target protected establishments, high office holders (HOHs, i.e. members of the Australian Federal Parliament, including the prime minister and cabinet members, senators and the governor-general) and Commonwealth public officials who fall under the AFP's protection remit. AFP FTAT has a national remit for assessing and managing fixated persons who target Commonwealth interests, and as such the team liaises with state police and health services across Australia.

AFP FTAT commenced operations in April 2016, accepting referrals from other areas of the AFP, including those that have direct contact with HOHs and their staff via parliamentary and electoral offices. This also includes protected establishments such as the Australian Parliament House, embassies and consulates and a number of sites where the AFP provides a protective role.

Staffing and operational structure

The AFP FTAT staffing structure consists of a sworn team leader, a sworn leading senior constable, an AFP-appointed clinical psychologist and a psychologist seconded under arrangement with the Australian Capital Territory (ACT) Mental Health, Justice Health and Alcohol & Drug Services.

Method

Number and source of referrals assessed

In the first year of operations (1 April 2016 to 31 March 2017), AFP FTAT received 263 referrals from stakeholders via the AFP regional protection liaison teams and the protection assessment team in Canberra. Referrals were received from ministerial and electoral offices, established law enforcement reporting lines and agency partners.

Assessment methods

All referrals were assessed jointly by a police officer and a psychologist. Referrals were assessed using the risk aide-memoire adapted from FTAC for use by QFTAC. The risk aide-memoire is a screening and case prioritisation tool that provides a structure to aid in the clinical assessment of the currently known information. Screening tools also assist in allocating resources appropriately. Such information typically comprises police holdings, open source information and mental health holdings if applicable. Subsequently, a concern level is determined (low, moderate or high) which establishes whether or not

intervention is required, and the urgency of undertaking any intervention. Where the case is assessed as a low concern, feedback is provided to the referrer and no further action is taken by FTAT. Cases assessed as a moderate or high concern however are then directly managed by FTAT.

Information-sharing

The AFP and state police services have arrangements in place to share information about operational matters, and each state police service has information-sharing protocols for cooperating with their counterpart health service. In the ACT, the AFP/ACT policing has a memorandum of understanding (MoU; see Memorandum of Understanding, 2016) relating to information-sharing, and the ACT Health clinician in FTAT is able to provide relevant information from the ACT mental health record system according to the guidelines set out in the MoU. FTAT also exchanges information in accordance with the *Australian Federal Police Act 1979 (Cth)* and *Privacy Act 1988 (Cth)*.

Case management

Once cases have been assessed as a moderate or high concern, possible case management strategies are then identified and discussed within the team, and the most appropriate course of action is then taken. Strategies include referral to acute and community mental health services or private health practitioners (e.g. psychologists, psychiatrists, general practitioners). In some cases, direct assessment face to face or via telephone is undertaken. Other strategies include applying for mental health assessment orders, policing interventions and providing information and advice to services (e.g. government departments, public office holders) regarding strategies for managing the fixated individual.

Hypotheses and variables explored

A referral database was created for AFP FTAT cases. Information was recorded for each referral on age, gender, the protected entity that was the target of the correspondence and his or her ministerial portfolio (if applicable), the jurisdiction in which the referred individual resided and whether or not the individual had travelled during the course of the referral (in particular whether or not he or she had travelled to the ACT) to seek proximity to the target. Information was also recorded regarding the mode of the correspondence and whether or not there had been more than one mode, the target of the fixation (person or cause), criminal history and police contact, history of mental health contact and whether or not the individual was being managed by a mental health service at the time of referral, the type of intervention provided by FTAT and any psychiatric diagnosis if applicable. Information was sourced from national police indices, health service databases where appropriate and other sources if available (e.g. open sources, family members and private health practitioners).

Results

Of the 263 referrals received by AFP FTAT, 36 were considered by FTAT and forwarded to QFTAC for further action, primarily where the person of interest resided in Queensland and the referral fell within their operational remit. The remaining referrals were assessed and managed by AFP FTAT. The following data pertain to the 76 referrals assessed as having a moderate or high level of concern. Where cases were initially assessed as being of low concern, feedback was provided to the referrer and the cases were not managed by AFP FTAT.

Age and gender

The majority of individuals referred to AFP FTAT were male (87%). The age of the individuals ranged from 26 to 68 years, with an

average age of 47 years. Only 7% of referrals were aged 30 years and under, 26% were between 31 and 40 years, 34% were between 41 and 50 years, 29% were between 51 and 60 years and just 4% were 61 years and over.

Prior contact with police and mental health services

A high proportion of the individuals referred (88%) were known to the police prior to their referral to AFP FTAT. Examples of previous contact with the police include criminal charges, welfare checks and instances where previous correspondence or other concerns had been reported to the police. In 36% of cases, the individual had a history of serious violence (defined as assault occasioning actual or grievous bodily harm, manslaughter, attempted murder, murder). The majority of individuals referred were also known to mental health services, with 86% having had prior contact with a public mental health service. In 75% of cases, the individual was known to both the police and mental health services. However, only 35% of cases judged at referral to have a mental disorder were being actively managed by a mental health service when referred to FTAT, again highlighting the significant number of individuals that were potentially not receiving any mental health care at the time they had come to FTAT's attention.

Targets of correspondence

The targets of correspondence included MPs (33%), the prime minister (13%), other office holders or figures included in the AFP protection remit (11%), embassies (9%), senators (8%), the British royal household (5%), the AFP executive (4%), protected establishments (4%), the judiciary (3%) and the governor-general (1%). In 9% of cases there were multiple targets.

Type of contact

There were a number of modes of contact in the cases referred to FTAT. The most frequent

was email (37%), followed by phone calls (22%), approaches to MP electoral offices (11%), approaches to protected establishments (9%), typed letters (5%), handwritten letters (4%), direct approach to a HOH (4%), text messages (3%), approaches to embassies (1%) and approaches to the police (1%). In 3% of cases, approaches occurred at another venue. In 32% of cases, another mode of contact was recorded after the initial referral to FTAT.

Motivation

The majority of the individuals referred were fixated on a cause (70%) rather than a person (11%). In the remainder of cases (19%) the motivation of the individual could not be clearly identified.

Concern level at intake vs closure

Of the cases initially assessed as having a moderate or high level of concern, the majority (88%) were reduced to a low level of concern and closed as the result of active case management. Of the referrals initially assessed as a moderate concern (29% of total referrals), 87% were managed to a low concern prior to closure, and the remainder continued to be case managed. Of the referrals assessed as high (13% of total referrals), 91% were managed to low and a further 9% were managed to moderate and continued to be managed by AFP FTAT.

Referrals by jurisdiction

The individuals referred to AFP FTAT resided across all Australian states and territories, with the exception of the Northern Territory. Victoria had the highest number of referrals (37%), followed by New South Wales (24%), the ACT (12%), Western Australia (12%), South Australia (11%), Queensland (4%) and Tasmania (1%).

Table 1. Primary psychiatric diagnosis ($n = 66$).

Primary diagnosis	%
Psychotic disorder	65
Affective disorder	14
Personality disorder	5
Adjustment disorder	4
Substance use disorder	4
Acquired brain injury	3
Anxiety disorder	3

Travel to ACT

Seven individuals (9% of the cases managed) travelled to Canberra, ACT from other states in Australia. Six of these individuals made approaches to establishments falling under the AFP protection remit, including the Australian Parliament House, embassies and other government buildings. The longest distance travelled was a total of almost 6000 km (a 22-hour plane and car journey).

Primary diagnosis

Table 1 describes the primary psychiatric diagnosis which was identified in 87% of the cases managed by AFP FTAT.

Intervention

A number of intervention strategies were utilised by AFP FTAT, primarily involving either mental health or policing interventions. In 34% of cases, the individuals were referred to community mental health services for further assessment and intervention. A further 24% of cases involved inpatient psychiatric admission as a direct result of FTAT referral to mental health services. Assessment order application for mandated psychiatric assessment was made by FTAT in 1% of cases. Referral to private practitioners (e.g. psychologists, psychiatrists, general practitioners) was completed for 5% of cases, and in 1% of cases the individuals were referred for both police and community mental health intervention. FTAT conducted a home visit in the Canberra area

for direct assessment in one case, which later resulted in inpatient admission, and direct assessments were conducted by telephone in 5% of cases. Individuals in 26% of cases were referred to either state police or the AFP for further action, as there was no mental health involvement indicated or available. The remaining 4% of cases were managed using multiple interventions.

Intervention vs primary diagnosis

Of the individuals presenting with a psychotic illness, 47% were referred to a community mental health service, 30% were admitted to inpatient psychiatric care, 12% were managed by police intervention (such as protection orders, criminal charges, warnings, etc.), 5% were referred to a private practitioner, 2% had an assessment order completed, 2% had a face-to-face assessment and 2% were managed by a combination of public mental health referral, police liaison and private practitioner care. For those diagnosed with a mood disorder, 33% were admitted to inpatient care, 33% were managed by police liaison in the first instance, 23% were referred to private practitioners and 11% had a telephone assessment (Table 2).

In the cases where the individual presented with a personality disorder, 50% were managed by police intervention, 25% were managed by community mental health referral and 25% were managed by both police and community mental health services. Substance use disorders were referred to community mental health (33%), inpatient admission (33%) and police liaison (33%). Adjustment disorder cases were managed by police liaison (67%) and phone assessment (33%). Anxiety disorder cases were admitted to inpatient care (50%) or managed by police intervention (50%). Acquired brain injury cases were referred to community mental health (50%) or managed by phone assessment (50%). Where diagnosis was unknown or not available, 60% of cases were managed by police intervention, 30% were managed by community mental health

Table 2. Intervention type vs primary psychiatric diagnosis for the managed cases ($n = 76$).

	Diagnosis						
	ABI	Adjustment	Affective	Anxiety	Personality disorder	Psychotic	Substance use
Intervention type (%)							
Assessment order	—	—	—	—	—	2	—
Community mental health service	50	—	—	—	25	47	33
Home visit	—	—	—	—	—	2	—
Inpatient admission	—	—	33	50	—	30	—
Phone assessment	50	33	11	—	—	—	10
Police liaison	—	67	33	50	50	12	60
Private practitioner	—	—	23	—	—	5	—
Multiple	—	—	—	—	25	2	—

referral and 10% were managed by phone assessment.

Case study

AFP FTAT received a referral for an individual who was displaying a number of indicators of fixated behaviour towards Commonwealth HOHs. It became apparent that the correspondence demonstrated an escalation when compared with earlier emails, and the last two emails had contained direct threats to a specific HOH. The individual was recorded on police indices as having a history of 'mental health issues'. His whereabouts were unknown as he was believed to be transient.

Following the initial AFP FTAT assessment, the individual was assessed as representing a high level of concern. AFP FTAT liaised with mental health services and it was established that he was in breach of a community mental health treatment order. This information had not previously been known to the police. The individual was located several days later by the police and conveyed to hospital under the breach of the treatment order. He was given leave the next morning and promptly absconded from care. Over the course of a few weeks, the individual came to the attention of the police in various locations across several state jurisdictions. Community mental health orders are not transferable or visible to other jurisdictions, including within the subject's home state. At one point the individual came to the attention of a health service; however, because the health authority was in a different catchment area, the professionals who interacted with him were unaware that he was in breach of treatment order.

AFP FTAT commenced engagement with partner agencies across three jurisdictions, providing information about the individual's history of fixated behaviour and recent deterioration, advocating for urgent action to be taken before the individual was hospitalised and later transferred back to a mental health ward in his home state. He appeared to demonstrate some level of cooperation with treatment

at this point. He remains engaged in community-based mental health treatment after a lengthy admission and has not corresponded with any HOHs since treatment began. AFP FTAT now assess him as a low concern.

Discussion and future directions

Summary of results

Although the predominant focus is on HOHs, the findings from AFP FTAT's first year of operations are largely consistent with those from similar services already operating in the UK and Queensland. The majority of referrals received by AFP FTAT were for middle-aged males with a personalised cause and a mental illness influencing their fixated behaviour. These individuals are likely to already be known to the police and to have had some previous contact with a mental health service, although it is unlikely that they are being actively managed at the time of their referral to AFP FTAT. A large number of individuals were already known to both the police and mental health services. Most harassing communication occurred in writing, although a proportion of individuals had made approaches to either a protected establishment or a public figure, increasing the likelihood that they had come into prior contact with the police. Some had shown considerable commitment to their cause, travelling significant distances to make contact with the HOH. The number of cases AFP FTAT was able to reduce to a low concern, predominantly through the facilitation of mental health care, is further support for the efficacy of the model of joint intervention strategies for managing fixated individuals. As AFP FTAT continues its operations, further data may be able to demonstrate whether or not persistence and recurrence are addressed by the FTAT model over time.

Challenges of multijurisdictional and multiagency management

There are a number of challenges that are unique to a service that accepts and manages

referrals across the whole of Australia, as the country has a federal system of government comprising state police and health services, as well as a national police service (the AFP). Each state has its own mental health legislation, with variations regarding how treatment can be mandated and how information can be shared between agencies. There is limited recognition of community mental health orders between jurisdictions, meaning that an individual being treated involuntarily in one state can easily fall out of mental health care when travelling to another state. Further, each Australian state jurisdiction maintains its own medical record systems, with no mechanism for real-time access to interstate records unless an individual clinician identifies the need to do so and makes the necessary contact with other mental health services. This becomes problematic in managing mentally ill fixated individuals who travel across jurisdictional borders, as police and health services may be unaware of any history of mental illness or of any fixated behaviours towards public figures.

Face-to-face assessments of individuals residing in or visiting the ACT can be undertaken more readily, as AFP FTAT is based in Canberra. The practicalities of conducting face-to-face assessments across a country as geographically large as Australia somewhat limits the team's ability to do so outside of the ACT. Thus, in most cases where face-to-face assessment is indicated, a referral is made to the individual's local mental health services. A number of challenges are also presented by cases wherein there is some evidence of mental illness but the individual does not meet the threshold for involuntary assessment in their jurisdiction. Provisions for involuntary assessment vary somewhat between state jurisdictions, and if an individual is not accepted by a service for treatment because he or she declines, engagement in fixated behaviours is likely to continue. From a threat management perspective this issue can be challenging in cases where it is evident that an untreated

mental illness is driving the behaviour, yet the avenues to address it (i.e. mental health care) are not accessible. Police intervention is, in some such cases, the most effective option when significant concerns are raised and the individual resides outside of Canberra.

Issues with the underreporting of harassing correspondence

Given that many politicians are frequently subjected to harassing and stalking behaviours from disgruntled constituents (Every-Palmer et al., 2015; Pathé et al., 2013) there may be a high threshold for the referral of such behaviours to policing agencies such as the AFP. A number of referrals received by FTAT were regarding emails sent by fixated individuals to multiple HOHs and other public office holders – yet, in many circumstances only one office holder referred the correspondence to the police. Therefore, it appears likely that only a relatively low percentage of concerning correspondence is referred to FTAT. As the team is able to provide more information and education to referral partners about the nature of fixated behaviours and its associated risks, the number of cases referred, assessed and managed by FTAT may increase.

Travel to Canberra and the potential for direct intervention

Earlier findings on public figure stalking suggest that those who go on to attack have made previous approaches to their target (James et al., 2007, 2008). For instance, Scalora et al. (2002) examined 315 cases of threats and inappropriate communications towards members of the United States (US) congress, finding that attacks are associated with a history of prior contact with law enforcement and using multiple modes of communication. There is also less likelihood of a threat being communicated prior to attack. Approach behaviour has also been shown to be related to serious mental illness, grandiosity and a sense of entitlement

to the public figure (James, Meloy, et al., 2010).

The results of this study demonstrate that establishments such as the Australian Parliament House are something of an attraction for fixated individuals who seek to target Commonwealth HOHs and other public officials. A number of persons travelled to Canberra to pursue their grievance or cause, sometimes over significant distances and at great personal expense. The detection of approaches to protected establishments by fixated individuals provides an opportunity for engagement and intervention where there may be risks of escalation, disruption, persistence and distress.

Conclusion

The results of this study add further weight to the efficacy of a multidisciplinary model for managing fixated behaviours towards public office holders. Further efforts to address the challenges presented by the federated system of Australian government will hopefully assist in dealing with the problem of managing fixated persons in Australia, particularly in terms of those individuals who may require mental health care. Opportunities for intervention should be sought, where possible, prior to the individual reaching crisis point. This will not only reduce the risks posed to the HOHs and those around them but also the risks to the fixated individuals themselves, whose quality of life may be seriously compromised by their obsessive preoccupations and untreated mental illness.

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Ethical approval

This article does not contain any studies with human participants or animals performed by any of the authors.

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No potential conflict of interest was reported by the authors.

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