



Southport Phase 2 Survey Analysis Report

4 September 2026

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Executive summary

Foreword

- **This report sets out the findings of an independent analysis of eight surveys, commissioned by the Southport Inquiry,** to examine how the services most likely to encounter violence-fixated individuals (VFIs) - spanning health, education, local authorities, and statutory multi-agency bodies - understand this risk, and how well-equipped they feel to identify and respond to it.
- **In total, 802 usable responses were received across CAMHS, FCAMHS, Channel, Counter Terrorism Policing (CTP), Designated Safeguarding Leads (DSLs), Local Authority (LA) practitioners, LA senior leaders, and Multi-Agency Public Protection Arrangements (MAPPA).** The analysis combines both quantitative and qualitative analytical methods, including statistical analysis of closed survey questions and thematic analysis of open-text responses. This allows to set out both the scale of the issues identified and the practitioner experience that underpins them. The key findings are summarised below, organised under three themes: (1) preparedness and capability, (2) frameworks, thresholds and responsibility, and (3) capacity, coordination and support.

(1) Preparedness and capability

- **Overall preparedness to identify and manage violence-fixation (VF) risk cases is determined by VFIs being part of a service's remit.** DSLs, FCAMHS and LA practitioners report the highest preparedness, while CAMHS, Channel and MAPPA report the lowest. This suggests an important distinction between services with a specialist role and those where VFI is one of many risks practitioners manage.
- **No surveyed service reports a strong, confident understanding of VFIs, with the exception of CTP units who report the highest confidence in having a shared understanding.** This is most pronounced in CAMHS, where confidence is lower than in both DSL and LA practitioner services, and several CAMHS and LA practitioner respondents reported never having encountered the term 'VFI' before completing the survey.
- **Practitioners do not consider existing clinical tools adequate for identifying 'risk posed to others'.** CAMHS and FCAMHS clinicians report limitations in how well current assessment frameworks identify this risk. Reviewing a young person's digital or online behaviour is amongst the least commonly used assessment methods in both services. This is despite online indicators being reported as common in the majority of VFI cases encountered by these services.

(2) Frameworks, thresholds and responsibility

- **The current CTP structure is seen as unsuited and ineffective for VF-related risk.** The majority of CTP units reported that their structures are not well suited to managing non-ideological VF risk, while all CTP units agreed that the current arrangements are ineffective in practice. Respondents noted that counter-terrorism mechanisms were designed around vulnerability to terrorism rather than non-ideological violence fixation.
- **Some high-risk individuals currently fall outside current thresholds.** The majority of MAPPA respondents reported that they were aware of individuals presenting a high risk of serious violence who do not meet MAPPA thresholds, while believing that MAPPA should play a greater role in managing these cases. CTP units also identified age and consent requirements as barriers, suggesting some high-risk individuals lack a clear route for ongoing risk management.
- **Responsibility for managing VFI cases is often unclear, with no single agency consistently taking the lead.** Only one in three of CAMHS respondents said a lead agency is clearly identified in high-risk cases, while less than one in five of DSL respondents said a single agency is designated. Even within FCAMHS, fewer than half said a lead agency is typically identified for cases involving risk posed to others. This suggests strong evidence of gaps in ownership across the system.

(3) Capacity, coordination, and support

- Even if tailored structures are developed, services need more capacity and resources to manage VFI cohort. **Limited capacity and resources to manage VFI cases were the most commonly cited barriers across the services surveyed.** This indicates that effective VF risk management depends not only on guidance and practitioner capability, but also on sufficient capacity and specialist resources.
- **Partners rate their own information sharing more positively than the information they receive from others.** The overwhelming majority of CAMHS respondents (94%) rated their own information sharing as adequate or high quality, compared with 56% for information received from partners. The equivalent figures for FCAMHS were 100% and 65%. This points to both potential information-sharing barriers and differences in how agencies perceive the same multi-agency exchanges.
- **Identifying VFI risk does not always lead to an appropriate intervention or referral pathway.** Just under half of Channel respondents rated available VFI interventions as adequate, and 62% cent considered them less adequate than those for ideologically motivated cases. CAMHS, CTP and LA respondents also reported gaps in commissioned services, specialist capacity and suitable placements.

Introduction

Crest Advisory

Crest Advisory is a UK-registered limited company specialising in data and policy analysis relating to justice, policing and public safety matters since 2012. It has been commissioned previously by the Home Office, the Ministry of Justice, the Crown Prosecution Service, the Department for Education, the Youth Justice Board, policing bodies across England and Wales, violence reduction units and other public authorities. We have also provided services for third sector and commercial organisations involved in the delivery of criminal justice and public safety. We hold ISO 2022:270001 Information Security Management System (ISMS) accreditation and ISO 9001 Quality Management System (QMS) accreditation.

Our research team applies systematic, transparent, and replicable methods for data discovery, quality assessment, and synthesis, ensuring outputs are analytically rigorous and aligned with Government Social Research standards. This approach ensures our findings are directly usable by policymakers, practitioners, and commissioners. We place particular emphasis on analytical rigour, transparency and reproducibility. Our methods are clearly documented, our analytical decisions are traceable, and our findings are subject to appropriate quality-assurance and validation processes. This allows us to produce evidence that is both technically robust and accessible to non-specialist audiences.

Survey project team and experience

Lead analyst and report author: **Dr. Ehsan Solaimani, Lead Quantitative Analyst, Crest Advisory (UK) Ltd**

Dr Solaimani is a statistician and data scientist specialising in crime and social policy, with an academic background in mixed methods research and evaluation. His experience over the last seven years includes quantitative and qualitative research, advanced statistical modelling in both academic and operational/industrial settings. Dr Solaimani's work at Crest Advisory is focused on developing and applying robust quantitative methods to support evidence-based decision making. He has previously held academic posts at the University of York, the University of Essex, and the University of Fribourg, where he led quantitative research programmes, supervised data-driven projects, and trained postgraduate students and researchers in applied statistics and quantitative analysis. Dr Solaimani has a substantial record of research leadership, analytical rigour, and cross-disciplinary collaboration.

Qualitative analyst: **Madeline Rolfe, Senior Strategy & Insight Manager, Crest Advisory (UK) Ltd**

Madeline Rolfe is a Senior Strategy and Insight Manager at Crest, specialising in designing and overseeing research to address complex policy and operational challenges across the criminal justice sector.

Qualitative analyst: **John Milik, Senior Analyst, Crest Advisory (UK) Ltd**

John Millik is Senior Analyst at Crest Advisory, specialising in policy analysis for public inquiries, and data visualisation.

Southport Inquiry surveys

On 29 July 2024, AR carried out a knife attack at a children's dance club in Southport. He murdered 3 young girls, Elsie Dot Stancombe, Alice da Silva Aguiar and Bebe King, and injured 10 other people. Sixteen others survived the attack but live with serious emotional scars. The Southport Inquiry has been set up to examine the circumstances surrounding the attack and the events leading up to it. The terms of reference for Phase 2 of the Southport Inquiry set out to understand how services that may come into contact with violence-fixated children and young people understand this risk, and how equipped they feel to deal with them. Phase 2 will examine the following areas:

- The adequacy of arrangements in England and Wales for managing the risk from violence-fixated individuals (VFIs);
- The role of the internet and social media in influencing and enabling VFIs to prepare and carry out violent attacks;
- The effectiveness of current laws and systems for identifying, monitoring and disrupting the activities of VFIs online and reducing the harm caused by online spaces which promote extreme violence;
- The effectiveness of policies, regulation and criminal enforcement in relation to the sale and possession of offensive weapons and articles with a point or blade.

The Southport Inquiry commissioned support from Crest in the design and analysis of eight detailed surveys. These surveys were distributed in order to widen and deepen the evidence base on both the current approach adopted to VFIs, including its strengths and weaknesses, and on the options for change.

Each of the surveys was directed at one of the following eight cohorts:

- **Chairs of Channel panels whose cases were referred through Prevent**
This survey sought to understand the number of VFI-type cases handled by Channel panels, their views on multi-agency working in relation to cases both adopted and not adopted by Channel, and their views on potential improvements and future changes.

- **Multi-Agency Public Protection Arrangements (MAPPA) Chairs**

This survey sought information on the number of VFI cases currently being managed through MAPPA, MAPPA Chairs' views on current multi-agency working, and the potential for MAPPA to play a greater role in VFI risk management in the future.

- **Child and Adolescent Mental Health Services (CAMHS)**

This survey explored the prevalence of VFI cases, relevant clinical training, referral routes, clinicians' confidence in managing VFI cases, risk assessment tools, information sharing, multi-agency working, and the effectiveness of working relationships between CAMHS and Forensic CAMHS (FCAMHS).

- **Forensic CAMHS (FCAMHS) practitioners**

This survey considered broadly similar issues to those covered in the CAMHS survey, while also exploring FCAMHS practitioners' views on how effectively CAMHS services work with them.

- **Local Authority (LA) senior leaders, principally at director of children's services level**

This survey addressed training, the prevalence of VFI cases, the effectiveness of multi-agency working, access to specialist input and support, and the role and effectiveness of Multi-Agency Safeguarding Hubs (MASH).

- **Frontline LA practitioners**

This survey considered broadly the same topics as the survey for LA Senior Leaders, including training, VFI prevalence, multi-agency working, access to specialist support, and the role of MASH.

- **Designated safeguarding leads (DSLs) in education settings**

This survey explored the effectiveness of multi-agency co-operation in VFI cases, training, confidence in handling VFI cases, risk assessment, information sharing, and experiences of Prevent, among other topics.

- **Detective inspectors from each of the nine regional counter terrorism units in England and Wales**

This survey asked Detective Inspectors to gather the views of relevant Counter Terrorism Policing Prevent practitioners within their teams. Topics included the prevalence of VFI cases, training, the effectiveness of current arrangements for managing VFI cases within Prevent, multi-agency working, and the adequacy of tools used to assess subjects' online activity.

Section 1: About the surveys

Each survey combined closed questions (e.g., multiple-choice, single-select, and scaled questions) with open-text questions exploring narrative responses. Five questions were asked in identical form across all eight surveys to allow group-wise comparisons. These questions addressed organisational understanding of VFIs, staff recognition of early indicators, confidence in identification, clarity of organisational process, and staff's ability to take appropriate action when a VFI case is identified. Each survey additionally included closed and open-text questions specific to that service's statutory or organisational role, reflecting the distinct functions performed by each service within the wider system. The full text of every question, as presented to respondents, as well as the complete number and percentage breakdown of responses to every closed question, is set out in Appendix 1.

Who responded

Across the eight surveys, a total of 802 usable responses were received.

Survey	Number of responses submitted	Potential number of responses	Final sample	Response rate
LA practitioners	398	550	396	72%
LA seniors	127	164	127	77%
CAMHS	90	106	89	84%
Channel	96	175	94	54%
FCAMHS	23	28	23	82%
MAPPA	30	42	30	71%
DSL	33	60	33	55%
CTP	10	9 CTUs (England and Wales)	10	See note below
Total	807	-	802	-

Counter terrorism policing (CTP): CTP operates through 9 counter terrorism units (CTUs) covering England and Wales (Northern Ireland and Scotland are outside this survey's scope); therefore, 9 was the maximum number of regional responses achievable. Each response was completed by a single nominated representative after collating the views of colleagues within their CTU, that is, each entry reflects a regional team position rather than one individual's

personal opinion. All 9 regions responded (100% response rate). One region, namely East Midlands, was represented twice, by two individuals submitting independently rather than jointly, which is why the final sample was 10. We have retained both East Midlands responses in the analysis.

How the survey was communicated

The Inquiry contacted each of the eight groups using the most effective method to reach the relevant individuals. Local Authority senior leaders, principally directors of children's services across England, were contacted directly by email. These senior leaders were also asked to distribute the questionnaire to frontline staff in their local authority area. Similarly, the Inquiry received a list of contact details for the chairs of MAPPA and Channel panels and CAMHS and FCAMHS teams across Wales, and was therefore able to contact them directly. For the remaining groups, CAMHS and FCAMHS in England, Counter Terrorism Policing, directors of children's services in Wales and Designated Safeguarding Leads, the Inquiry contacted the body which oversees the organisation, namely NHS England, Counter Terrorism Policing Headquarters, All Wales Heads of Children's Services Group and the National Association of Designated Safeguarding Leads respectively, and requested these bodies distribute the survey to the relevant individuals.

Data quality checks

Initially, we manually reviewed a dip sample of responses ($n = 5$ per survey; $n = 40$ in total) to identify any potential inconsistencies within the submitted answers. This quality-assurance step was important to assess whether responses were internally coherent and to identify any issues that might affect the reliability or interpretation of the survey findings. For example, we checked whether a respondent reported that they had received no relevant training but later provided an answer suggesting that such training had been received. No inconsistencies were identified in the responses reviewed.

Three respondents (across Channel Chairs and LA practitioners) submitted the same survey twice. In each of these cases, we retained the most recent complete submission and removed the earlier response to avoid counting the same individual twice within the same survey. We also excluded one additional response because there were concerns about the reliability and internal consistency of the answers provided. This was done to reduce the risk that an unreliable response could distort the analysis or affect the interpretation of the findings. Furthermore, nine individuals completed more than one of the eight surveys. This occurred where respondents held roles that cut across more than one part of the system. For example, some individuals reported working in both LA practitioner and senior leadership roles, while others held responsibilities spanning both Channel and LA functions. We retained all of these responses because they reflected respondents' genuine involvement across different professional roles and settings, and

therefore provided relevant evidence for each survey population in which they participated. As a result, however, a small number of individuals are represented more than once across the dataset as a whole. This should be borne in mind when interpreting findings that combine or compare responses across multiple surveys.

As an additional check on the quality and reliability of the survey data, we assessed whether respondents answered the five cross-cutting questions in an internally consistent manner. These questions were designed to capture related aspects of organisational preparedness for responding to VFIs. We therefore expected respondents who gave a relatively favourable answer to one question to tend to respond in a broadly similar way to the other related questions. For example, a respondent who agreed that their organisation had a clear understanding of VFI might also be expected to agree that staff understood what actions to take in response to VFI-related concerns. By contrast, a highly inconsistent pattern of responses across the five questions could indicate that the questions were not functioning as a coherent set or, potentially, that some respondents were not engaging carefully with them.

We assessed this using *Cronbach's alpha*, a widely used measure of the internal consistency of a set of related survey items. Higher values indicate that responses to the items tend to move together more consistently. As a general rule, an alpha of 0.70 or above is commonly regarded as indicating acceptable internal consistency, while values of 0.80 or above are generally regarded as very good levels of internal consistency. Across the combined sample from all eight surveys, the five cross-cutting questions produced a Cronbach's alpha of 0.83. This indicates very good internal consistency and provides evidence that the five questions were operating coherently as a related set of measures.

We also calculated Cronbach's alpha separately for each of the eight surveys rather than relying solely on the result for the combined sample. This was important because a high level of consistency in the combined data could, in principle, arise partly from systematic differences between the surveyed services. For example, if one service tended to answer all five questions more positively than another service, this could increase the apparent consistency of the items when all respondents were analysed together, even if responses were less consistent within individual groups. Calculating alpha separately for each survey therefore allowed us to assess whether the same pattern of internal consistency was evident within each group separately.

Across the eight surveys, Cronbach's alpha ranged from 0.72 for Channel to 0.92 for CTP. Six of the eight groups returned a value above 0.80, and all eight exceeded the 0.70 threshold. These results indicate that the five cross-cutting questions showed acceptable or good internal consistency within every group surveyed, rather than this pattern being evident only in the combined sample. Taken together, the findings provide confidence in the reliability of responses to these five questions and offer broader reassurance that respondents engaged with the surveys in a coherent and meaningful way.

Methodology

This report draws on two complementary forms of evidence derived from the surveys: quantitative analysis of responses to closed questions (multiple-choice, single-select, scaled questions), and qualitative thematic analysis of responses to open-text questions. All quantitative analysis was conducted using R, which is a statistical programming language widely used in academic and applied social research. Using both forms of evidence allows the analysis to examine not only the prevalence and distribution of particular views or experiences, but also the reasons and experiences that may help explain those patterns.

The quantitative analysis provides a structured measure of how common a particular response or finding was across the survey population. It allows us to establish, for example, how many respondents agreed or disagreed with a particular statement, the strength of those responses, and whether response patterns differed between the surveyed services. This provides an indication of the scale and distribution of particular issues and enables systematic comparisons across the eight services. The qualitative thematic analysis, by contrast, provides additional depth and context by examining what respondents said in their own words. It helps explain why particular views were expressed, identify the experiences or circumstances underlying respondents' answers, and capture issues that may not be fully represented through predefined response options. For example, where the quantitative analysis identifies that a substantial proportion of respondents regarded a particular aspect of multi-agency working as ineffective, the open-text responses can provide insight into the specific barriers, experiences or concerns that contributed to that assessment.

Quantitative analysis

Descriptive Statistics

For each closed question, we report the number and percentage of respondents selecting each available response option. Percentages are presented as a proportion of respondents who answered that specific question and, where relevant, also as a proportion of the total sample for that survey. The number of respondents contributing to each question is not always the same as the total number who completed the survey. Some questions were only shown to respondents who provided a particular answer to an earlier question. For example, respondents who indicated that they had received relevant training might subsequently have been asked to assess the quality or usefulness of that training, whereas respondents who had not received training would not have been shown the follow-up question. In addition, some questions were optional and were therefore left unanswered by a proportion of respondents. Full question-level counts, percentages and response rates are provided in Appendix 1.

Within-group analysis

Most closed questions were presented as statements to which respondents indicated their level of agreement on a five-point scale ranging from ‘Strongly Disagree’ to ‘Strongly Agree’. For example, respondents were asked whether they agreed that their organisation had a clear and shared understanding of violence-fixation risk. Where sample size allowed, for each group and each of these questions, we tested whether the pattern of responses differed systematically from the neutral midpoint of ‘Neither Agree nor Disagree’.

The purpose of this analysis was to establish whether responses within a group showed sufficient evidence of an overall tendency towards agreement or disagreement, rather than simply describing the percentages falling into each response category. For example, a group might contain more respondents selecting ‘Disagree’ than ‘Agree’, but this difference may be relatively small, particularly where the number of respondents is limited or responses widely range across the scale. The statistical test helps assess whether the observed pattern provides sufficient evidence that responses tend to fall on one side of the neutral midpoint.

Throughout this report, where a within-group result is described as statistically significant, this means that the observed pattern would be unlikely to arise through ordinary sampling variation (that is, due to the specific respondents who turned out to complete the surveys, as opposed to the full scale of intended population within each service) if there were no underlying tendency for responses to differ from the neutral midpoint. In other words, the pattern is unlikely to be explained simply by who happened to respond to the surveys, and instead provides evidence of a similar underlying tendency in the wider group. Statistical significance should not, however, be interpreted as a measure of the size or practical importance of a finding. A statistically significant result may represent a relatively modest tendency towards ‘agreement’ or ‘disagreement’, while a substantively notable difference may not reach statistical significance where the number of respondents is small. Statistical significance is therefore considered alongside the size and distribution of the responses and the wider substantive evidence, rather than being treated on its own as an indication of the importance of a finding.

Technical note

- **For significance testing, we used a statistical test appropriate for ranked survey responses.** This approach does not require the five response categories to be treated as though the numerical distance between each category is necessarily equal (e.g., it does not assume that the distance between ‘strongly agree’ and ‘agree’ is the same as the distance between ‘agree’ and ‘neither agree or disagree’). A separate statistical test was conducted for each relevant question within each of the surveyed services.
- Notably, conducting a large number of statistical tests creates an additional issue because, **even where no underlying differences exist, the probability of obtaining at least one apparently significant result by chance increases as more tests are performed.** For example, just as repeatedly tossing a fair coin makes it increasingly likely that an unusual sequence will occur at some point, conducting many statistical tests makes it more likely that an apparently unusual result will arise simply through chance variation.
- **We therefore applied a standard adjustment for multiple statistical comparisons.** This makes the criterion for identifying statistically significant findings more stringent and reduces the likelihood that a finding is classified as significant solely because a large number of separate tests have been conducted. Findings described as statistically significant in this report therefore remained statistically significant after taking account of the number of comparisons undertaken. This provides a more cautious basis for identifying systematic within-group patterns in the survey responses.

Between-group analysis

In addition to examining response patterns within each group separately, we also assessed whether responses differed systematically among the surveyed services. The purpose of this analysis was to determine whether apparent differences among groups were sufficiently large to provide statistical evidence of a genuine difference in their response patterns. For example, the descriptive results might show that CAMHS respondents reported lower levels of confidence than LA practitioners on some questions. Looking only at the percentages, however, does not allow us to robustly assess whether that difference is sufficiently large and consistent, relative to the number and range of responses in each group, to provide statistical evidence that the groups are meaningfully different.

Technical note

- **For between-group comparisons, we employed a widely used statistical technique known as regression analysis.** Regression is a statistical method for assessing whether variation in an outcome is systematically associated with one or more characteristics of the respondents. In this analysis, the outcome was the respondent's answer to (most frequently a five-point) agreement question, while the principal explanatory factor was the group to which the respondent belonged.
- **Because responses were recorded on an ordered scale, ranging from 'Strongly Disagree' through to 'Strongly Agree', we used ordinal regression.** This form of regression is specifically designed for outcomes where response categories have a meaningful order but where the distance between adjacent categories cannot necessarily be assumed to be equal.
- **For each relevant question, we first conducted an overall test of whether there was evidence of any difference in the responses across the surveyed groups at all.** A statistically significant overall result indicates that the response patterns were not the same across all eight groups. Where the overall analysis provided evidence of statistically significant between-group variation, we then conducted pairwise comparisons to identify the specific services between which statistically significant differences were present.
- **Because comparing multiple pairs of groups involves conducting a substantial number of statistical tests, we applied an appropriate adjustment for multiple comparisons.** This reduces the risk of identifying a difference as statistically significant purely because many comparisons have been undertaken. Findings described in this report as showing a statistically significant difference between two named groups therefore reflect differences that remained statistically significant after this adjustment was applied.

As with the within-group analysis, statistical significance should not be interpreted as a measure of the substantive importance of a difference. Rather, it indicates that there is sufficient statistical evidence to conclude that the response patterns of the two groups are different. The size and practical significance of that difference are considered alongside the descriptive results and the wider quantitative and qualitative evidence presented in the report.

Regional analysis

We additionally examined whether each of the patterns reported was broadly consistent across different parts of the country or whether it was disproportionately concentrated in particular regions. This provided an additional check on whether an apparent national-level finding reflected a widespread pattern or was being driven primarily by responses from a smaller number of geographical areas. To conduct this analysis, respondents were assigned to one of the nine English regions, or to Wales, on the basis of the organisation they reported working for. Organisations were mapped using the standard geographical classifications published by the Office for National Statistics (ONS).

Regional analysis was undertaken only for the two largest surveys, namely LA practitioners and Channel respondents. These surveys contained sufficient numbers of responses across regions to allow comparisons to be made with a reasonable degree of confidence. The remaining surveys had substantially smaller regional subsamples, meaning that any apparent differences between regions would have been highly sensitive to the responses of a very small number of individuals and could therefore have produced misleading results.

Regional findings are reported only where they materially affect the interpretation of the overall results. This includes, for example, cases where a pattern that appears evident at national level is in fact driven disproportionately by a small number of regions, or where meaningful geographical variation is itself an important finding. Where no regional variation is discussed in relation to a particular finding, this should not automatically be interpreted as evidence that all regions produced identical results. Rather, it means either that the regional analysis did not identify variation substantial enough to change the interpretation of the overall finding, or that the relevant survey did not contain sufficient responses within regions to support a reliable and robust comparison.

Note on statistical analysis on CTP and LA senior surveys

- **CTP is treated differently from the other seven surveys throughout the statistical analysis in this report.** Each of the other seven surveys captures the individual, independent views of many respondents; by contrast, each CTP response represents a single collated position submitted on behalf of an entire Counter Terrorism Unit, following consultation among colleagues within that area (see Section 1). Because CTP's responses are not independent individual opinions but positions agreed on behalf of nine areas, formal tests of statistical significance comparing CTP to the other seven groups, or testing whether CTP's own responses collectively differ from a neutral position, would not be a meaningful exercise given what each response represents. For this reason, CTP's results are reported descriptively throughout this report, rather than tested for statistical significance alongside the other seven groups.
- **Statistical analysis is conducted and reported for the LA senior survey in the same way as for the other six groups (excluding CTP), despite each submitted response reflecting a collated view from multiple colleagues.** Directors of Children's Services were instructed to complete the survey themselves, while drawing together views from across their senior safeguarding team, including members of the Multi-Agency Safeguarding Hub (MASH), rather than responding solely on the basis of their own individual views. However, the survey was distributed to Directors of Children's Services across all 164 Local Authorities in England and Wales, of whom 127 responded. The analysis therefore draws on 127 independent Local Authority-level responses, representing a substantially larger number of independent reporting units than the nine CTUs covered by the CTP survey. As the reliability and interpretability of statistical significance testing depend in part on the number of independent observations available for analysis, the LA senior survey provides a sufficient number of independent units to support meaningful statistical comparisons.

Qualitative analysis

Codebook development

A structured codebook was developed before the open-text responses were reviewed in detail. This allows us to establish the principal themes of interest in advance, helping ensure that responses from different surveys were analysed using a consistent framework. The codebook combined a common set of themes with a smaller number of survey-specific themes. Fifteen core codes were applied consistently across all eight surveys to capture issues expected to be relevant across the wider system, including:

- **Definition** - Whether there is a clear, consistently understood definition of VFI, and how it is distinguished from related concepts such as ideologically motivated risk, mental illness, or neurodevelopmental presentation.
- **Identification** - Confidence and consistency in recognising early indicators of this type of risk.
- **Ownership** - Clarity about which agency or service holds lead responsibility for a case, including responses describing responsibility as unclear or contested.

- **Information-sharing** - The ease or effectiveness of sharing relevant information between agencies, including barriers, delays, or fragmentation.
- **Statutory thresholds** - Whether legal, statutory, or organisational thresholds are well suited to this type of risk.
- **Training** - The availability and adequacy of role-specific training.
- **Capacity** - Workforce capacity and resourcing to respond effectively.
- **Assessment tools** - Whether existing assessment frameworks and tools are considered fit for identifying and formulating this type of risk.
- **Service provision** - Availability of appropriate services, interventions, or referral pathways for this cohort.
- **Legislative change** - Views on whether new legislation or legal powers are needed, including support, opposition, or uncertainty.
- **Contextual factors** - Wider contributing or contextual factors, such as online activity, trauma, or family and social circumstances.
- **Multi-agency structure** - Views on current multi-agency structures, panels, or forums, including their adequacy, complexity, or duplication.
- **Suggestions for improvement** - Concrete, actionable recommendations for improving systems or processes.
- **Direct experience** - The respondent's own reported level of direct case experience, including where none was reported.
- **Flagging** - Reference to the need to flag or escalate a case to a line manager or other body, without further demonstrated understanding of the process this would trigger.

Alongside these shared codes, each survey included a small number of additional codes for the analysis of open-text responses, designed to capture issues specific to that service's statutory, professional or organisational role. For example, the CTP-specific codes included respondents' views on whether counter terrorism policing represented an appropriate institutional setting for managing this type of risk. The codes developed for LA senior leaders, by contrast, included themes relating to organisational governance and approaches to recording relevant data. This combined structure served two purposes. The common codes provided a consistent basis for identifying themes that appeared across different parts of the system, while the survey-specific codes allowed the analysis to retain important differences in the responsibilities, experiences and perspectives of individual stakeholder groups.

Coding process

All open-text responses were coded against the relevant shared and survey-specific codes by two members of the analysis team. For each applicable code, the direction or valence of the response was also recorded. Responses were classified as *positive*, *mixed*, *uncertain*, *negative*, *descriptive/factual*, or *not applicable*. A mixed classification was used where a response contained both positive and negative elements, while the descriptive/factual category was used

where the respondent provided relevant information without expressing a clearly positive or negative assessment. Recording valence alongside the thematic code allowed the analysis to distinguish between the presence of a theme and respondents' views about that theme. For example, two respondents might both discuss information-sharing between agencies, but one might describe existing arrangements as effective while another identifies significant difficulties.

Where a response did not fit an existing code, it was flagged for consideration as a candidate additional code rather than assigned to the closest available category. This reduced the risk of losing or distorting issues that had not been anticipated when the original codebook was developed. The initial coding was subsequently reviewed by the lead analyst, who checked the application of codes, the interpretation of valence and the treatment of any proposed new themes. This provided an additional quality-assurance step intended to promote consistency in how the coding framework was applied across surveys and respondents.

Synthesis

Following coding, responses were brought together by theme and examined both within individual surveys and across the eight groups. This allowed the analysis to identify issues that were prominent within a particular service as well as themes that recurred across different parts of the system. Particular attention was given to findings that emerged independently across several surveyed services. Recurrence across groups provides a stronger basis for treating a theme as potentially system-wide because it indicates that the issue is not confined to the perspective or organisational circumstances of a single surveyed group in the system. It does not, by itself, establish that a respondent's account is objectively correct, but it provides greater corroboration within the survey evidence than a theme raised only within one group.

For example, concerns that existing statutory or legal thresholds may be poorly suited to managing non-ideological violence-fixed risk were independently identified in responses from four different groups: Channel Chairs, CTP, LA practitioners and LA senior leaders. The recurrence of this concern across groups occupying different positions within the system strengthens the basis for presenting it as a cross-cutting finding, while the report also considers the particular context in which each group raised the issue.

Illustrative quotations presented throughout the report were selected from the coded material to demonstrate themes identified through the wider analysis. They were not treated as evidence simply because an individual quotation was particularly striking. Instead, quotations were chosen because they clearly expressed or illustrated a pattern found across a broader set of responses. They should therefore be read as examples of the underlying thematic finding rather than as isolated anecdotes. The full frequency with which each code was applied, broken down by survey and by valence, is set out in Appendix 2.

Section 2: Preparedness to identify and respond to VFI

Five questions were asked in identical form across all eight surveys, each addressing a different aspect of what it means, in practice, to be prepared to identify and respond to a case of VF. The five questions asked whether: (1) the respondent's organisation has a shared understanding of what VFI means; (2) staff can recognise the early behavioural signs of it; (3) staff feel confident identifying a potential case; (4) the organisation has clear processes in place for responding once a case is identified; and (5) staff understand what specific actions to take. These five questions move progressively from conceptual preparedness (do we understand what we are looking for) through to operational preparedness (do we know what to do once we have found it), providing a rounded picture of readiness across the whole identification-to-response pathway.

To provide an overall summary of preparedness across each surveyed group, in addition to reporting each of the five questions individually (set out later in this section), we combined each respondent's five answers into a single composite score, converted to a 0%-100% scale, where a higher score indicates greater perceived preparedness. This composite measure was then averaged within each of the eight groups, allowing direct comparison of overall preparedness across the system as a whole. As explained in the Methodology section, the strong internal consistency of these five questions (Cronbach's alpha of 0.83 overall, and above 0.7 within every individual survey) supports their use as a single combined measure for this purpose.

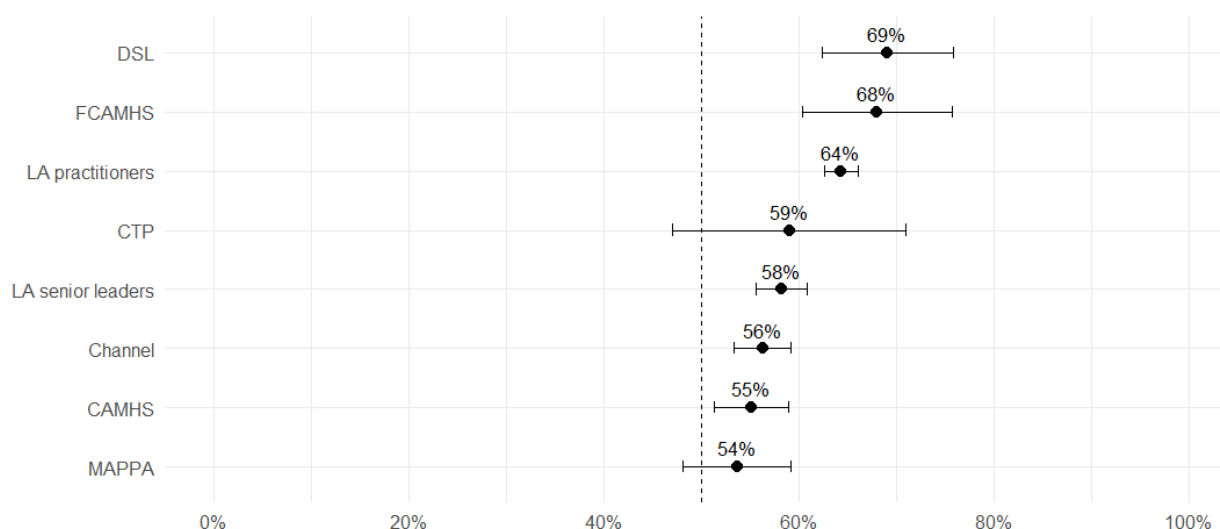
Overall preparedness varies considerably across the system

Composite preparedness varied markedly between groups, indicating that different parts of the system feel very differently equipped to identify and respond to VFI. An overall statistical test confirmed a significant difference among the eight groups surveyed ($p < .001$). DSLs and FCAMHS reported the highest overall preparedness of any group surveyed, with LA practitioners also comparatively positive. At the opposite end of the scale, MAPPA, CAMHS, and Channel reported the lowest levels of preparedness in the data.

Several of these differences were shown to be statistically significant when groups were compared directly against one another. Both DSLs ($p = .001$) and FCAMHS ($p = .024$) reported significantly higher preparedness than CAMHS. LA practitioners, in turn, reported significantly higher preparedness than four separate groups: CAMHS ($p < .001$), Channel ($p = .001$), MAPPA ($p = .018$), and LA senior leaders ($p = .009$).

Interpretive note

- Each dot shows the **average composite preparedness score per surveyed service**, on a scale from 0% (lowest perceived preparedness) to 100% (highest). Groups are ordered from highest average score at the top to lowest at the bottom. The dashed line marks the halfway point (50%), to mark where each group's preparedness sits.
- The horizontal line through each dot indicates **variability within each group's responses**. A shorter line means less variability in responses within that group, while a longer line suggests more variability.
- For CTP, this range should be read differently from every other group. **Each CTP response represents a single collated view submitted on behalf of a whole Counter Terrorism Unit, rather than one individual's personal opinion** (see Section 1). The wide range shown for CTP therefore reflects variation between the small number of CTU areas that responded, not variation between individual people's views within a much larger group, as is the case for every other group in this chart.



These results point to a strong mismatch between where preparedness is highest and where the risk is most likely to first present. The two clinical services in this dataset sit at opposite ends of the scale: FCAMHS, a specialist forensic service that most children will only reach after a case has already been identified and escalated, reports significantly higher preparedness than CAMHS, which is the generalist service far more likely to be a young person's first point of contact. This suggests preparedness in the clinical pathway is concentrated at the point where a case has already been recognised as high-risk, rather than at the point where early identification would matter most. Outside the clinical settings, however, the pattern is different. LA practitioners - who, like CAMHS, are typically closer to day-to-day contact with children and families than the specialist and statutory bodies they were compared against - report significantly higher preparedness than four other groups. This includes Channel, the statutory multi-agency

structure that VFI cases are ultimately meant to be escalated into, and MAPPA, which existing guidance does not designate as a formal escalation route for VFI cases but which several respondents in this report suggested could play a more active role in managing high-risk individuals who fall outside Channel's remit.

Read together, this indicates that preparedness is not straightforwardly concentrated at either the 'front line' or the 'specialist' end of the system, but is unevenly distributed in a way that does not consistently track where responsibility for identification and management actually sits, which is a pattern this report returns to in later sections addressing multi-agency working and lead responsibility.

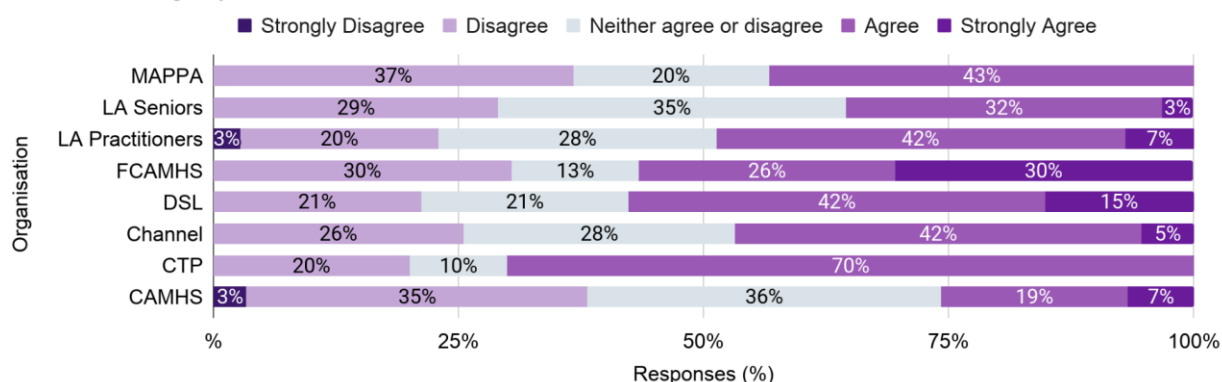
The individual questions making up this composite score, set out below, help explain where these differences in overall preparedness arise, and show that the pattern is not uniform across all five aspects of preparedness even within a single surveyed service.

Shared understanding of VFI is the exception rather than the rule

Overall, more than half of respondents (55%) did not agree that their organisation has a clear and shared understanding of VFI. In fact, a recurring pattern - mostly from CAMHS and LA practitioners - was that they had never encountered the term before completing the survey:

- *'No training, I have never heard of this term!' - CAMHS respondent*
- *'I had never heard of that term prior to this survey.' - LA practitioner*

Our organisation has a clear and shared understanding of violence fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk



This pattern differs meaningfully depending on which part of the system is examined, however:

- Counter Terrorism Policing: Seven in ten CTP respondents (70%) agreed that CTUs have a clear and shared understanding of VFI, which is the highest figure of any of the eight groups, and reflects a good level of agreement across CTP as a whole regarding how they understand VFI risk.

- Health/Clinical (CAMHS, FCAMHS): CAMHS recorded the lowest confidence of any group in the survey, with approximately three-quarters of respondents either disagreeing or sitting neutral, while FCAMHS was considerably more positive, with over half agreeing. This reflects FCAMHS's more specialist remit: FCAMHS clinicians typically encounter VFI-type cases once they have already been identified and escalated by a generalist service such as CAMHS, and might therefore be expected to have engaged with the concept more directly and more frequently.
- Statutory Multi-Agency Panels (Channel, MAPPA): Channel and MAPPA - the two panels bringing multiple agencies together to make joint decisions on risk - both sat closer to the middle point, with fewer than half of respondents in either group agreeing that their organisation has a clear and shared understanding of VFI.
- LA/Education (LA practitioners, LA seniors, DSL): This cluster shows a mixed picture. DSLs were relatively confident that their organisation has a clear and shared understanding of VFI risk, but LA practitioners, and especially LA senior leaders, were less so, with LA seniors among the lower-confidence groups overall.

Within-group analysis

The majority of groups surveyed - including CAMHS, MAPPA, LA seniors, FCAMHS - did not show a statistically significant pattern indicating that their organisations have a clear and shared understanding of VFI risk. Only three groups - LA practitioners, Channel Chairs, and DSLs - showed a pattern that would significantly sit above the midpoint of 'neither agree or disagree' that their organisation has a clear and shared understanding of VFI risk. Even among these groups, however, agreement did not exceed 57% of the responses. As such, except CTP, which showed 70% agreement that they have a clear and shared understanding of violence-fixation risk, the pattern is much more limited within other surveyed organisations.

Between-group analysis

CAMHS's agreement that it has a shared understanding of VFI was found to be significantly lower than both DSLs' and LA practitioners'. No other pairwise comparisons between groups reached statistical significance.

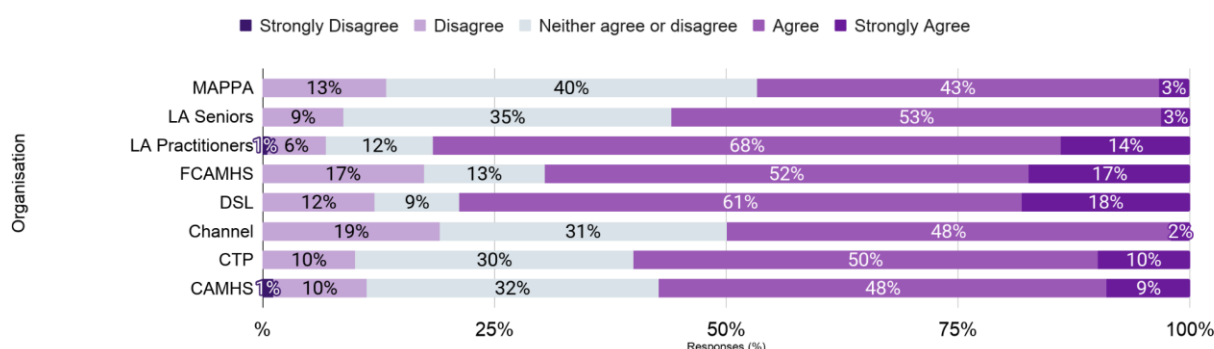
Together, these results confirm that the majority of surveyed groups do not have a clear and shared understanding of VFI, and that this gap is most pronounced in CAMHS - the generalist clinical service most likely to be a young person's first point of professional contact, and the service for which a shared, working understanding of this concept arguably matters most at the earliest possible stage of identification. Only three groups - LA practitioners, Channel Chairs, and DSLs - strongly agreed that their organisation has a clear and shared understanding of VFI risk. Importantly, this more limited finding is not evenly spread across the country: among LA practitioners, regional agreement ranged from 31% in Yorkshire and The Humber to 59% in London, and among Channel respondents from 20% in Yorkshire and The Humber to 88% in

the West Midlands, meaning the picture in these two groups is driven more strongly by some regions than others, and does not hold uniformly everywhere. Taken as a whole, a clear and shared understanding of VFI is the exception across this system, not the norm.

Recognition of early warning signs is stronger, but remains uneven

The second cross-cutting question asked whether staff can recognise the early behavioural signs of potential VF, including online and offline behaviours. Confidence that staff can recognise early behavioural indicators on this question was measurably higher and more widely shared than on shared understanding of VFI risk, though the gap between the most and least confident groups remained wide.

Staff in our organisation can recognise early behavioural indicators of potential violence fixation (including online and offline behaviours)



- Counter Terrorism Policing: Six in ten CTP respondents (60%) agreed that staff can recognise early behavioural indicators of VFI.
- Health/Clinical: Both CAMHS and FCAMHS services showed a more consistent picture than on shared understanding of VFI risk - CAMHS with 57% agreement and FCAMHS with 70% agreement that their organisations can recognise early behavioural indicators, which is a narrower gap than the wide split seen between the two services on whether these organisations have a clear and shared understanding of violence-fixation risk.
- Statutory Multi-Agency Panels: MAPPA recorded the lowest level of agreement of any of the eight groups, at 47%, with a substantial proportion (40%) sitting neutral rather than actively disagreeing that staff can recognise early behavioural indicators of violence-fixation risk. Channel Chairs sat only slightly higher, with only half (50%) agreeing that they can recognise the early behavioural indicators.
- LA/Education: This cluster was the clear area of strength on this question. LA practitioners reported the highest agreement of any group surveyed, at 82%, with DSL also at 79%. LA senior leaders were more moderate, at 56%, similar to the health and CTP.

Within-group analysis

Unlike the previous question, every one of the seven groups tested - CAMHS ($p < .001$), FCAMHS ($p = .010$), Channel ($p < .001$), DSL ($p < .001$), LA practitioners ($p < .001$), LA seniors ($p < .001$), and MAPPA ($p = .018$) - showed a statistically significant pattern indicating that they were more likely to agree (vs. disagree) that their organisation can indeed recognise early behavioural indicators of potential VF. This holds even for MAPPA, which represents the lowest-scoring group on this question: although fewer than half of MAPPA respondents actively agreed, disagreement was comparatively rare, and the overall balance of responses was still skewed toward the agreement end of the scale rather than sitting neutrally.

This is a more positive and more consistent finding than the previous question on shared understanding of violence-fixation risk, where only three of the seven groups reached statistical significance, and suggests that recognising the early behavioural signs of VFI is a more evenly held capability across the system than a shared conceptual understanding of the term itself.

Between-group comparisons

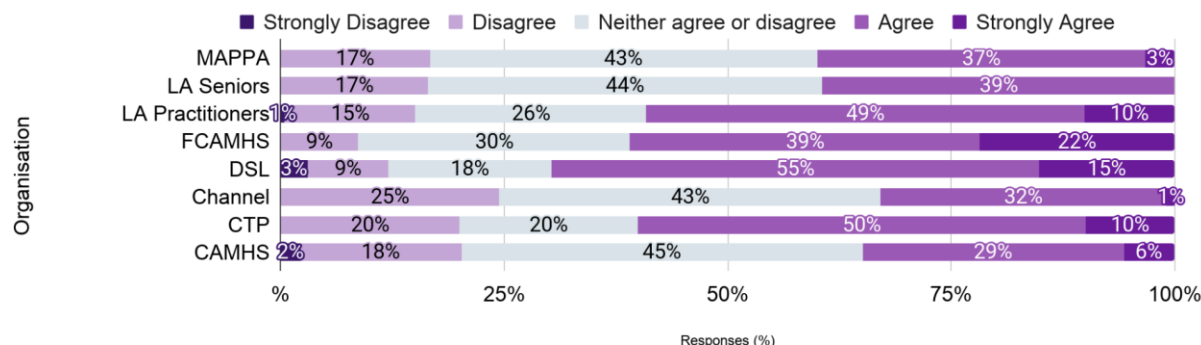
LA practitioners showed a stronger pattern in the recognition of early behavioural indicators of violence-fixation risk, compared to CAMHS ($p < .001$), Channel ($p < .001$), LA senior leaders ($p < .001$), and MAPPA ($p = .001$). Channel Chairs' response pattern also suggested significantly lower levels of agreement on this question, compared to DSL's ($p = .009$).

These results suggest that recognising the early signs of VFI is a genuine, statistically supported strength across nearly the whole system, in clear contrast to the more limited and unevenly held shared understanding of the very concept of VFI risk. The exception to this broadly positive picture sits with the two multi-agency panels, Channel and MAPPA, where agreement remains comparatively low and, in MAPPA's case, falls short of showing a statistically significant pattern - despite LA practitioners, the group ultimately responsible for referring many of these cases onward, showing the strongest recognition of any group surveyed.

Confidence in identifying potential VFI risk remains low

The third question asked whether staff feel confident identifying potential VFI risk early.

Staff in our organisation are confident in identifying potential violence fixation risk at an early stage



- Counter Terrorism Policing: Six in ten CTP respondents (60%) agreed they feel confident identifying potential VFI risk early.
- Health/Clinical: CAMHS sat at the lower end, with only 35% agreeing that they feel confident in identifying potential violence-fixation risk early. FCAMHS, by contrast, was among the more confident groups surveyed, at 61%.
- Statutory Multi-Agency Panels: Channel Chairs recorded the lowest agreement of any group surveyed, at 33%, while MAPPA sat slightly higher, at 40%. This is a notable pattern given the two groups' respective positions in the system: Channel is the statutory process specifically responsible for managing VFI cases, among other types of referrals, yet reports lower confidence than MAPPA, which has no formal statutory role in managing this cohort.
- LA/Education: DSL (70%) and LA practitioners (59%) both reported to be relatively confident in identifying potential violence-fixation risk. However, LA senior leaders sat considerably lower, at 39%, which represents a figure closer to the health and multi-agency panel groups than to the other two groups in their own cluster.

Within-group analysis

Four of the seven groups tested showed a statistically significant pattern indicating that they feel confident in identifying potential violence-fixation risk: LA practitioners ($p < .001$), LA seniors ($p = .004$), DSL ($p = .004$), and FCAMHS ($p = .011$). This holds for LA seniors despite its comparatively low raw agreement figure, as disagreement rates remained relatively rare on this question (17%). This needs to be interpreted with caution, however, as even within these groups, the majority of respondents did not strongly agree that they feel confident in identifying potential violence-fixation risk at an early stage, despite agreement rates being significantly higher than disagreement rates. CAMHS, Channel, and MAPPA did not reach statistical significance, indicating divided views within these three groups rather than a clear collective lean in either direction.

Between-group analysis

CAMHS's confidence in identifying potential violence-fixation risk early was significantly lower than both DSL's ($p = .019$) and LA practitioners' ($p = .003$). Channel's confidence was significantly lower than DSL's ($p = .004$) and LA practitioners' ($p < .001$). LA practitioners' confidence was also found to be significantly higher than LA seniors' ($p = .003$), and DSL's confidence was significantly higher than LA seniors' ($p = .033$). No other pairwise comparisons reached statistical significance.

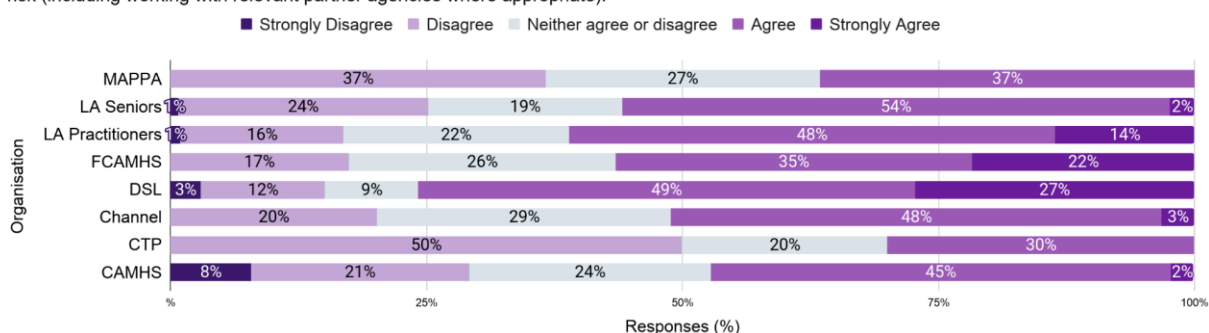
It is worth noting that CAMHS clinicians and Channel Chairs consistently sat at the lower end of the first three questions, namely understanding of VFI, recognition of its early indicators, and confidence identifying it directly, and showed statistically significant gaps behind DSL and LA practitioners on all three. This is a notable pattern given the roles these two groups actually hold in the system: CAMHS is typically one of the more likely first points of clinical contact for a child showing early signs of concern, and Channel is one of the statutory bodies specifically responsible for managing this risk once identified. MAPPA, the other statutory multi-agency body, showed a related pattern and recorded the lowest agreement rates of any group on the question around recognition of indicators.

Altogether, the analysis on the first three questions suggests that groups closest to the front line of first contact (CAMHS), and Channel, the group formally responsible for statutory risk management of VFI cases, are, on this evidence, no more confident than - and on several measures significantly less confident than - LA frontline staff and school DSLs. MAPPA, which has no formal statutory role in managing this cohort but was raised by several respondents as a structure that could play a greater part, shows a similar pattern of comparatively low confidence.

Knowing how to respond presents a further challenge

The final two cross-cutting questions asked (4) whether respondents feel there are clear, effective processes in place for managing and responding to VFI risk, and (5) whether staff understand what actions to take once a risk is identified.

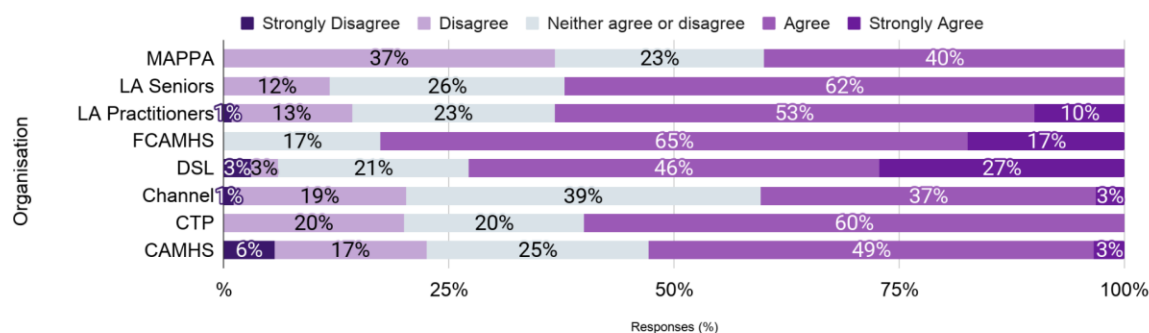
Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence fixation risk (including working with relevant partner agencies where appropriate).



- Counter Terrorism Policing: CTUs showed a notable split between these two questions. Only three in ten (30%) CTP respondents indicated that they agreed there are clear, effective processes in place - which corresponds to the lowest figure of any group on this question - while six in ten (60%) agreed that staff know what actions to take once a risk is identified. This suggests that, in CTUs, individual staff knowledge of appropriate action may be outpacing the formal organisational processes meant to support it.
- Health/Clinical: CAMHS was low on process clarity, at 47%, while FCAMHS was slightly more positive, at 57% agreeing that their organisation has clear and effective processes for managing and responding to VFIs.
- Statutory Multi-Agency Panels: MAPPA recorded the lowest agreement of any group on process clarity, at 37%, and Channel was also comparatively low, at 51%.
- LA/DSL: DSL (76%) and LA practitioners (62%) both reported the strongest process clarity of any groups surveyed.

The pattern repeats closely on staff understanding of what actions to take: FCAMHS (83%) and DSL (73%) reported the highest level of agreement on what actions to take when a potential violence fixation risk was identified, with LA practitioners (63%) and LA seniors (62%) also reporting high levels of agreement. CAMHS clinicians and Channel Chairs again sat toward the lower end, with 52% and 40%, respectively.

Staff in our area understand what actions to take when a potential violence fixation risk is identified



Within-group analysis

On process clarity, five of the seven groups tested showed a statistically significant pattern indicating that their area has a clear and effective process for managing and responding to individuals identified with violence-fixation risk: LA practitioners ($p < .001$), LA seniors ($p = .001$), Channel ($p = .001$), DSL ($p = .002$), and FCAMHS ($p = .040$). CAMHS ($p = .606$) and MAPPA ($p = 0.978$) did not reach statistical significance in their response patterns, suggesting divided views within these two groups rather than a clear collective lean.

On staff understanding of actions to take, six of the seven groups reached statistical significance: LA practitioners ($p < .001$), LA seniors ($p < .001$), FCAMHS ($p < .001$), DSL ($p < .001$), CAMHS (p

= .033), and Channel ($p = .033$). Only MAPPA ($p = .848$) did not reach significance. This is a more positive and more widely shared pattern than on process clarity, suggesting that where organisational processes remain unclear, individual staff understanding of what to do is nonetheless more consistently present across the system.

Between-group analysis

On process clarity, DSL's agreement that they had clear processes was significantly higher than CAMHS's ($p = .002$), Channel's ($p = .024$), LA seniors' ($p = .020$), and MAPPA's ($p = .002$). LA practitioners' agreement was significantly higher than CAMHS's ($p = .005$) and MAPPA's ($p = .023$).

For staff understanding of the actions to take, DSLs reported significantly higher agreement that staff understand what actions to take, compared to both CAMHS ($p = .006$) and MAPPA ($p = .001$). FCAMHS respondents likewise reported higher agreement than CAMHS ($p = .014$) and MAPPA ($p = .001$). LA practitioners reported higher agreement than Channel ($p = .001$) and MAPPA ($p = .013$), while Channel respondents reported lower agreement than both DSLs ($p < .001$) and FCAMHS ($p = .002$).

Taken together, the analysis on the last two cross-cutting questions shows that the two statutory multi-agency risk frameworks, Channel and MAPPA, together with CAMHS clinicians, consistently report the weakest process clarity and, for Channel and MAPPA specifically, the weakest staff understanding of appropriate action when a VFI case is identified. For Channel, which is the designated statutory process for managing VFI cases as current guidance stands, this is the opposite pattern to what its formal responsibility for managing this risk would suggest. LA practitioners and DSLs, by contrast, remain the most consistent area of strength across both dimensions of response readiness on these two questions, echoing the pattern already established on understanding of violence fixation, recognition, and confidence noted earlier in this section.

Section 3: Training and Workforce capability

The previous section showed clear differences between groups in how prepared staff feel to identify and respond to VFI. One factor that may contribute to these differences is the training and guidance available to staff, which is explored in this section.

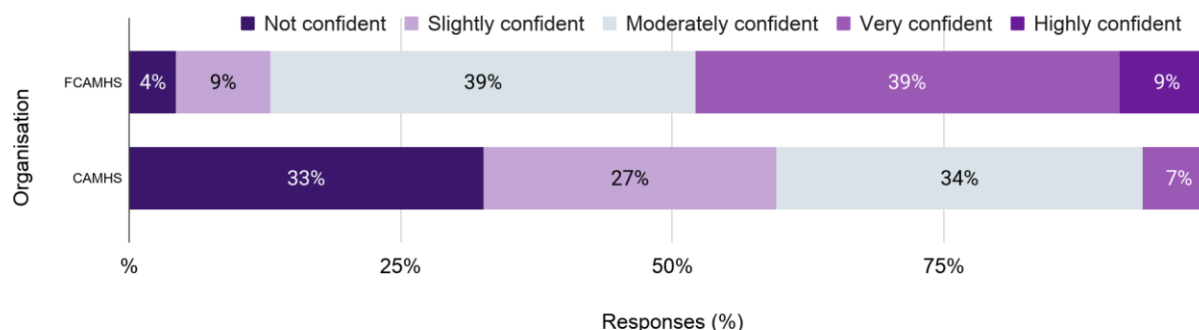
It should be noted that, unlike the five cross-cutting questions examined in Section 2, the training-related questions discussed in this section were largely tailored to each survey individually, reflecting the different roles, responsibilities, and existing training structures of each surveyed group. As a result, formal statistical comparison across groups is possible for only one measure in this section - confidence distinguishing violence-fixation risk from ideologically-

driven radicalisation risk, which was asked in a directly comparable form in CAMHS and FCAMHS. Elsewhere in this section, findings are reported descriptively, on the basis of the percentage of respondents within each survey, rather than tested for statistical significance between groups.

Health/Clinical: a confidence gap between generalist and specialist services

CAMHS and FCAMHS showed a significant split in confidence distinguishing non-ideological violence-fixation risk from ideological risk ($p < .001$): Six in ten CAMHS respondents (60%) reported feeling 'not confident' or only 'slightly confident' distinguishing violence-fixation risk from ideologically-driven radicalisation risk, compared with fewer than one in seven FCAMHS respondents (13%).

How confident are CAMHS / FCAMHS professionals distinguishing non-ideological VF risk from ideological radicalisation risk?



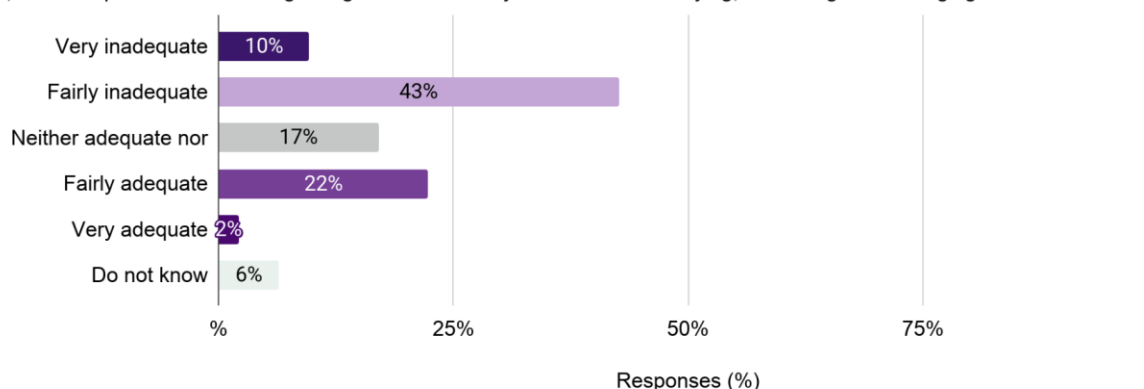
This pattern also extends to the type of training received. CAMHS staff most commonly cited Prevent/counter-radicalisation training and general safeguarding training, while FCAMHS respondents most commonly cited FCAMHS-specific training and structured risk-assessment tools, such as SAVRY. This points to a difference in the type of training each service draws on, consistent with FCAMHS's more specialist forensic remit.

This reflects the two services' different roles. FCAMHS is the specialist forensic arm, while CAMHS is the much larger generalist frontline service that FCAMHS supports. Unlike CAMHS, FCAMHS is not present in every local authority area, reflecting its status as a specialist rather than universal service. Importantly, these results also suggest that the workforce most likely to be a child's first point of clinical contact is also the workforce reporting the least confidence in distinguishing violence-fixation risk from ideological radicalisation risk and the least VFI-specific training.

Channel, CTP and MAPPA: where training falls short

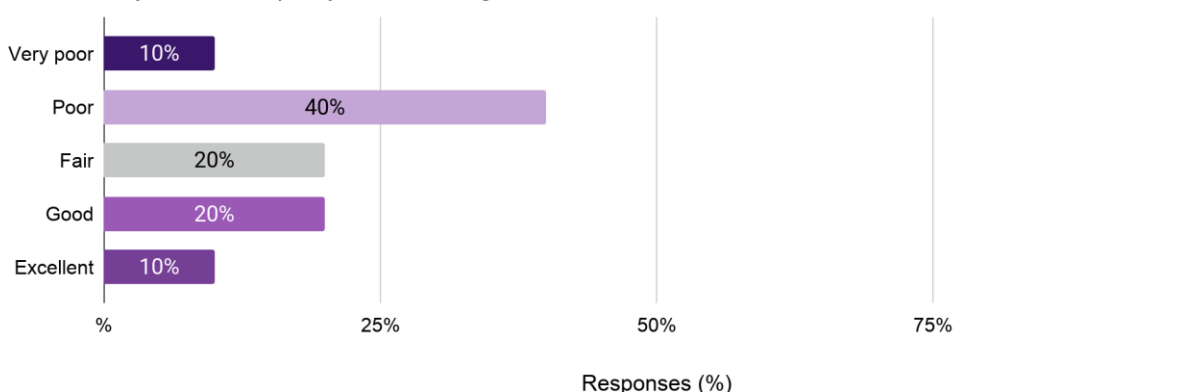
Training adequacy was rated lowest in this cluster of any surveyed. Over half of Channel Chairs (53%) rated the training and guidance currently available to them as 'fairly' or 'very' inadequate; only around one in four (24%) rated it adequate.

Overall, how adequate are the training and guidance currently available for identifying, assessing and managing VF risk?



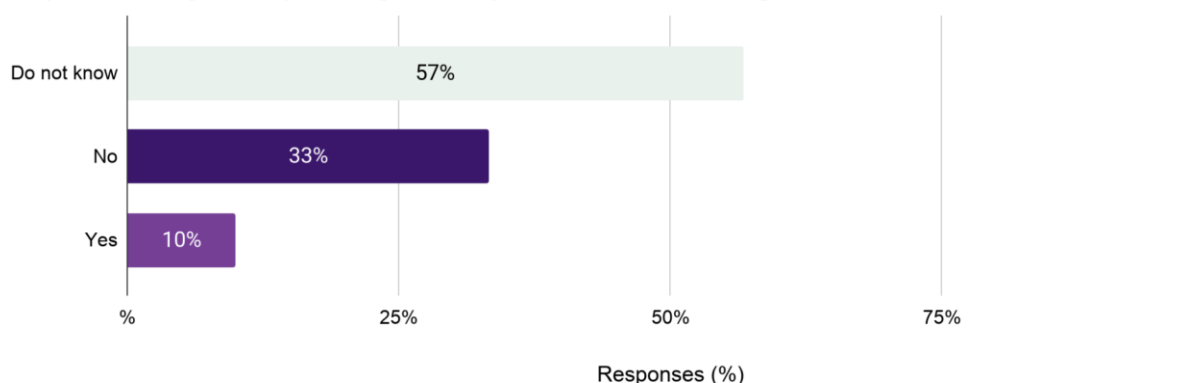
Half of all CTP responses indicated that the quality of the training CTUs received was ‘poor’ or ‘very poor’. This sits alongside moderate-to-high self-reported confidence distinguishing VF from ideological risk in the CTP survey, suggesting officers may be drawing on general professional experience and judgement to compensate for gaps in formal training, rather than the training itself providing this confidence. One respondent noted: *‘We were not set up for this. We have been well versed in the meaning of terrorism and what constitutes terrorist offending but we are not trained or experienced in dealing with individuals with such high levels of complex needs.’*

How would you rate the quality of the training?



As for MAPPA, when respondents were asked whether partner agencies in their area had received training relevant to VFI, the largest single response (57%) was ‘do not know’, with only one in ten respondents answering yes. This points to a training and awareness gap that extends beyond MAPPA's own service, to visibility across the wider system MAPPA depends upon.

To your knowledge, have partner agencies in your area received training relevant to VF risk?



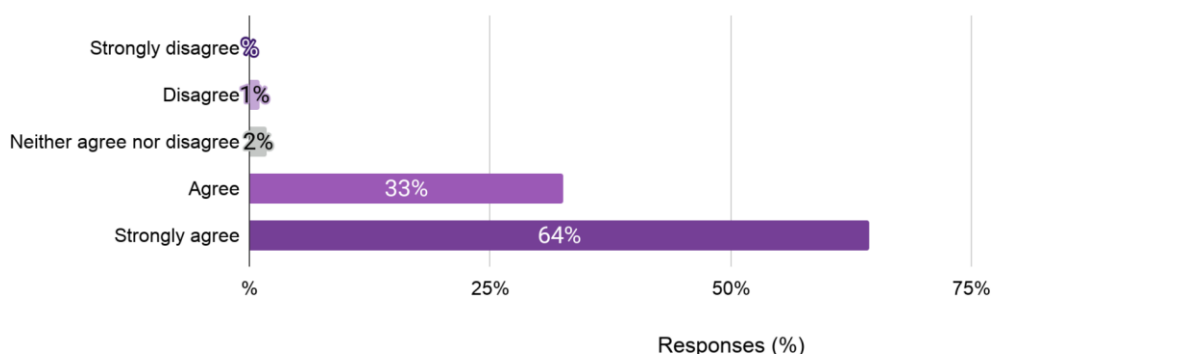
Local Authority/Education: the widest gap between confidence in escalating and confidence in the concept of violence-fixation risk itself

This cluster shows a distinctive pattern: high levels of confidence in knowing who to contact and how to escalate a concern, as opposed to considerably lower confidence in formal training on violence-fixation risk specifically.

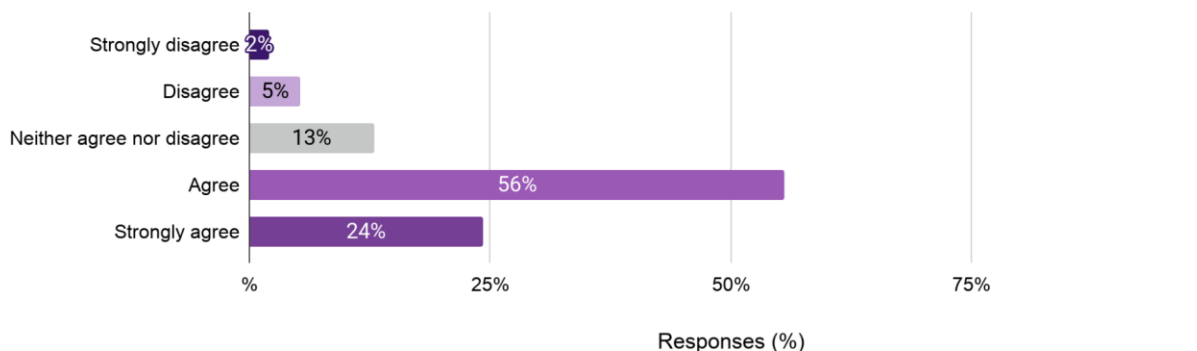
Among LA practitioners, 97% said they would feel confident raising a VFI case with senior managers when there is a risk of harm to others, and 80% agreed they know who the key partners are. However, when asked about training received specifically on VFI, 70% reported having received none at all. One respondent noted: *'I need to be clear that I have not been offered or attended any training on violence fixation.'*

Notably, responsibility for VFI-related training is not uniform across the country: the Home Office provides e-learning centrally, and funds face-to-face training for education and Local Authority staff in some areas, but in areas without this funding, responsibility for arranging equivalent training falls to individual Local Authorities and education settings themselves. This may help explain the pattern of training gaps reported here and elsewhere in this section, rather than reflecting a uniform lack of effort or priority across all areas.

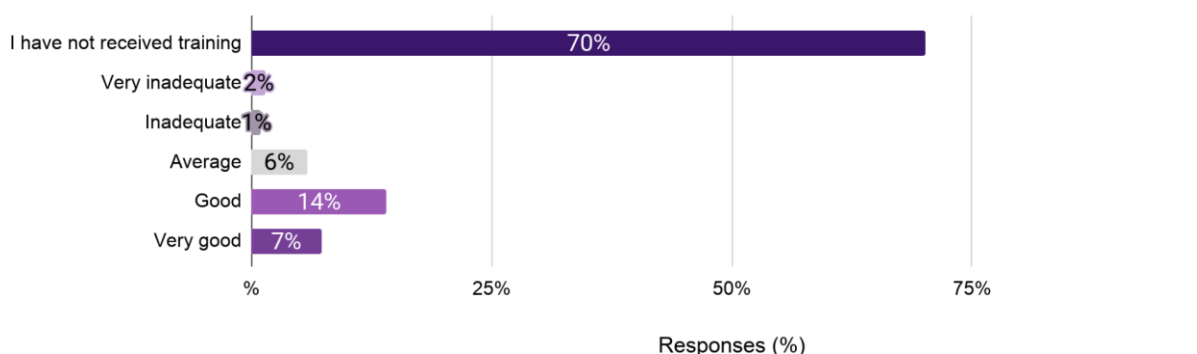
I would feel confident raising cases of VFIs with senior managers, particularly where there is a risk of harm to others.



I am aware of who the key partners are and how to contact them, for support, in the identification and management of an individual with violence-fixation or vulnerable to being drawn toward violence-fixated harm.

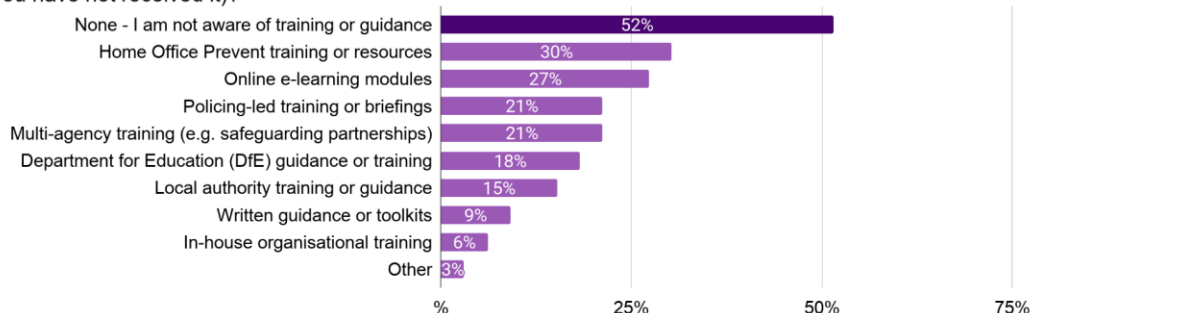


How would you rate the adequacy of the training you have received in identifying and responding to concerns about fixation with violence?



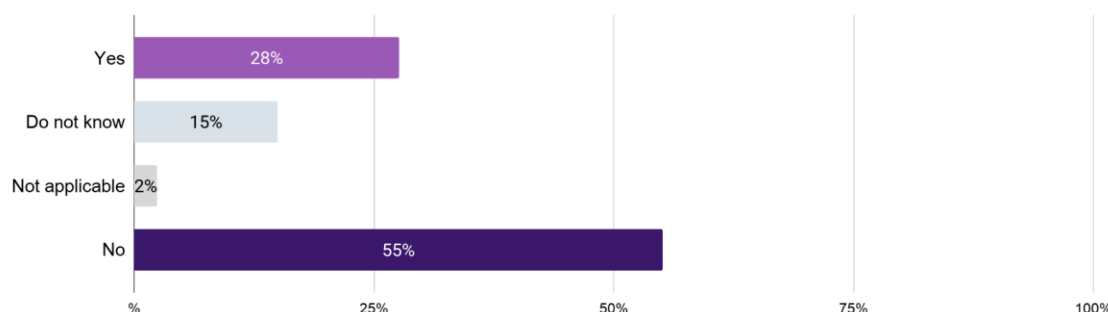
Over half of DSL respondents (52%) said they were not aware of any training or guidance currently available to them on violence-fixation risk, and nearly three in four (73%) reported receiving no specialist training in identifying or responding to violence-fixation risk. One DSL respondent summarised what they perceived to be the underlying challenge: *'training for educators should be mandatory and free, not simply 'best practice' and exclusive to colleges who can pay for it.'*

Are you aware of any training or guidance that is currently available to you on violence fixation/targeted violence risk (even if you have not received it)?



Regarding LA senior leaders, over half (55%) reported that teams in their area have not received training relevant to identifying or assessing violence-fixation risk, and a further 15% didn't know either way.

How would you rate the adequacy of the training you've received on VFIs?



Overall, a similar pattern is evident across both training and process clarity questions. DSLs, FCAMHS and LA practitioners consistently reported comparatively greater clarity of processes and stronger levels of training, whereas CAMHS, Channel and MAPPA reported comparatively lower levels on both measures. This broadly reflects the pattern identified in Section 2 in relation to understanding of violence-fixation risk and recognition of its indicators, with similar groups tending to fall at the higher and lower ends of the findings. Across these themes, services with a more specialist or frontline-focused role tended to report greater confidence and clarity than more generalist or statutory multi-agency bodies. This suggests that the differences observed may relate less to the capability of individual staff and more to the extent to which organisations provide the specialist training, guidance and processes required to support a confident response to VFI.

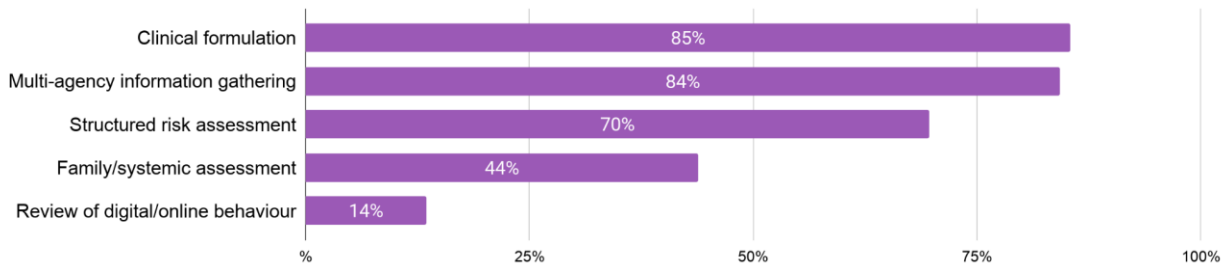
Section 4: Assessment, Tools & Case Management Practice

The clinical services (CAMHS, FCAMHS) were also asked which specific assessment methods and tools they use to evaluate a case, and how well existing clinical frameworks support identifying different aspects of risk.

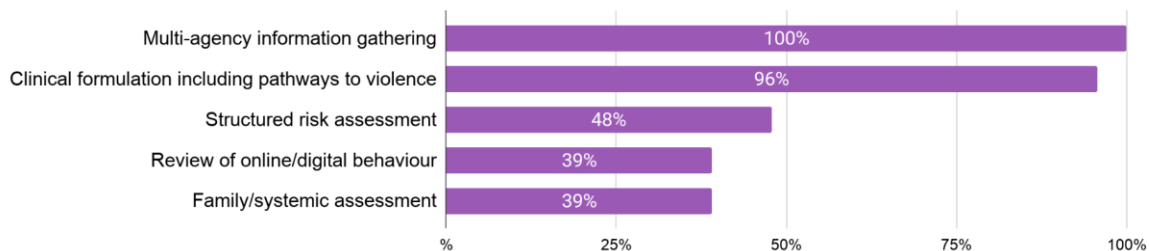
Health/Clinical: limitation of current assessment methods

Both CAMHS and FCAMHS were asked which methods they routinely use when assessing a possible VFI case.

CAMHS: When assessing violence fixated individuals, which are routinely completed?



FCAMHS: When assessing violence fixated individuals, which are routinely completed?



- Clinical formulation and multi-agency information gathering were the two most commonly used methods in both services, used by 84-100% of respondents).
- Review of a young person's digital or online behaviour is, in both services, among the least-used assessment methods of all - used by only around 1 in 7 (14%) of CAMHS respondents and 2 in 5 (40%) of FCAMHS respondents.

This finding warrants particular consideration because it contrasts with the indicators that CAMHS and FCAMHS respondents reported observing in practice. Both groups identified online-related indicators - including engagement with violent or extremist content, obsessive research into weapons or attacks, and the sharing or posting of concerning content - as common features of the cases they encounter, with these indicators reported in 55-87% of cases across the two services. Nevertheless, online behaviour appears to be among the areas least likely to be formally reviewed as part of the assessment process.

This may indicate a gap between the indicators practitioners observe in practice and those that are systematically captured within formal assessment processes. The finding is also consistent with the earlier result that clinical assessment frameworks were perceived as providing only limited support for identifying risk. In CAMHS, 41% of respondents rated existing frameworks as providing either 'not at all' or 'limited' support in relation to the 'risk posed to others' domain.

Notably, CAMHS respondents provided significantly lower ratings on this measure than FCAMHS respondents ($p = .002$). This suggests that CAMHS respondents perceived the assessment frameworks available to them as offering less support for identifying risk to others than those used within the more specialist FCAMHS context.

This issue was also raised directly by practitioners elsewhere in the survey. One Youth Justice respondent noted: *'in social care, the assessment framework focuses on assessing risk to the child/yp and not risk they may pose to others.'* A MAPPA respondent raised a similar concern from a different part of the system, stating that *'the Continuum of Need framework primarily focuses on risks to the child, rather than risks posed by the child to others.'* These comments are consistent with the quantitative findings above and suggest that, in some parts of the system, existing assessment frameworks may place greater emphasis on risks to the child or young person than on risks they may pose to others.

Neurodivergence and the risk of mislabelling

Neurodivergence, and autism in particular, was one of the most frequently reported characteristics associated with VFI cases across the clinical services surveyed. Specifically, 85% of CAMHS respondents and 96% of FCAMHS respondents identified autism spectrum condition as a feature observed in these cases. Channel respondents also identified 'neurodivergence/autism spectrum disorder expertise' as a specific gap in the expertise available to some panels.

One DSL respondent highlighted the apparent scale of this association from an education perspective and explicitly invited further analysis by the Inquiry: *'We know that around 50% of referrals include a neurodivergent diagnosis - while this isn't causal... Is there further analysis that can be done - e.g. of those with a violent fixated interest, how many are neurodivergent?'*

Importantly, several respondents also raised concerns about the potential for the term 'violence-fixated individual' to result in the mislabelling of neurodivergent children where intense or highly focused interests may be interpreted as indicators of violence-related risk. One LA practitioner observed: *'Most of the children we support are neurodiverse and can become fascinated rather than fixated with [a topic]... I do feel slightly concerned about children being labelled as being a violence-fixated individual'*. Another LA practitioner linked this concern to the interventions available once a case enters a formal pathway: *'Intervention Providers are trained around ideology which is of little use... these services are stretched and are set up to focus on the risk TO the individual rather than the risk to the wider public FROM them'*.

A similar concern was expressed by an LA senior leader, who argued that greater emphasis should be placed on underlying needs and circumstances rather than on the VFI

label itself: *‘the term violence fixated or fascinated individuals is often unhelpful because it describes a symptom rather than a distinct cohort. The focus should instead be on understanding the underlying causes, such as mental health needs, neurodiversity, trauma, social isolation, relationship difficulties, radicalisation, offending behaviour or exploitation’*. Another LA senior leader drew a parallel with a previous Serious Case Review involving a child with complex autism, referring to a similar pattern of *‘fragmented ownership of risk, diagnostic uncertainty, [and] false reassurance created by periods of apparent stability’*.

In summary, neurodivergence was frequently reported alongside VFI-related indicators across the services surveyed, but respondents also cautioned against treating this association as evidence that neurodivergence itself is indicative of violence-fixation risk. The findings therefore point to the importance of distinguishing between neurodivergent characteristics and behaviours that may genuinely indicate risk, to reduce the potential for over-identification or inappropriate labelling.

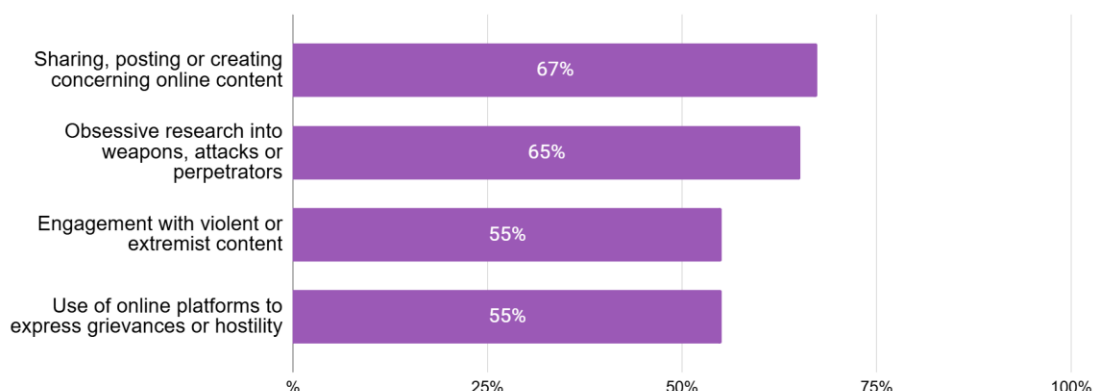
Section 5: Online and Digital Dimensions

Across the surveys, two consistent findings emerged regarding the role of the internet and social media in VFI-related cases. First, online activity was frequently reported as a feature of these cases. Second, respondents identified limitations in their ability to assess and respond to this activity, including in relation to legal powers, technical capability and organisational capacity.

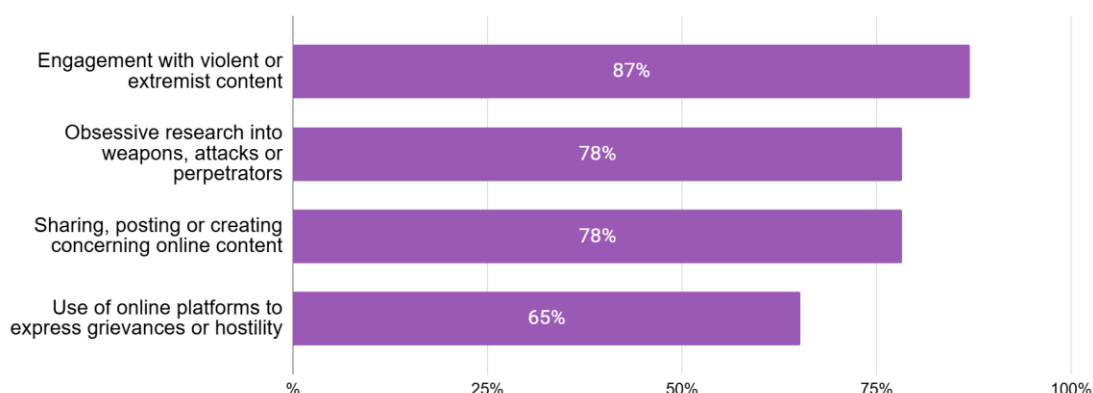
Online activity is a routine, not occasional, feature of violence-fixation risk

All CTUs (100%) reported that VFI cases within their experience involved online activity either ‘relatively frequently’ (30%) or ‘very frequently’ (70%). This is consistent with findings from CAMHS and FCAMHS concerning the indicators observed in practice. Across both services, online-related behaviours - including engagement with violent content, obsessive research into weapons or attacks, and the posting or sharing of concerning material - were reported as being present in more than 55% of the cases encountered.

CAMHS - Which of the following online indicators are most commonly observed in referrals of this type?

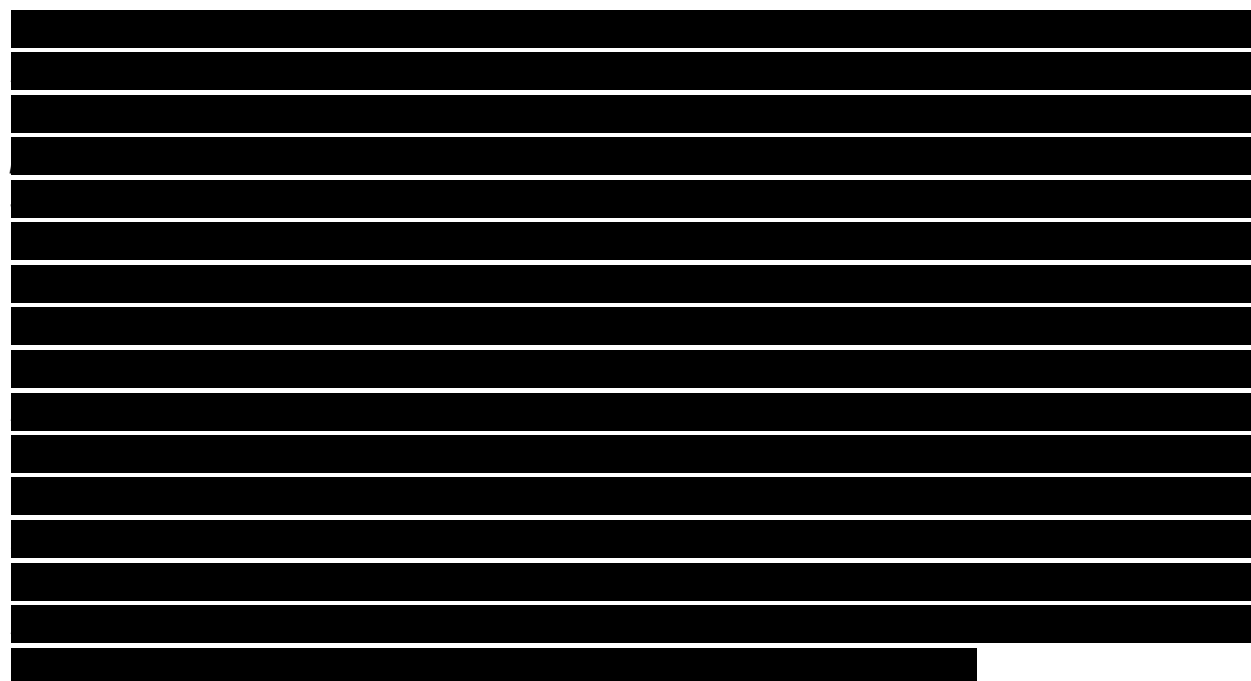


FCAMHS - Which of the following online indicators are most commonly observed in referrals of this type?



Limitations in the tools and powers available to assess online indicators of risk

Counter terrorism units were asked whether they had appropriate tools and powers to access and assess online activity for the purposes of identifying and managing risk. Their responses identified three recurring areas of concern, namely the adequacy of existing legal powers, operational capacity and resourcing, and the extent of cooperation from online platforms.



These responses suggest that the challenge identified by CTUs is not confined to a single aspect of online risk assessment. Rather, respondents described a combination of legal, operational and platform-related constraints which may limit the extent to which online activity can be systematically accessed, assessed and addressed in VFI-related cases.

Channel and LA perspectives: capability gaps and emerging online cultures

Channel Chairs identified similar concerns from the perspective of panel capability. Half (50%) reported *‘online behaviour and online escalation’* as an area in which their panel lacked sufficient expertise. One Channel Chair linked this directly to questions of access, capability and resourcing: *‘much of a young person's online activity takes place in the home/on personal devices... If panels are to be responsible for identifying, assessing and monitoring the risk from online influences, then there is a need for rights to access and digital capability/resource as well’*.

Local Authority practitioners provided further detail on the forms that online-related concerns may take in practice. One respondent described what they perceived to be an increasingly visible pattern: *‘There has been a noticeable rise in young people, predominantly males, engaging with online content linked to the ‘manosphere,’ influencers such as Andrew Tate, and drill music culture, which can normalise or promote harmful attitudes towards violence, masculinity, and control’*. Other respondents raised related concerns about algorithmic exposure to content, the difficulty of identifying or monitoring encrypted or otherwise less visible online activity, and differences in digital knowledge and familiarity between practitioners and the young people they support.

Together, this indicates that the online dimension of VFI-related risk is widely recognised across the services surveyed. At the same time, respondents identified limitations in the legal powers, technical capability, specialist expertise and workforce capacity available to assess and respond to online activity consistently.

Section 6: Multi-Agency Working, Information Sharing, and Lead Agency Clarity

Lead agency responsibility is not consistently clear

Across the groups asked about lead agency responsibility, the findings indicate that a clear lead agency is not consistently identified. In relation to high-risk cases, only 33% of CAMHS respondents reported that a lead agency is clearly identified, compared with 61% of FCAMHS respondents. This difference was statistically significant ($p = .025$). This finding is consistent with the broader pattern identified earlier, whereby FCAMHS respondents tended to report greater clarity of roles and processes than CAMHS respondents. However, this distinction was less pronounced when FCAMHS respondents were asked specifically about cases involving risk to others. In these cases, fewer than half (48%) reported that a lead agency is typically identified, indicating that clarity of responsibility is not consistent across all case types even within the more specialist service. A similar pattern was evident outside the clinical system. Among DSLs, only 18% reported that a single agency is typically designated as the lead, while 55% reported that no single agency is designated. Among MAPPA respondents, also only half (50%) described responsibility while a case remains open as being ‘usually’ or ‘always’ clear.

This suggests that responsibility for managing violence-fixation risk is not consistently allocated to a clearly identified lead agency across the services surveyed. In a substantial proportion of cases, respondents reported either uncertainty about where responsibility sits or the absence of a single agency designated to take the lead.

Clarity of responsibility following closure or transition varies across services

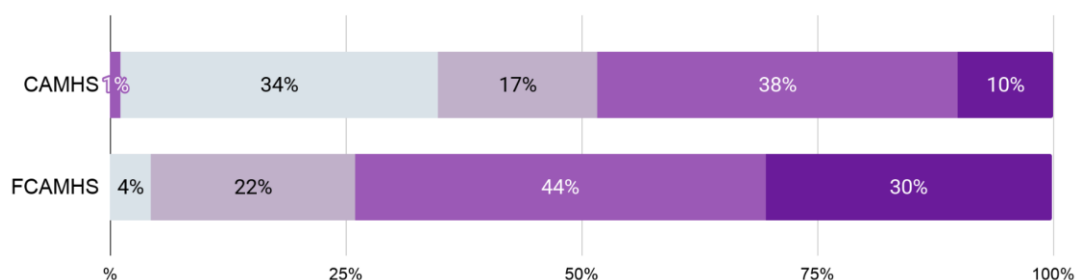
Where a case moves out of formal management, the clarity of lead responsibility appears to vary between services. Among Channel Chairs, 39% reported that lead responsibility was ‘usually’ or ‘always’ clear while a case remained open. This proportion fell to 34% where a case was closed or not adopted. MAPPA respondents reported a different pattern, however. Half (50%) described responsibility as ‘usually’ or ‘always’ clear while a case remained open, rising to 63% once the case was closed. This suggests that closure and transition may represent a point of uncertainty in some parts of the system, particularly within Channel, but that this pattern is not consistent across all services.

The perceived effectiveness of multi-agency working is uneven

The findings indicate that, even where agencies work together, respondents do not consistently regard those arrangements as effective. FCAMHS respondents rated partnership working more positively than CAMHS respondents: 74% of FCAMHS respondents described working with partner agencies as ‘effective’ or ‘very effective’, compared with 48% of CAMHS respondents, with this gap being statistically significant ($p = .050$).

How effectively does your service work with partner agencies in VFI-type cases?

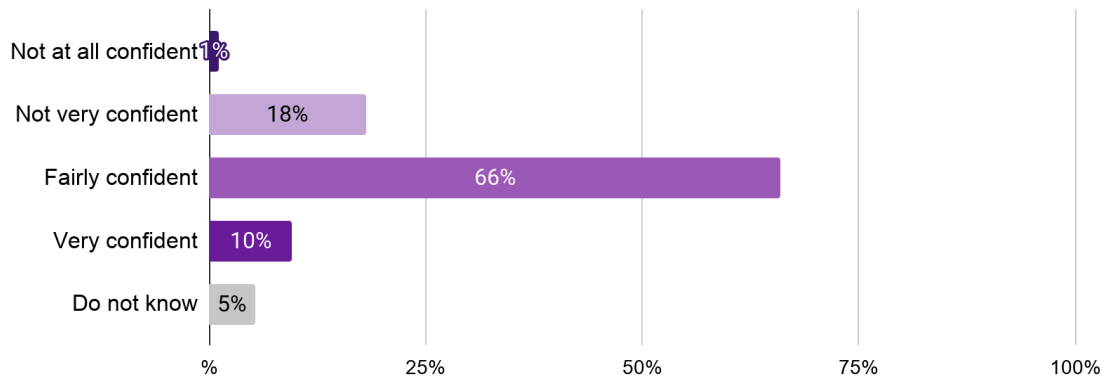
■ Ineffectively ■ Unsure / varies depending on agency ■ Neither effectively nor ineffectively ■ Effectively ■ Very effectively



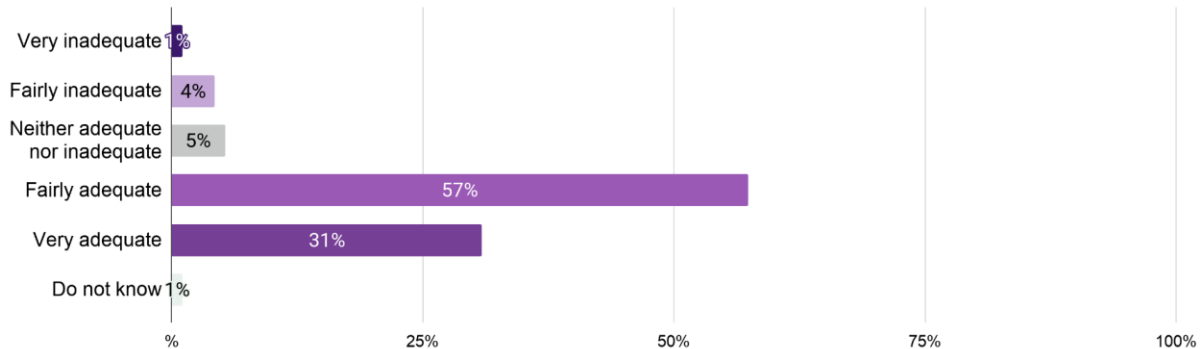
Channel Chairs reported comparatively positive views of the expertise and seniority represented on their panels, but were less positive about the interventions available to support their work. More than three-quarters (76%) rated panel expertise and 88% rated panel seniority as ‘fairly adequate’ or ‘very adequate’. By comparison, 44% rated the interventions currently available as ‘adequate’, while 62% considered interventions for VFI-related cases to be less adequate than those available for cases involving ideologically motivated terrorism. This indicates that, although respondents generally viewed the expertise and seniority within Channel positively, they were

less confident about the range or adequacy of interventions available once risks had been identified.

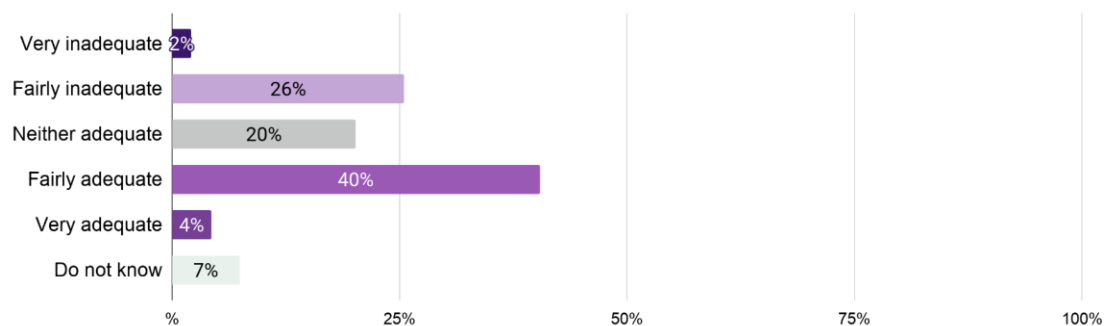
How confident are you that your panel has the expertise needed to identify, assess and manage VF risk?



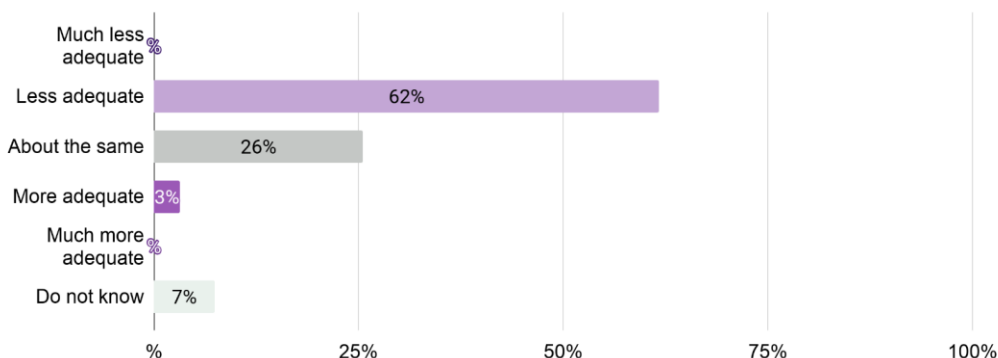
When dealing with cases involving violence-fixed risk, how adequate is the seniority of panel members for effective decision making?



Overall, how adequate are the interventions currently available for managing VF risk?

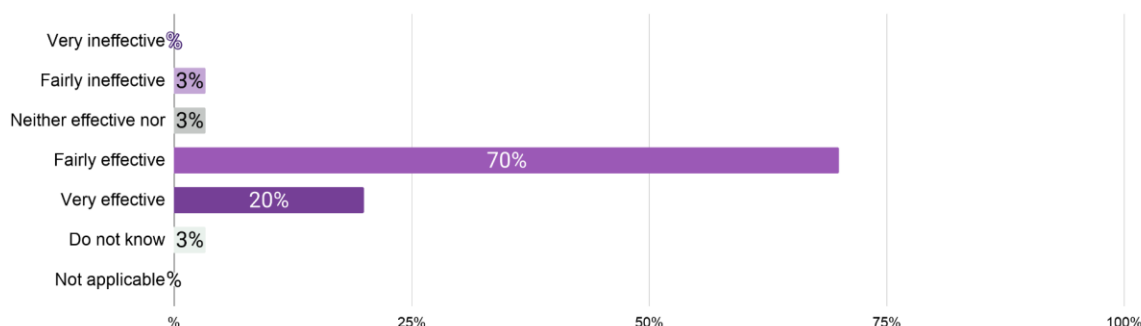


Compared with cases involving ideologically motivated terrorism risk, how would you define the adequacy of interventions for violence-fixated risk?



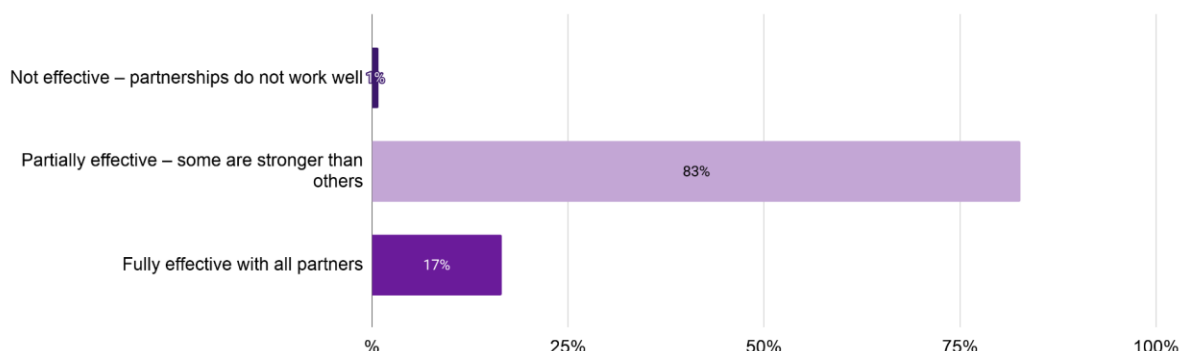
MAPPA respondents reported particularly positive experiences of information sharing, with 90% describing information sharing with other key local processes as ‘fairly effective’ or ‘very effective’.

How would you describe information sharing between the multi-agency public protection arrangements in your area and other key local safeguarding or threat management processes?



Local Authority senior leaders presented a more mixed picture. The majority (83%) described working arrangements with key partners as partially effective, indicating that some arrangements worked more effectively than others, while 17% regarded partnership working as fully effective across the board.

How effective do you consider working arrangements and relationships with key partners to be in managing VFI-type cases?



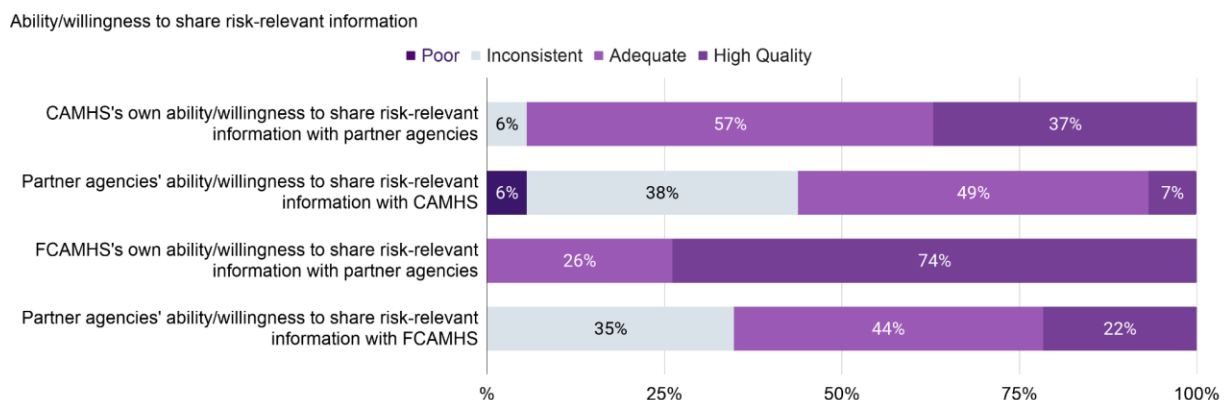
These findings suggest that multi-agency arrangements are operating across the services surveyed, but their perceived effectiveness varies between organisations and across different

aspects of partnership working. The Channel findings also indicate that positive assessments of panel expertise and seniority do not necessarily correspond with equivalent confidence in the interventions available to respond once a risk has been identified.

Lack of trust in adequacy of information received via partner agency

Another noteworthy pattern emerged among the two services asked to assess information sharing in both directions: the quality of information their own service shares with partner agencies, and the quality of information received from those partners. In both CAMHS and FCAMHS, respondents rated information shared by their own service substantially more positively than information received from other agencies. These differences were statistically significant within the same respondents.

Among CAMHS respondents, 94% rated the information their service shared with partner agencies as 'adequate' or 'high quality', compared with 56% who gave the same rating to information received from partner agencies. This difference was statistically significant ($p < .001$). A similar pattern was evident among FCAMHS respondents: 100% rated their own service's outward information sharing as 'adequate' or 'high quality', compared with 65% for information received from partner agencies ($p = .001$).

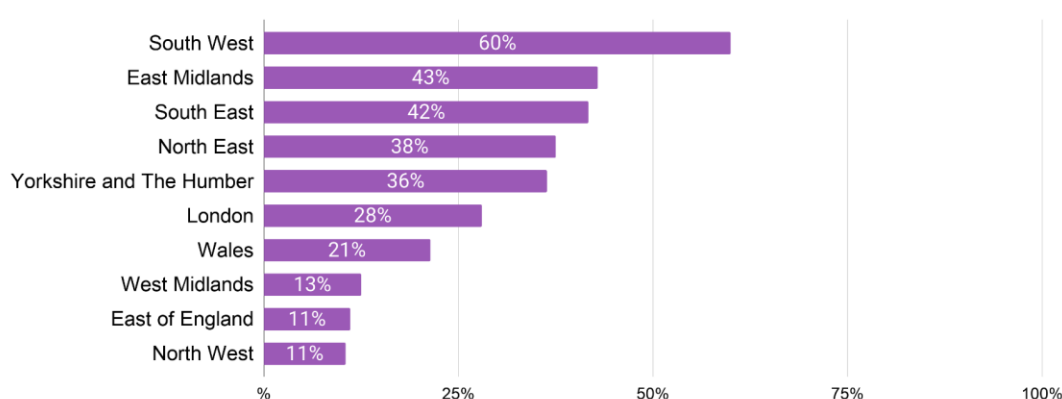


Respondents in both services expressed high levels of confidence in the information provided by their own organisation, while assessing information received from partner agencies less positively. The findings do not establish where responsibility for this difference lies. They may reflect barriers in the transfer of information between agencies, differences in the type or quality of information required by different services, or differing perceptions of the same information-sharing processes. This is therefore an area that may warrant further examination by the Inquiry.

Ownership gaps and non-recording

Uncertainty regarding lead responsibility is accompanied, in some parts of the system, by limitations in the extent to which VFI cases are routinely recorded. Among LA senior leaders, 51% reported that their teams had managed individuals presenting violence-fixation risk during the previous three months. However, 27% reported that their organisation did not record whether it had managed individuals of this kind. This limits the extent to which the overall volume of VFI-related activity within local authorities can be reliably quantified. There was also regional variation in the reported recording practices. The proportion of LA senior leaders reporting that their organisation did not record VFI cases ranged from 60% in the South West and 43% in the East Midlands to 11% in both the North West and East of England.

Non-recording of VFI cases by region

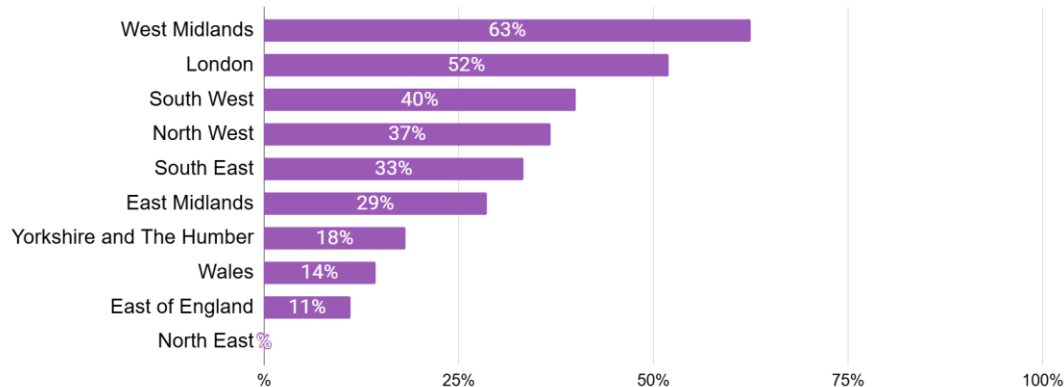


One respondent illustrated the practical implications of these recording limitations, particularly where VFI cases do not progress sufficiently far through a formal pathway to be captured by existing records. *'Children's Social Care does not routinely collect data on children identified as violence-fixated individuals (VFI), so it cannot reliably quantify the number identified in the last year. A manual review of Channel Panel records identified fewer than 10 children. However, this excludes children who completed a Gateway Screening or Assessment and did not progress to Channel Panel'*.

Uncertainty regarding ownership was also reported across several of the other groups surveyed, although to differing degrees. Among LA senior leaders, 32% reported having experienced cases in which ownership was unclear. This proportion varied across regions, including 63% in the West Midlands and 52% in London, compared with zero in the North East and 11% in the East of England. Among DSL respondents, 21% reported having experienced unclear ownership or responsibility. The proportion was substantially higher among CTP respondents, all of whom (100%) indicated that their CTUs had experienced a VFI-related case in which ownership or responsibility was unclear. One CAMHS respondent described the consequences of uncertainty over responsibility in practice: *'People with violence fixation risk appear to fall between the gaps,*

if they have not committed any crime, there is often nowhere for them to go... Social care will say it's a health issue and health say its a social care issue'.

Unclear case ownership by region



Consistent with these findings, respondents across LA practitioners, LA senior leaders, DSLs and MAPPA identified a recurring set of barriers when asked why joint working may break down. Limited capacity or resources and unclear roles or responsibilities were among the most frequently cited factors, alongside limited expertise in this type of risk and differences in legal or statutory thresholds.

This analysis, therefore, highlights two related challenges, namely uncertainty about which agency holds responsibility for some VFI-related cases, and limitations in the systems used to record and quantify those cases. The latter also constrains the extent to which the scale and distribution of VFI-related activity across the system can be established from routinely collected data.

Section 7: Statutory/Legal Framework and Thresholds

Concerns over suitability of existing statutory frameworks for VFI cases

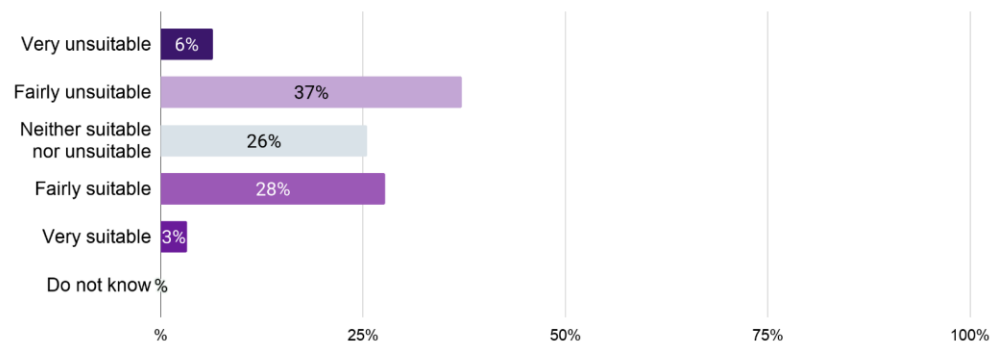
Respondents from CTP, Channel and MAPPA were asked about the suitability of the statutory or operational frameworks within which they manage VFI-related risk. Views varied between the three groups, although concerns about the extent to which existing arrangements are suited to this form of risk were evident across the responses.

Counter terrorism units expressed the strongest concerns. Nine in ten CTP respondents (90%) indicated that the existing CTP structures and working practices are not well suited to identifying, assessing and managing non-ideological or violence-fixation risk. All CTUs (100%) also reported that, within the current framework and level of resourcing, CTP was not effective in practice at managing this form of risk. One respondent described the perceived statutory limitation as:

'Section 36 states that there must be reasonable grounds to believe that the individual is vulnerable to being drawn into terrorism, however this often does not align with VFI-type cases... Similarly, the Prevent Assessment Framework is not designed with VFI in mind and so some aspects of it are not applicable to these cases'.

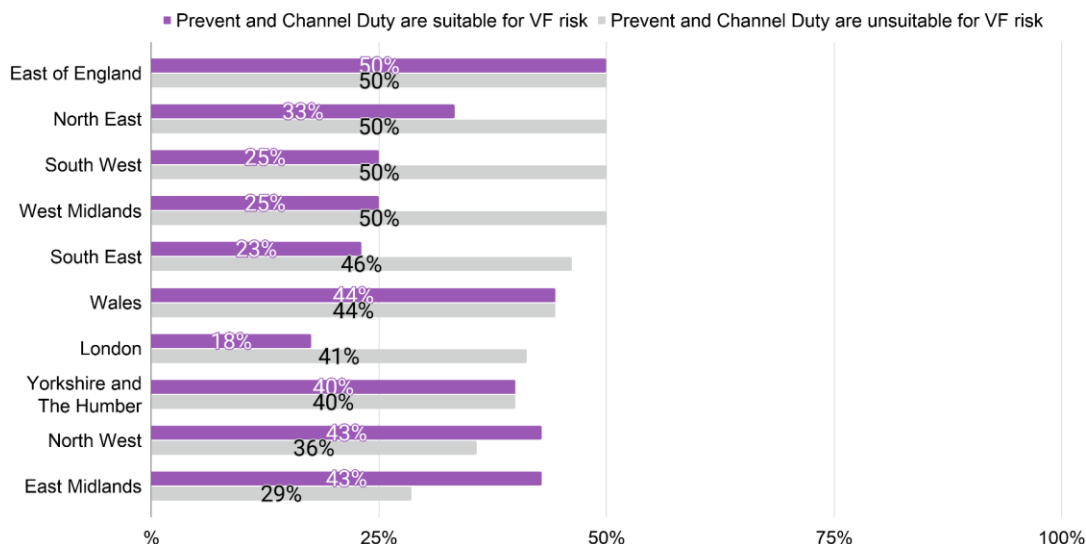
Channel Chairs expressed more mixed views. Just under one-third (31%) rated the current Prevent framework and Channel Duty Guidance as 'fairly suitable' or 'very suitable' for managing violence-fixated risk, while 43% rated it 'fairly unsuitable' or 'very unsuitable'.

Overall, how suitable are the current Prevent framework and Channel Duty guidance for managing VF risk?

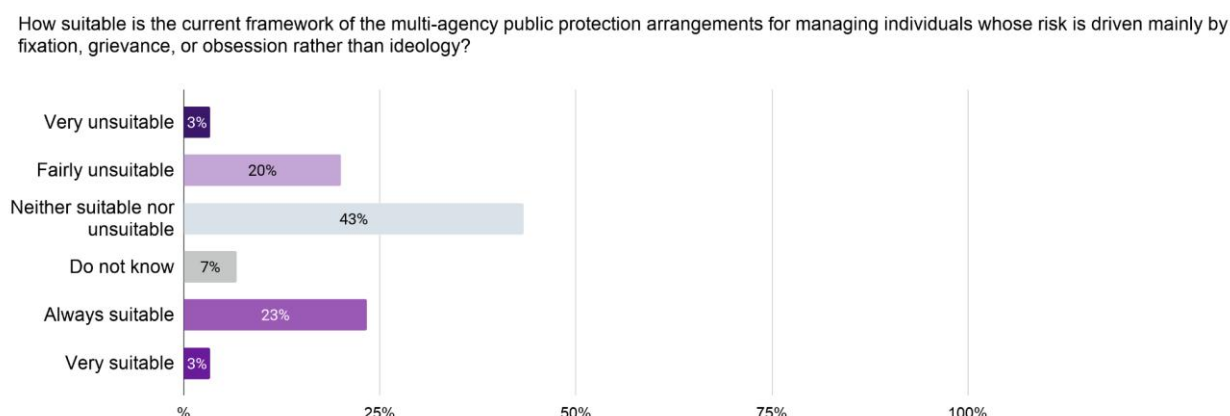


Notably, there was some regional variation in these assessments. Among London respondents, 18% rated the framework as suitable and 41% as unsuitable, while respondents in the East Midlands, North West and Wales were comparatively more likely to rate it as suitable, at approximately 43-44%. The proportion rating the framework as unsuitable ranged from 29% to 50% across the regions examined.

Regional variation on views regarding suitability of Prevent and Channel Duty for VF risk



MAPPA respondents expressed more mixed views of their existing framework. Around one-quarter (26%) rated the current MAPPA framework as suitable for managing fixation- or grievance-driven risk, compared with 23% who rated it as unsuitable. The remainder did not express a view at either end of the scale, indicating a greater degree of uncertainty or neutrality than was evident among other groups surveyed.



Some respondents also questioned whether extending existing statutory arrangements to encompass VFI-related risk would necessarily provide an appropriate solution. One CTP respondent expressed concern that doing so could extend Prevent beyond its existing purpose: *‘General consensus that Prevent are not the right agency/department to be managing such risk. The addition of the VFI cohort has had a detrimental effect upon Prevent efficiency in managing ideological risk. It has watered down the roles and remit of Prevent’*. From a different perspective, one FCAMHS clinician raised concerns about the implications of creating legislation directed specifically at individuals considered to present risk in the absence of a diagnosable mental health condition: *‘legislation specifically for those considered to be a risk, but without diagnosable mental health illness, pathologises violent behaviour, removing autonomy, personal responsibility and accountability for those who do have capacity’*.

These findings indicate concerns across several parts of the system about the extent to which existing statutory and operational frameworks are suited to violence-fixation risk, particularly where VF is not accompanied by an ideological or terrorism-related basis for intervention. The strength of these concerns varied between groups - concerns were most pronounced among CTP, more mixed among Channel Chairs, and substantially less clear-cut among MAPPA respondents. Responses also indicate that some practitioners questioned not only the adequacy of existing frameworks, but whether adapting or extending those frameworks would itself be an appropriate response.

The eligibility gap: individuals who need managing but do not meet the threshold

The perceived limitations of existing frameworks were also reflected in concerns about individuals who present a high risk of serious violence but do not meet the criteria for management within existing statutory arrangements. Among MAPPA respondents, 67% reported being aware of individuals known to local agencies who presented a high risk of serious violence but did not meet the threshold for management under MAPPA. When asked whether MAPPA should play a greater role in managing high-risk individuals who do not meet traditional offender-based criteria, 63% agreed. This suggests support among a majority of MAPPA respondents for considering whether the framework should have a broader role in relation to individuals who currently fall outside its eligibility criteria.

A separate but related concern was raised across several other groups in relation to the transition from children's to adult services. Respondents described circumstances in which the nature or availability of support changed substantially once an individual reached adulthood, potentially creating gaps in continuity of oversight or intervention. Channel Chairs described this issue particularly clearly. One noted that *'the overwhelming majority of referrals into Channel involving violence-fixated individuals are for young people (under 18)'*, and identified *'a gap in statutory interventions in transition - often, post 18, continuity of services radically changes'*. Another Channel Chair highlighted the potential limitations of adult safeguarding criteria, noting that the legislation requires evidence that an individual *'[is] experiencing abuse and/or neglect from another person... [and is] not able to protect themselves'* - criteria which, in their view, *'may not apply to an individual who is fixated by violence'*. Another Channel respondent described provision for some adults as: *'adults who do not have care and support needs, are not known/current to probation and who do not have mental health issues receive only patchy provision'*.

Local Authority practitioners raised similar concerns from a Youth Justice perspective. One respondent noted that Youth Justice Service involvement may end *'when they turn 18 due to their bail conditions being altered'*, while *'there is no equal support available from the Probation Service'* until after conviction. The respondent considered that this could leave a gap in *'information-sharing, professional monitoring and/or multi-agency working for some young adults awaiting trial'*. A DSL respondent raised a related concern from an education and health perspective: *'CAMHS waiting lists are so long that they won't take on anyone aged 17... but they also don't qualify for adult support, and end up falling through the net'*.

Similarly, CTP raised questions around age-based eligibility thresholds. One respondent questioned the rationale for the age-25 threshold, asking, *'Why have we drawn a line at 25? I do not understand the reason we are not considering over 25?'*

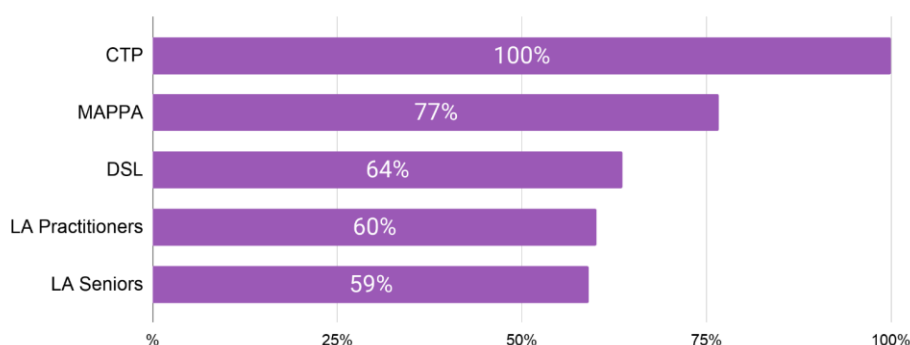
These findings suggest two related areas of concern. First, MAPPA respondents identified a group of individuals who may present a high risk of serious violence but fall outside existing eligibility criteria. Second, respondents across Channel, LA, education and CTP raised concerns about continuity of support and oversight as individuals move between age-based service frameworks. Although the nature of these concerns differed between services, their recurrence across several parts of the system suggests that eligibility criteria and transitions between services warrant further consideration.

Section 8: Service Provision and Specialist Support Gaps

Capacity and resourcing as a recurring barrier

Capacity and resourcing emerged as a recurring concern across several surveyed services. Where respondents were asked about barriers to effective joint working, limited capacity or resources was among the most frequently cited factors. Counter terrorism units described the practical implications of these pressures. One respondent stated: *‘Case load has tripled over the last 18 months, with little in the way of extra support or interventions that we can use to manage such cases. It does very much feel as though we are struggling along to manage these cases and holding a huge amount of risk, without the tools to deal with them.’*

Proportion of respondents who cite limited capacity or resources as a joint working challenge



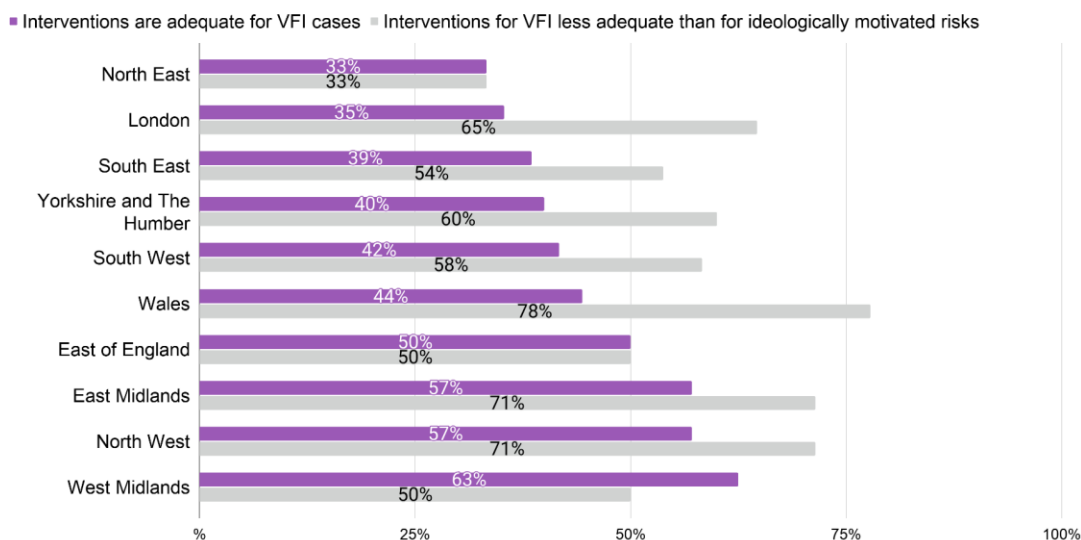
Waiting times and access barriers

CAMHS and FCAMHS respondents were also asked about the main barriers to accessing their services for the VFI cohort. The pattern differed between the two services. Among CAMHS respondents, waiting times were the most frequently cited barrier (41%), followed by consent requirements (30%) and high eligibility thresholds (30%). Among FCAMHS respondents, however, waiting times were not identified as a barrier. Instead, consent requirements were the most frequently cited barrier (30%), followed by high eligibility thresholds (17%).

Adequacy and availability of interventions

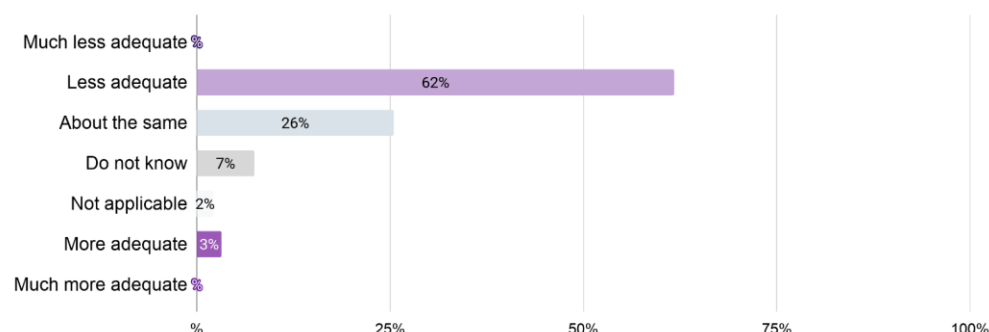
Channel Chairs also raised concerns about the adequacy of interventions available for managing VFI-related risks. Fewer than half (45%) rated the interventions currently available as ‘fairly adequate’ or ‘very adequate’, while 28% rated them as ‘fairly inadequate’ or ‘very inadequate’. Notably, this pattern was not uniform across the regions represented in the survey, with the proportion rating interventions as adequate ranging from 63% in the West Midlands to 33% in the North East.

Adequacy of Channel interventions for VFI cases



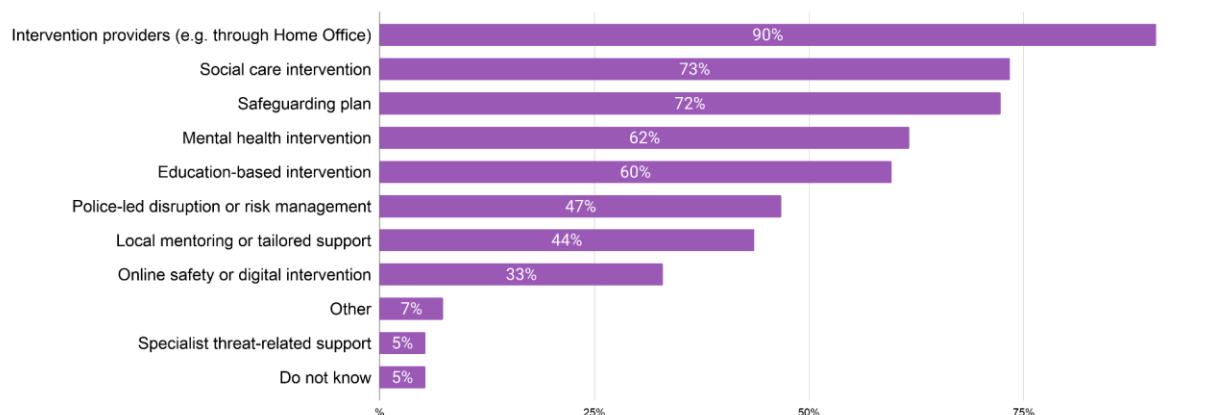
When asked to compare the interventions available for VFI-related cases with those available for ideologically motivated terrorism cases, 62% of Channel Chairs considered VFI-related interventions to be less adequate, while 3% considered them more adequate. One respondent described the distinction as: ‘*Whilst existing safeguarding, Prevent and Channel arrangements provide a strong foundation for identifying and managing complex risk, violence-fixated risk where ideology is not the primary driver remains a less clearly defined area of practice.*’

Compared with cases involving ideologically motivated terrorism risk, how would you define the adequacy of interventions for violence-fixated risk?



The most frequently identified intervention reported to be available to Channel was the use of Home Office-commissioned intervention providers, reported by 90% of respondents. Given that these arrangements have traditionally operated within an ideologically focused Prevent context, this figure raises a question about the extent to which the interventions currently available are suited to cases in which ideology is not the principal driver of risk.

What types of intervention are most commonly available to your panel for managing referrals involving violence-fixated risk?



Concerns about gaps in provision were not restricted to Channel but also raised more broadly. One CAMHS respondent described the position within their region as: *‘Currently no commissioned service for this that we are aware of in our region that leads to gaps in provision & CYP being bounced backwards & forwards between agencies’*. Counter terrorism units identified similar pressures from an operational perspective. All CTP respondents (100%) cited resource and capacity constraints as a challenge when working with partner agencies on VFI-related cases. This indicates that concerns about capacity extend beyond the interventions available once a case enters Channel and include the wider resources available to agencies involved in identifying, assessing and managing this form of risk. An LA senior leader raised a related concern regarding provision for children who did not meet the threshold for custody: *‘where we have concerns for children who are not deemed to meet a threshold for custody then there is no resource for caring for these children... there is a lack of welfare secure and tier 4 adolescent MH beds’*.

This indicates recurring concerns about the availability and capacity of services and interventions for VFI-related cases. Channel Chairs generally assessed the available interventions less positively than those provided for ideologically motivated cases, while respondents from CAMHS, CTP and local authorities described limitations in commissioned provision, workforce capacity and appropriate placements. Therefore, even where VFI-related risk is identified, practitioners may in some circumstances have limited options for referral, intervention or ongoing support.

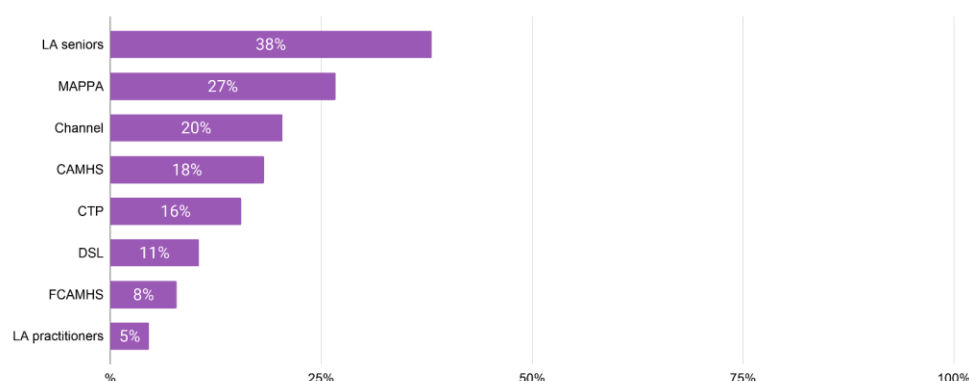
Section 9: What services want to change

For this section, open-text responses across all surveys were reviewed to identify suggestions for improvement or change. This included responses to questions concerning challenges, gaps and potential improvements. Where similar suggestions were raised by multiple respondents, these were grouped thematically. More specific or detailed proposals made by individual respondents are presented through anonymised quotations, with only the respondent's organisation type identified.

How much appetite is there for change, and where is it loudest?

The number of suggestions for change varied considerably across respondent groups.

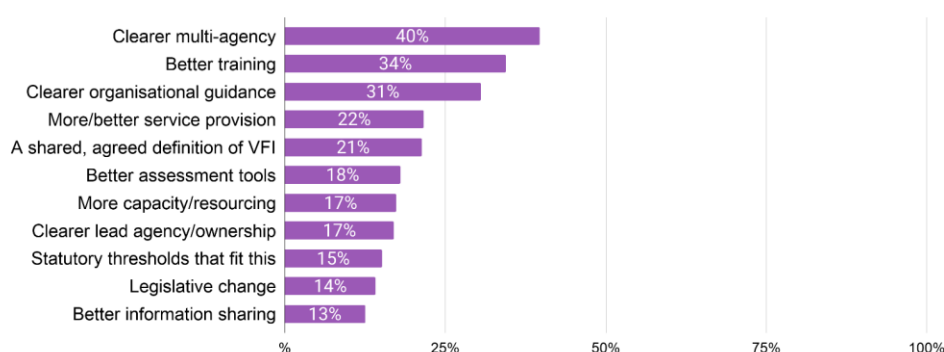
% of Responses with suggestions for improvement



LA senior leaders raised more suggestions for change than any other surveyed group. This indicates that respondents in this group identified a comparatively broad range of areas in which they considered changes or improvements to be required.

What forms of change did respondents propose?

Respondents' suggestions were reviewed thematically to identify recurring areas in which change was considered necessary. The two most frequently identified themes were clearer multi-agency structures and improved training. Both are consistent with findings presented earlier in the report, including those relating to training and preparedness and to multi-agency working and lead agency responsibility.



Proposals for a dedicated multi-agency route

A recurring proposal across several respondent groups was the development of a clearer multi-agency route for managing VFI-related risk. Respondents differed, however, in whether this should involve extending an existing framework, adapting an established model such as MAPPA or Channel, or creating a new structure specifically for this cohort.

Local Authority senior leaders expressed this particularly directly. One respondent stated *‘There is a need for a MAPPA type panel that has the same status as MAPPA’*, while another LA senior leader separately suggested extending existing MAPPA arrangements to include this cohort. Channel Chairs proposed a related but distinct model in which mental health services would have a more explicit coordinating role. One respondent suggested: *‘Establish VFI Case Panels where MH take responsibility for co-ordination in the same way that LA's do for Channel, and Probation for MAPPA’*. Counter terrorism units also proposed alternative multi-agency arrangements. One respondent suggested that relevant cases could be fast-tracked into MAPPA alongside the creation of a multi-agency triage function within CTP. Another proposed a more centralised national model in which safeguarding referrals would be screened before allocation to an existing pathway, drawing comparison with the US *‘Behavioural Threat Assessment Centre’* model. The same respondent also emphasised the need for any such arrangement to operate proportionately: *‘At present anyone referred to Prevent is ending up being assessed by CTP and placed on a CT database. This cannot be proportionate use of State authority... This is the responsible, proportionate way to govern’*. This reflects an important qualification within some of the proposals for greater centralisation or clearer structures. Respondents advocating changes to the way cases are triaged or managed also raised concerns about ensuring that any expanded arrangements remain proportionate, particularly where individuals have not committed a criminal offence. MAPPA respondents expressed more cautious views about extending the existing MAPPA framework without corresponding changes to the powers available within it. One respondent stated that MAPPA *‘would only be suitable for managing these individuals if powers were introduced to allow for appropriate offender management’*, and instead suggested the development of *‘a separate process similar to Prevent’*. There was not, however, universal support for creating a new structure. One CAMHS respondent argued that *‘the issue may be less*

about creating new structures and more about ensuring effective use of existing public protection frameworks alongside strong multi-agency collaboration’.

These responses indicate recurring support for greater clarity in the multi-agency route through which VFI-related risk is managed, but less agreement about the form that such arrangements should take. Suggestions ranged from extending existing frameworks, to creating new specialist panels or triage arrangements, to making more effective use of structures already in place.

Examples of practice already happening locally

A handful of respondents pointed to things already up and running in their area that they consider worth the Inquiry looking at more closely:

- **Hull City Council's Young Futures Panel**, run jointly with the Humber Violence Prevention Partnership, was described as identifying vulnerable young people earlier and coordinating support before things escalate (Yorkshire and The Humber).
- **Operation UMBER25**, a structured force-wide approach to identifying and managing a cohort of violence-fixated individuals, built around a clear 'Pursue, Prevent, Protect, Prepare' framework with defined governance (Staffordshire Police, West Midlands).
- **Lewisham's Integrated Adolescent Service**, which brings together youth justice, missing children, risk outside the home, youth homelessness, and edge-of-care support under a single service (London).
- **Durham's Family Help** model, combining early help and specialist social work with a specific focus on harm to self and others (North East).
- The **REACH Safeguarding Adolescent Service**, an integrated multi-agency service that proactively identifies and manages both the risk a young person poses to others and the risks they themselves face (Wigan, North West).
- Sheffield's **Below Thresholds Prevent Pilot Panel** - described as a genuine local success, but with an honest caveat that its legal footing is unclear, and that this would need resolving before it could be rolled out more widely (Yorkshire and The Humber).

Where respondents identified existing local approaches, these provide examples of how individual areas are attempting to address perceived gaps through earlier identification, integrated services or dedicated multi-agency arrangements. Although such models may differ substantially in their design and remit, they may provide useful areas for further examination by the Inquiry, including consideration of their operation, potential transferability and any legal or structural constraints on wider adoption.

Section 10: Conclusion

Across the groups surveyed, there is a low sense of preparedness to identify, understand and manage young VFIs. No group reports a strong, confident understanding of VFIs except CTP, and this is more pronounced in CAMHS, which have particularly weak confidence, despite being one of the organisations that is most likely to come into contact with CYP. Additionally, practitioners do not feel the tools at their disposal are adequate for identifying the risk posed to others from VFI. There is also a mismatch between the assessments available and the perceived risks. For example, online indicators are reported as a common factor in many actual VFI cases, but this is not an indicator regularly used in assessments by practitioners. Any changes need to be complemented with more training - currently, training is not reaching the practitioners most likely to encounter VFI cases first. Seventy per cent of LA practitioners and 73% of DSLs report having received no VFI-specific training at all.

More broadly, the system is not considered to be suited to cope with the risks posed by VFIs. In particular, counter terrorism mechanisms are not well suited to managing non-ideological violence-fixation risks. Ninety per cent of CTP responses suggest that CTP's structures are not well suited to managing non-ideological violence-fixated risk, and every CTU says CTP is not effective in practice at doing so under current resourcing. Likewise, MAPPA thresholds do not apply to many of the individuals presenting a high risk of VF. This is despite the belief from many respondents that MAPPA should play an important role in managing this cohort, while some MAPPA respondents showed caution in playing a role without the expansion of remit: *'would only be suitable for managing these individuals if powers were introduced to allow for appropriate offender management'*.

Overall, many respondents across all surveys reported being unclear on who should manage the risk, and information sharing looks asymmetric almost everywhere it was measured. Groups consistently rate their own outward sharing more positively than they rate partners' sharing inward - CAMHS rates its own outward sharing as adequate/high quality 94% of the time vs. 56% for partners sharing in; FCAMHS shows an even more substantial 100% vs. 65% gap.

Together, a system not built for this cohort, including structures and thresholds, and limited accountability and clarity on responsibilities, highlights the opportunity to develop structures specifically to manage this cohort, along with clear responsibilities. The two most common issues the respondents want changed are clearer multi-agency structures and better training. However, even if tailored structures are developed, services need more capacity and resources to manage this cohort. Limited capacity or resources were the most commonly cited barrier across stakeholder groups in VFI cases.

Appendix 1. Raw counts and percentages per survey

This appendix presents the questions included in the surveys, together with the number and percentage of respondents selecting each response option. For multi-select questions, the number and percentage of respondents who selected at least one option are reported. Percentages for individual response options are shown both as a proportion of respondents who answered the question and as a proportion of the total sample. These percentages will not sum to 100%, as respondents could select more than one option. For open-text questions, the number of respondents who responded is reported. Individual free-text responses are not reproduced in this appendix but are analysed thematically in the qualitative sections of the report and presented in the subsequent appendix. Where a question was shown only to a subset of respondents - for example, as a follow-up conditional on a response to an earlier question - this is indicated by reporting the number who answered the question relative to the total sample (n answered out of N total).

Raw counts and percentages for CAMHS survey

Q1. Our organisation has a clear and shared understanding of violence-fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk.

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	6	7%	7%
Agree	17	19%	19%
Neither agree or disagree	32	36%	36%
Disagree	31	35%	35%
Strongly Disagree	3	3%	3%

Q2. Staff in our organisation can recognise early behavioural indicators of potential violence-fixation (including online and offline behaviours).

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	8	9%	9%
Agree	43	48%	48%
Neither agree or disagree	28	31%	31%
Disagree	9	10%	10%
Strongly Disagree	1	1%	1%

Q3. Which of the following best describes your area's experience in identifying potential violence-fixation cases in the past 12 months?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
My organisation does not record this dataset	29	33%	33%
No cases identified	8	9%	9%
Fewer than 10 cases identified	42	47%	47%
More than 10 cases identified	10	11%	11%

Q4. Staff in our organisation are confident in identifying potential violence-fixation risk at an early stage.

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	5	6%	6%
Agree	26	29%	29%

Neither agree or disagree	40	45%	45%
Disagree	16	18%	18%
Strongly Disagree	2	2%	2%

Q5. Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence-fixation risk (including working with relevant partner agencies where appropriate).

89 out of 89 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	2	2%	2%
Agree	40	45%	45%
Neither agree or disagree	21	24%	24%
Disagree	19	21%	21%
Strongly Disagree	7	8%	8%

Q6. Staff in our area understand what actions to take when a potential violence-fixation risk is identified.

89 out of 89 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	3	3%	3%
Agree	44	49%	49%
Neither agree or disagree	22	25%	25%
Disagree	15	17%	17%

Strongly Disagree	5	6%	6%
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Q7. Details Service Type

89 out of 89 respondents answered this question.

Response option	n	% answered	% of total sample
Community CAMHS	57	64%	64%
Specialist CAMHS	18	20%	20%
Other	14	16%	16%

Q8. Additional comments: (re: Service Type)

39 out of 89 respondents answered this question.

Q9. Role type (please select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Leading or senior consultant psychiatrist	17	19%	19%
Leading or senior consultant psychologist	22	25%	25%
Lead CAMHS social worker	3	3%	3%
Senior service manager/team lead	41	46%	46%
Other	32	36%	36%

Q10. Additional comments: (re: Role type)

14 out of 89 respondents answered this question.

Q11. Within your service, how are these types of presentations most commonly understood or conceptualised? (Please select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Primarily as a mental health presentation requiring clinical treatment	31	35%	35%
Primarily as a safeguarding issue requiring risk management	53	60%	60%
Primarily as a behavioural or contextual concern	42	47%	47%
As a multi-agency issue requiring joint responsibility	67	75%	75%
Understanding varies depending on the specific case	61	69%	69%
Other	5	6%	6%

Q12. Please elaborate: (re: how presentations are conceptualised)

49 out of 89 respondents answered this question.

Q13. In the 3 months between January 2026 and March 2026, has your service worked with children or young people presenting with concerns consistent with violence fixation?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	43	48%	48%

No	15	17%	17%
NA	31	35%	35%

Q14. If yes, please estimate approximate number:

35 out of 89 respondents answered this question.

Q15. Please elaborate: (re: children/young people worked with, Jan-Mar 2026)

36 out of 89 respondents answered this question.

Q16. Through which routes do these referrals most commonly enter your service? (Select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Schools or Designated Safeguarding Leads (DSLs)	51	57%	57%
General Practitioners (GPs) or primary care	49	55%	55%
Children's Social Care/Multi-Agency Safeguarding Hubs (MASH)	57	64%	64%
Police	21	24%	24%
Prevent/Channel	6	7%	7%
Family or self-referral	37	42%	42%
Other	22	25%	25%

Q17. Please elaborate: (re: referral routes)

31 out of 89 respondents answered this question.

Q18. In your assessments of violence-fixated individuals, how central is the risk of the patient to others?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Sometimes considered	4	4%	4%
Routinely considered	49	55%	55%
Central to Formulation	36	40%	40%

Q19. Please provide further detail or examples: (re: centrality of risk to others)

39 out of 89 respondents answered this question.

Q20. Based on your experience, which of the following BEHAVIOURAL indicators are most commonly observed in referrals of this type? (Select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Fixation on mass violence events or previous attacks	28	31%	31%
Targeted grievance towards specific individuals or groups	54	61%	61%
Escalating anger, resentment or grievance narratives	67	75%	75%
Verbal threats or expressions of intent to harm others	83	93%	93%
Sudden or significant behavioural change	50	56%	56%

Q21. Based on your experience, which of the following ONLINE indicators are most commonly observed in referrals of this type? (Select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Engagement with violent or extremist content	49	55%	55%
Obsessive research into weapons, attacks or perpetrators	58	65%	65%
Sharing, posting or creating concerning online content	60	67%	67%
Use of online platforms to express grievances or hostility	49	55%	55%

Q22. Based on your experience, which of the following RISK-RELATED indicators are most commonly observed in referrals of this type? (Select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Access to, or attempts to obtain, weapons	25	28%	28%
Previous incidents involving aggression or violence	74	83%	83%
Increasing preoccupation with harm to others	67	75%	75%

Q23. Based on your experience, which of the following CLINICAL/PRESENTATION indicators are most commonly observed in referrals of this type? (Select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
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Social withdrawal or isolation	79	89%	89%
Mental health illnesses or conditions (e.g. depression, anxiety, psychosis, conduct disorder, personality disorder, others)	55	62%	62%
Emotional dysregulation or impulsivity	79	89%	89%

Q24. Based on your experience, which of the following NEURODEVELOPMENTAL/SEND indicators are most commonly observed in referrals of this type? (Select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Autism spectrum condition	76	85%	85%
Attention deficit hyperactivity disorder	52	58%	58%
Learning disability	25	28%	28%
Speech, language and communication needs	34	38%	38%
Physical disability, sensory impairment or long-term health condition	8	9%	9%
Other	20	22%	22%

Q25. Based on your experience, which of the following CONTEXTUAL/ENVIRONMENTAL indicators are most commonly observed in referrals of this type? (Select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Family stress or instability	77	87%	87%
Safeguarding concerns within the home	78	88%	88%
School exclusion or disengagement	85	96%	96%

Other	14	16%	16%
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Q26. Please comment: (re: contextual/environmental indicators)

24 out of 89 respondents answered this question.

Q27. To what extent are early warning signs of this type of risk typically identifiable at the point of referral to your service?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Not identifiable at all	3	3%	3%
Identifiable to a limited extent	30	34%	34%
Identifiable to some extent	50	56%	56%
Identifiable to a great extent	5	6%	6%
Clearly identifiable	1	1%	1%

Q28. Please elaborate: (re: early warning signs identifiable at referral)

38 out of 89 respondents answered this question.

Q29. How confident are you / CAMHS professionals in your service in distinguishing between non-ideological violence fixation risk and ideologically driven radicalisation risk?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Not confident	29	33%	33%

Slightly confident	24	27%	27%
Moderately confident	30	34%	34%
Very confident	6	7%	7%
Highly confident	0	0%	0%

Q30. Please elaborate: (re: confidence distinguishing non-ideological from ideological risk)

39 out of 89 respondents answered this question.

Q31. Is specialist training in identifying or responding to risk of harm to others (including violence fixation, serious violence risk, or related behaviours) provided to CAMHS professionals in your service?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	27	30%	30%
No	47	53%	53%
Not sure	15	17%	17%

Q32. Please elaborate: (re: specialist training provision)

0 out of 89 respondents answered this question.

Q33. If yes, which types of training are provided? (Select all that apply)

27 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
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Formal CAMHS or NHS training	11	41%	12%
Forensic CAMHS (FCAMHS) training or input	11	41%	12%
Safeguarding/multi-agency training	19	70%	21%
Prevent/counter-radicalisation training	24	89%	27%
Police-led training or briefings	4	15%	4%
Local Authority training	6	22%	7%
Online or e-learning modules	17	63%	19%
Other	1	4%	1%

Q34. Please elaborate: (re: types of training provided)

11 out of 89 respondents answered this question.

Q35. To what extent do existing clinical assessment frameworks and tools used within your service adequately support the identification and formulation of fixation (persistent and intense focus on violence)

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Not at all	8	9%	9%
Limited	46	52%	52%
Moderate	24	27%	27%
Strong	11	12%	12%
Comprehensive	0	0%	0%

Q36. To what extent do existing clinical assessment frameworks and tools used within your service adequately support the identification and formulation of escalation (increasing intensity, planning, or behavioural change)

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Not at all	6	7%	7%
Limited	37	42%	42%
Moderate	29	33%	33%
Strong	16	18%	18%
Comprehensive	1	1%	1%

Q37. To what extent do existing clinical assessment frameworks and tools used within your service adequately support the identification and formulation of risk posed to others

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Not at all	5	6%	6%
Limited	18	20%	20%
Moderate	32	36%	36%
Strong	30	34%	34%
Comprehensive	4	4%	4%

Q38. Please comment: (re: adequacy of clinical assessment frameworks)

32 out of 89 respondents answered this question.

Q39. When assessing violence-fixated individuals, which are routinely completed?

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Structured risk assessment	62	70%	70%
Clinical formulation	76	85%	85%
Multi-agency information gathering	75	84%	84%
Review of digital/online behaviour	12	13%	13%
Family/systemic assessment	39	44%	44%

Q40. If you selected 'Structured risk assessment', what tool/system(s) were used?

47 out of 89 respondents answered this question.

Q41. Please elaborate if you selected Family/systemic assessment.

31 out of 89 respondents answered this question.

Q42. Does your service have sufficient capacity, expertise and training to respond to these cases effectively?

83 out of 89 respondents answered this question.

Q43. Are there cases where individuals present with concerning behaviours or risks that do not clearly fit within existing diagnostic categories or established care pathways?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
No	0	0%	0%
Rarely	4	4%	4%

Sometimes	45	51%	51%
Yes frequently	40	45%	45%

Q44. Please elaborate: (re: cases not fitting existing diagnostic categories)

45 out of 89 respondents answered this question.

Q45. How clear are your service's referral and acceptance criteria when responding to cases involving potential violence-fixated individuals?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Very unclear	12	13%	13%
Somewhat unclear	18	20%	20%
Mixed or variable	33	37%	37%
Mostly clear	18	20%	20%
Very clear	8	9%	9%

Q46. Please elaborate: (re: referral/acceptance criteria clarity)

50 out of 89 respondents answered this question.

Q47. How often do you encounter referrals where concerns about risk to others (of the potential VFI kind) are present but the case does not meet the clinical threshold for CAMHS involvement?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Never	2	2%	2%
Rarely	21	24%	24%

Sometimes	52	58%	58%
Often	14	16%	16%

Q48. Please elaborate: (re: referrals not meeting clinical threshold)

38 out of 89 respondents answered this question.

Q49. In situations where a referral does not meet your service threshold, what actions are typically taken? (Select all that apply)

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Advice and signposting provided	70	79%	79%
Referral redirected to another service	66	74%	74%
Joint working established with other agencies	51	57%	57%
Case managed outside CAMHS involvement	38	43%	43%
No further action	5	6%	6%
Other	11	12%	12%

Q50. Please elaborate: (re: actions taken when threshold not met)

20 out of 89 respondents answered this question.

Q51. Have you encountered cases where the individual's needs or risks appear to sit between different services or systems (e.g. CAMHS, FCAMHS, safeguarding, policing), with no clear lead?

89 out of 89 respondents answered this question.

Response option	n	% answered	% of total sample
No	5	6%	6%

Rarely	4	4%	4%
Sometimes	41	46%	46%
Yes frequently	39	44%	44%

Q52. Please elaborate: (re: cases sitting between services with no clear lead)

1 out of 89 respondents answered this question.

Q53. In high-risk cases, is a clear lead agency identified?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
No	4	4%	4%
Sometimes	56	63%	63%
Yes	29	33%	33%

Q54. What are the main barriers to accessing CAMHS support for this cohort?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Waiting times	26	29%	29%
Consent	19	21%	21%
High thresholds	19	21%	21%
Other	25	28%	28%

Q55. Please elaborate: (re: barriers to accessing CAMHS support)

41 out of 89 respondents answered this question.

Q56. In cases involving potential risk to others, is a lead agency typically identified to take overall responsibility?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
No	10	11%	11%
Sometimes	53	60%	60%
Yes	26	29%	29%

Q57. Please elaborate: (re: lead agency for risk-to-others cases)

32 out of 89 respondents answered this question.

Q58. How effectively does your service work with partner agencies in VFI-type cases (e.g. FCAMHS, Local Authority, police, education, Prevent/Channel)?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Ineffectively	1	1%	1%
Unsure / varies depending on agency	30	34%	34%
Neither effectively nor ineffectively	15	17%	17%
Effectively	34	38%	38%
Very effectively	9	10%	10%

Q59. Please elaborate: (re: effectiveness working with partner agencies)

16 out of 89 respondents answered this question.

Q60. How clear is the role of CAMHS in contributing to or managing risk to others within these cases?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Very unclear	1	1%	1%
Somewhat unclear	10	11%	11%
Mixed or variable	50	56%	56%
Mostly clear	24	27%	27%
Very clear	4	4%	4%

Q61. Please elaborate: (re: clarity of CAMHS's role)

33 out of 89 respondents answered this question.

Q62. How clearly defined are processes for escalating concerns when risk increases?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Somewhat unclear	14	16%	16%
Mixed	23	26%	26%
Mostly clear	40	45%	45%
Very clear	12	13%	13%

Q63. Please elaborate: (re: escalation process clarity)

34 out of 89 respondents answered this question.

Q64. What types of interventions are provided to violence-fixated individuals, and how effective are they in managing or reducing risk?

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Structured risk management interventions	32	36%	36%
Offence-related psychological work	12	13%	13%
Individual therapeutic interventions	50	56%	56%
Family interventions	40	45%	45%
Multi-agency risk planning	73	82%	82%
Secure or intensive care involvement	14	16%	16%
Referral to Forensic CAMHS	68	76%	76%
Other	13	15%	15%

Q65. How effective are they? Please comment in respect of each intervention.

89 out of 89 respondents answered this question.

Q66. Which systems do you use for information recording?

89 out of 89 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Electronic Patient Record (EPR)	85	96%	96%
Formal risk documentation	39	44%	44%
Case summaries	16	18%	18%
Informal notes	5	6%	6%

Q67. Please elaborate: (re: systems used for information recording)

35 out of 89 respondents answered this question.

Q68. How would you rate your information recording systems?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	14	16%	16%
Inconsistent	21	24%	24%
Adequate	45	51%	51%
High Quality	9	10%	10%

Q69. Please elaborate: (re: rating of information recording systems)

Column reference: please_elaborate_137

36 out of 89 respondents answered this question.

Q70. What is your / your Service's experience of the ability and willingness of partner agencies (CAMHS, social care, education, police, probation, counter-terrorism police/Prevent etc.) to share risk of violence to others-relevant information with your CAMHS service?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	5	6%	6%
Inconsistent	34	38%	38%
Adequate	44	49%	49%
High Quality	6	7%	7%

Q71. Please elaborate particularly in relation to what if any barriers appear to exist: (re: partner agencies sharing information with CAMHS)

53 out of 89 respondents answered this question.

Q72. What is your / your Service's experience of the ability and willingness of your own Service to share risk of violence information to partner agencies (social care, education, police, probation, counter-terrorism police/Prevent etc.)?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	0	0%	0%
Inconsistent	5	6%	6%
Adequate	51	57%	57%
High Quality	33	37%	37%

Q73. Please elaborate particularly in relation to what if any barriers appear to exist: (re: CAMHS sharing information with partner agencies)

41 out of 89 respondents answered this question.

Q74. What is your / your Service's experience of the overall availability and quality of input from Forensic CAMHS services in relation to children and young people presenting with concerns consistent with violence fixation?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	11	12%	12%
Inconsistent	25	28%	28%
Adequate	40	45%	45%
High Quality	13	15%	15%

Q75. Please elaborate: (re: availability/quality of Forensic CAMHS input)

54 out of 89 respondents answered this question.

Q76. In cases where FCAMHS have been involved in supporting your Service in relation to children and young people presenting with concerns consistent with violence fixation, what is

your experience of the input and support of FCAMHS specifically in relation to structured risk assessments in appropriate cases?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	14	16%	16%
Inconsistent	21	24%	24%
Adequate	40	45%	45%
High Quality	14	16%	16%

Q77. Please elaborate: (re: FCAMHS input on structured risk assessments)

34 out of 89 respondents answered this question.

Q78. In cases where FCAMHS have been involved in supporting your Service in relation to children and young people presenting with concerns consistent with violence fixation, how clear is the delineation of roles and responsibilities as between FCAMHS and your CAHMS Service?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Very unclear	8	9%	9%
Somewhat unclear	8	9%	9%
Mixed or variable	33	37%	37%
Mostly clear	28	31%	31%
Very clear	12	13%	13%

Q79. Please elaborate: (re: clarity of FCAMHS/CAMHS role delineation)

32 out of 89 respondents answered this question.

Q80. Have you changed (or are you planning to change) your approach to violence fixation in individuals in the last 12 months?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	55	62%	62%
No	34	38%	38%

Q81. If yes, what has changed (e.g. earlier escalation, improved information sharing, focus on fixation indicators):

30 out of 89 respondents answered this question.

Q82. Are there gaps in specialist provision or interventions for this cohort?

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	63	71%	71%
No	1	1%	1%
Unsure	25	28%	28%

Q83. If yes, please provide details of the gaps that exist and the barriers to improved provision or interventions.

63 out of 89 respondents answered this question.

Q84. What are the main challenges in identifying and managing violence fixation risk and what improvements would you recommend?

89 out of 89 respondents answered this question.

Q85. Does your Service have a view on whether legislative change is required to allow mental health clinicians to assess children and young people who are isolated from professional support and may pose a risk of violence, particularly where powers under the Mental Health Act 1983, as amended by the Mental Health Act 2025, do not permit assessment or detention. (For background, see Chapter 10 of this Inquiry's Phase 1 Report, particularly at paragraphs 290-291; 337-339 and the recommendation at 364: [here](#).)

89 out of 89 respondents answered this question.

Q86. Is there any further relevant information you would like to share with the Inquiry in relation to the topics raised in this questionnaire?

89 out of 89 respondents answered this question.

Q87. I am happy to be contacted by the Inquiry to discuss aspects of my answers further:

89 out of 89 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	29	33%	33%
No	60	67%	67%

Raw counts and percentages for FCAMHS survey

Q1. Our organisation has a clear and shared understanding of violence-fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk.

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	7	30%	30%
Agree	6	26%	26%
Neither agree or disagree	3	13%	13%
Disagree	7	30%	30%
Strongly Disagree	0	0%	0%

Q2. Staff in our organisation can recognise early behavioural indicators of potential violence-fixation (including online and offline behaviours).

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	4	17%	17%
Agree	12	52%	52%
Neither agree or disagree	3	13%	13%
Disagree	4	17%	17%
Strongly Disagree	0	0%	0%

Q3. Which of the following best describes your area's experience in identifying potential violence-fixation cases in the past 12 months?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
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My organisation does not record this dataset	6	26%	26%
No cases identified	1	4%	4%
Fewer than 10 cases identified	4	17%	17%
More than 10 cases identified	12	52%	52%

Q4. Staff in our organisation are confident in identifying potential violence-fixation risk at an early stage.

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	5	22%	22%
Agree	9	39%	39%
Neither agree or disagree	7	30%	30%
Disagree	2	9%	9%
Strongly Disagree	0	0%	0%

Q5. Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence-fixation risk (including working with relevant partner agencies where appropriate).

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	5	22%	22%
Agree	8	35%	35%
Neither agree or disagree	6	26%	26%
Disagree	4	17%	17%
Strongly Disagree	0	0%	0%

Q6. Staff in our area understand what actions to take when a potential violence-fixation risk is identified.

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	4	17%	17%
Agree	15	65%	65%
Neither agree or disagree	4	17%	17%
Disagree	0	0%	0%
Strongly Disagree	0	0%	0%

Q7. Within your service, how are these types of presentations for violence-fixation in an individual most commonly understood or conceptualised? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
As part of structured forensic risk formulation (e.g. pathways to violence)	16	70%	70%
Primarily as a mental disorder requiring treatment	8	35%	35%
Primarily as a safeguarding/public protection issue	16	70%	70%
Primarily as behavioural/contextual risk (e.g. environmental stressors)	15	65%	65%
As a multi-agency risk requiring shared ownership	21	91%	91%
Understanding varies significantly between agencies	17	74%	74%
Other	5	22%	22%

Q8. Please elaborate (including reference to formulation approaches such as fixation, grievance, leakage, escalation):

23 out of 23 respondents answered this question.

Q9. In the 3 months between January 2026 and March 2026, has your service worked with children or young people presenting with concerns consistent with violence fixation?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	19	83%	83%
No	2	9%	9%
Unsure	2	9%	9%

Q10. If yes, please estimate the approximate number

19 out of 23 respondents answered this question.

Q11. (Optional) Additional details (e.g. complexity, severity, multi-agency involvement):

18 out of 23 respondents answered this question.

Q12. Through which routes do these referrals most commonly enter your service? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Generic CAMHS escalation	19	83%	83%
Youth Offending/Youth Justice Services	18	78%	78%

Children's Social Care/Multi-Agency Safeguarding Hubs (MASH)	14	61%	61%
Police/Public Protection Units	5	22%	22%
Prevent/Channel	7	30%	30%
Family or self-referral	3	13%	13%
Education (schools, PRUs, DSLs)	12	52%	52%
Secure estate/inpatient step-down	8	35%	35%
Other	2	9%	9%

Q13. Please elaborate (including appropriateness and timing of referrals):

22 out of 23 respondents answered this question.

Q14. In your assessments of violence-fixated individuals, how central is the risk of the patient to others?

23 out of 23 respondents answered this question.

Response option	n	% answered	% of total sample
Not prioritised	0	0%	0%
Sometimes considered	0	0%	0%
Routinely considered	5	22%	22%
Central to Formulation	18	78%	78%

Q15. (Optional) Please provide further detail:

17 out of 23 respondents answered this question.

Q16. Based on your experience, which of the following BEHAVIOURAL indicators are most commonly observed in referrals of this type? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Fixation on mass violence events or previous attacks	12	52%	52%
Targeted grievance towards specific individuals or groups	17	74%	74%
Escalating anger, resentment or grievance narratives	20	87%	87%
Verbal threats or expressions of intent to harm others	22	96%	96%
Sudden or significant behavioural change	6	26%	26%

Q17. Based on your experience, which of the following ONLINE indicators are most commonly observed in referrals of this type? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Engagement with violent or extremist content	20	87%	87%
Obsessive research into weapons, attacks or perpetrators	18	78%	78%
Sharing, posting or creating concerning online content	18	78%	78%
Use of online platforms to express grievances or hostility	15	65%	65%

Q18. Based on your experience, which of the following RISK-RELATED indicators are most commonly observed in referrals of this type? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
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Access to, or attempts to obtain, weapons	14	61%	61%
Previous incidents involving aggression or violence	19	83%	83%
Increasing preoccupation with harm to others	19	83%	83%

Q19. Based on your experience, which of the following CLINICAL/PRESENTATION indicators are most commonly observed in referrals of this type? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Social withdrawal or isolation	22	96%	96%
Mental health illnesses or conditions (e.g. depression, anxiety, psychosis, conduct disorder, personality disorder, others)	13	57%	57%
Emotional dysregulation or impulsivity	20	87%	87%

Q20. Based on your experience, which of the following NEURODEVELOPMENTAL/SEND indicators are most commonly observed in referrals of this type? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Autism spectrum condition	22	96%	96%
Attention deficit hyperactivity disorder	15	65%	65%
Learning disability	13	57%	57%
Speech, language and communication needs	14	61%	61%
Physical disability, sensory impairment or long-term health condition	6	26%	26%
Other	8	35%	35%

Q21. Based on your experience, which of the following CONTEXTUAL/ENVIRONMENTAL indicators are most commonly observed in referrals of this type? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Family stress or instability	20	87%	87%
Safeguarding concerns within the home	22	96%	96%
School exclusion or disengagement	23	100%	100%
Other	9	39%	39%

Q22. (Optional) Please elaborate on indicators:

12 out of 23 respondents answered this question.

Q23. To what extent are early warning signs of this type of risk typically identifiable at the point of referral to your service?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Not identifiable at all	0	0%	0%
Identifiable to a limited extent	1	4%	4%
Identifiable to some extent	14	61%	61%
Identifiable to a great extent	7	30%	30%
Clearly identifiable	1	4%	4%

Q24. (Optional) Please elaborate:

17 out of 23 respondents answered this question.

Q25. How confident are you / FCAMHS professionals in your service in distinguishing between non-ideological violence fixation risk, and ideologically driven radicalisation risk?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Not confident	1	4%	4%
Slightly confident	2	9%	9%
Moderately confident	9	39%	39%
Very confident	9	39%	39%
Highly confident	2	9%	9%

Q26. (Optional) Please elaborate, including interface with Prevent/Channel:

18 out of 23 respondents answered this question.

Q27. Is specialist training in identifying or responding to risk of harm to others (including violence fixation, serious violence risk, or related behaviours) provided to FCAMHS professionals in your service?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	16	70%	70%
No	4	17%	17%
Not sure	3	13%	13%

Q28. If yes, which types of training are provided? (Select all that apply)

16 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
FCAMHS-specific training	16	100%	70%

Structured professional judgement tools (e.g. SAVRY)	14	88%	61%
Safeguarding/multi-agency training	13	81%	57%
Prevent training	14	88%	61%
Police/public protection briefings	4	25%	17%
Local authority training	5	31%	22%
E-learning	10	62%	43%
Other	6	38%	26%

Q29. (Optional) Please elaborate, including any gaps in training:

12 out of 23 respondents answered this question.

Q30. To what extent do existing clinical assessment frameworks and tools used within your service adequately support the identification and formulation of: Fixation (persistent and intense focus on violence)

23 out of 23 respondents answered this question.

Response option	n	% answered	% of total sample
Not at all	0	0%	0%
Limited	9	39%	39%
Moderate	8	35%	35%
Strong	4	17%	17%
Comprehensive	2	9%	9%

Q31. To what extent do existing clinical assessment frameworks and tools used within your service adequately support the identification and formulation of: Escalation (increasing intensity, planning, or behavioural change)

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Not at all	0	0%	0%
Limited	6	26%	26%
Moderate	10	43%	43%
Strong	5	22%	22%
Comprehensive	2	9%	9%

Q32. To what extent do existing clinical assessment frameworks and tools used within your service adequately support the identification and formulation of: Risk posed to others

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Not at all	0	0%	0%
Limited	4	17%	17%
Moderate	3	13%	13%
Strong	8	35%	35%
Comprehensive	8	35%	35%

Q33. Please comment (including limitations of current tools in capturing emerging or atypical risk):

21 out of 23 respondents answered this question.

Q34. When assessing violence-fixated individuals, which are routinely completed?

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Structured risk assessment	11	48%	48%

Clinical formulation (including pathways to violence)	22	96%	96%
Multi-agency information gathering	23	100%	100%
Review of online/digital behaviour	9	39%	39%
Family/systemic assessment	9	39%	39%

Q35. If so, what tool/system(s) are used for the Structured risk assessment?

9 out of 23 respondents answered this question.

Q36. (Optional) Please elaborate (including barriers to information sharing)?

13 out of 23 respondents answered this question.

Q37. Does your service have sufficient capacity, expertise and mandate to respond effectively to these cases?

23 out of 23 respondents answered this question.

Q38. Are there cases where individuals present with concerning behaviours or risks that do not clearly fit within existing diagnostic categories or established care pathways?

23 out of 23 respondents answered this question.

Response option	n	% answered	% of total sample
No	0	0%	0%
Rarely	2	9%	9%
Sometimes	7	30%	30%
Yes frequently	14	61%	61%

Q39. Please elaborate (e.g. 'edge of threshold' cases):

23 out of 23 respondents answered this question.

Q40. How clear are referral and acceptance criteria for cases involving potential violence-fixated individuals?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Very unclear	0	0%	0%
Somewhat unclear	5	22%	22%
Mixed	6	26%	26%
Mostly clear	7	30%	30%
Very clear	5	22%	22%

Q41. Please elaborate:

20 out of 23 respondents answered this question.

Q42. How often do you encounter referrals where concerns about risk to others (of the potential VFI kind) are present but the case does not meet the clinical threshold for FCAMHS involvement?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Never	7	30%	30%
Rarely	5	22%	22%
Sometimes	11	48%	48%
Often	0	0%	0%

Q43. Please elaborate (including outcomes for these cases):

19 out of 23 respondents answered this question.

Q44. In situations where a referral does not meet your service threshold, what actions are typically taken? (Select all that apply)?

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Advice/signposting	18	78%	78%
Redirected elsewhere	16	70%	70%
Joint working	6	26%	26%
Managed outside FCAMHS	15	65%	65%
No further action	6	26%	26%
Other	9	39%	39%

Q45. Please elaborate:

18 out of 23 respondents answered this question.

Q46. Have you encountered cases where the individual's needs or risks appear to sit between different services or systems (e.g. CAMHS, FCAMHS, safeguarding, policing), with no clear lead?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
No	1	4%	4%
Rarely	3	13%	13%
Sometimes	8	35%	35%
Yes frequently	11	48%	48%

Q47. Please elaborate:

18 out of 23 respondents answered this question.

Q48. In high-risk cases, is a clear lead agency identified?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
No	1	4%	4%
Sometimes	8	35%	35%
Yes	14	61%	61%

Q49. Please elaborate:

17 out of 23 respondents answered this question.

Q50. What are the main barriers to accessing FCAMHS support for this cohort? (Select all that apply)

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
High thresholds	4	17%	17%
Waiting times	0	0%	0%
Consent	7	30%	30%
Other	16	70%	70%

Q51. Please elaborate:

16 out of 23 respondents answered this question.

Q52. In cases involving potential risk to others, is a lead agency typically identified to take overall responsibility?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
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No	4	17%	17%
Sometimes	8	35%	35%
Yes	11	48%	48%

Q53. Please elaborate:

18 out of 23 respondents answered this question.

Q54. How effectively does your service work with partner agencies in VFI-type cases (e.g. CAMHS, Local Authority, police, education, Prevent/Channel)?

23 out of 23 respondents answered this question.

Response option	n	% answered	% of total sample
Very ineffectively	0	0%	0%
Ineffectively	0	0%	0%
Varies	1	4%	4%
Neutral	5	22%	22%
Effectively	10	43%	43%
Very effectively	7	30%	30%

Q55. Please elaborate (including information sharing and joint decision-making):

18 out of 23 respondents answered this question.

Q56. How clear is the role of FCAMHS in contributing to or managing risk to others within these cases?

23 out of 23 respondents answered this question.

Response option	n	% answered	% of total sample
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Very unclear	0	0%	0%
Somewhat unclear	3	13%	13%
Mixed	4	17%	17%
Mostly clear	10	43%	43%
Very clear	6	26%	26%

Q57. Please elaborate:

20 out of 23 respondents answered this question.

Q58. How clearly defined are processes for escalating concerns when risk increases?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Not clear	0	0%	0%
Somewhat unclear	0	0%	0%
Mixed	7	30%	30%
Mostly clear	12	52%	52%
Very clear	4	17%	17%

Q59. Please elaborate (including any delays or breakdowns):

20 out of 23 respondents answered this question.

Q60. What types of interventions are provided to violence-fixated individuals, and how effective are they in managing or reducing risk?

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
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Structured risk management	15	65%	65%
Offence-focused work	13	57%	57%
Individual therapy	14	61%	61%
Family interventions	11	48%	48%
Multi-agency planning	22	96%	96%
Secure care or intensive care involvement	9	39%	39%
FCAMHS consultation	21	91%	91%
Other	6	26%	26%

Q61. How effective are they? Please comment in respect of each intervention:

19 out of 23 respondents answered this question.

Q62. Which systems do you use for information recording?

23 out of 23 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Electronic patient record (EPR)	23	100%	100%
Formal risk tools	12	52%	52%
Case summaries	9	39%	39%
Informal notes	3	13%	13%

Q63. (Optional) Please elaborate:

13 out of 23 respondents answered this question.

Q64. How would you rate your information recording systems?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	4	17%	17%
Inconsistent	5	22%	22%
Adequate	13	57%	57%
High Quality	1	4%	4%

Q65. Please elaborate (including accessibility across agencies):

17 out of 23 respondents answered this question.

Q66. What is your / your Services' experience of the ability and willingness of partner agencies (CAMHS, social care, education, police, probation, counter-terrorism police/Prevent etc.) to share risk of violence to others-relevant information with your FCAMHS service?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	0	0%	0%
Inconsistent	8	35%	35%
Adequate	10	43%	43%
High Quality	5	22%	22%

Q67. Please elaborate, particularly in relation to what if any barriers appear to exist:

18 out of 23 respondents answered this question.

Q68. What is your / your services' experience of the ability and willingness of your own Service to share risk of violence information to partner agencies (CAMHS, social care, education, police, probation, counter-terrorism police/Prevent etc.)?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	0	0%	0%
Inconsistent	0	0%	0%
Adequate	6	26%	26%
High Quality	17	74%	74%

Q69. Please elaborate, particularly in relation to what if any barriers appear to exist:

17 out of 23 respondents answered this question.

Q70. In cases where your FCAHMS service is offering input/advice/support to CAHMS in relation to VFI-type cases, what is your / your Services' experience of the overall ability of CAHMS to manage the risk and treat children and young people presenting with concerns consistent with violence fixation?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	3	13%	13%
Inconsistent	9	39%	39%
Adequate	8	35%	35%
High Quality	3	13%	13%

Q71. (Optional) Please elaborate:

17 out of 23 respondents answered this question.

Q72. In cases where your FCAHMS service is offering input/advice/support to CAHMS in relation to children and young people presenting with concerns consistent with violence fixation, what is your experience of the combined ability to produce structured risk assessments in appropriate cases?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Poor	4	17%	17%
Inconsistent	3	13%	13%
Adequate	8	35%	35%
High Quality	8	35%	35%

Q73. Please elaborate:

17 out of 23 respondents answered this question.

Q74. In cases where FCAMHS has been involved in supporting CAMHS in relation to children and young people presenting with concerns consistent with violence fixation, how clear is the delineation of roles and responsibilities as between CAMHS and your FCAMHS Service?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Very unclear	1	4%	4%
Somewhat unclear	0	0%	0%
Mixed or variable	6	26%	26%
Mostly clear	11	48%	48%
Very clear	5	22%	22%

Q75. (Optional) Please elaborate:

15 out of 23 respondents answered this question.

Q76. Have you changed (or are you planning to change) your approach to violence fixation in individuals in the last 12 months?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	11	48%	48%
No	12	52%	52%

Q77. If yes, what has changed (e.g. earlier escalation, improved information sharing, focus on fixation indicators):

12 out of 23 respondents answered this question.

Q78. Are there gaps in specialist provision for this cohort?

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	16	70%	70%
No	0	0%	0%
Unsure	7	30%	30%

Q79. Please specify:

19 out of 23 respondents answered this question.

Q80. What are the main challenges in identifying and managing violence fixation risk, and what improvements would you recommend?

23 out of 23 respondents answered this question.

Q81. Does your Service have a view on whether legislative change is required to allow mental health clinicians to assess children and young people who are isolated from professional support and may pose a risk of violence, particularly where powers under the Mental Health Act 1983, as amended by the Mental Health Act 2025, do not permit assessment or detention? (For

background, see Chapter 10 of this Inquiry's Phase 1 Report particularly at paragraphs 290-291; 337-339 and the recommendation at 364: [here](#).)

21 out of 23 respondents answered this question.

Q82. Is there any further relevant information you would like to share with the Inquiry in relation to the topics raised in this questionnaire?

23 out of 23 respondents answered this question.

Q83. I am happy to be contacted by the Inquiry to discuss aspects of my answers further:

23 out of 23 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	2	9%	9%
No	21	91%	91%

Raw counts and percentages for Channel survey

Q1. Our organisation has a clear and shared understanding of violence-fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk.

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	5	5%	5%
Agree	39	41%	41%
Neither agree or disagree	26	28%	28%
Disagree	24	26%	26%
Strongly Disagree	0	0%	0%

Q2. Staff in our organisation can recognise early behavioural indicators of potential violence-fixation (including online and offline behaviours).

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	2	2%	2%
Agree	45	48%	48%
Neither agree or disagree	29	31%	31%
Disagree	18	19%	19%
Strongly Disagree	0	0%	0%

Q3. Which of the following best describes your area's experience in identifying potential violence-fixation cases in the past 12 months?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
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My organisation does not record this dataset	16	17%	17%
No cases identified	3	3%	3%
Fewer than 10 cases identified	65	69%	69%
More than 10 cases identified	10	11%	11%

Q4. Staff in our organisation are confident in identifying potential violence-fixation risk at an early stage.

94 out of 94 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	1	1%	1%
Agree	30	32%	32%
Neither agree or disagree	40	43%	43%
Disagree	23	24%	24%
Strongly Disagree	0	0%	0%

Q5. Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence-fixation risk (including working with relevant partner agencies where appropriate).

94 out of 94 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	3	3%	3%
Agree	45	48%	48%
Neither agree or disagree	27	29%	29%
Disagree	19	20%	20%
Strongly Disagree	0	0%	0%

Q6. Staff in our area understand what actions to take when a potential violence-fixation risk is identified.

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	3	3%	3%
Agree	35	37%	37%
Neither agree or disagree	37	39%	39%
Disagree	18	19%	19%
Strongly Disagree	1	1%	1%

Q7. How long have you been Chair of the Channel panel?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Less than 1 year	18	19%	19%
1 year to less than 3 years	24	26%	26%
3 years to less than 5 years	16	17%	17%
5 years or more	34	36%	36%
Prefer not to say	2	2%	2%

Q8. How often does your Channel panel usually meet?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Weekly	0	0%	0%

Fortnightly	2	2%	2%
Monthly	88	94%	94%
Less often than monthly	4	4%	4%
Do not know	0	0%	0%

Q9. Have you personally received training relevant to identifying, assessing or managing violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	34	36%	36%
No	57	61%	61%
Do not know	3	3%	3%

Q10. To your knowledge, have panel members in your area received relevant training on identifying, assessing or managing violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	19	20%	20%
No	47	50%	50%
Do not know	28	30%	30%

Q11. Overall, how adequate are the training and guidance currently available to you and your panel for identifying, assessing and managing violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
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Very inadequate	9	10%	10%
Fairly inadequate	40	43%	43%
Neither adequate nor inadequate	16	17%	17%
Fairly adequate	21	22%	22%
Very adequate	2	2%	2%
Do not know	6	6%	6%

Q12. What most informs your response to the adequacy of training and guidance? (Select all that apply)

94 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Chair training	46	49%	49%
Wider panel training	48	51%	51%
National guidance	61	65%	65%
Experience of recent cases	52	55%	55%
Access to specialist advice	36	38%	38%
Gaps in training	45	48%	48%
Gaps in guidance	41	44%	44%
Lack of access to specialist advice	32	34%	34%
Other	4	4%	4%

Q13. How confident are you that your panel has the expertise needed to identify, assess and manage violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% answered	% of total sample
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Not at all confident	1	1%	1%
Not very confident	17	18%	18%
Fairly confident	62	66%	66%
Very confident	9	10%	10%
Do not know	5	5%	5%

Q14. If any, what are the main gaps in your panel's expertise? (Select all that apply)

94 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Threat assessment	24	26%	26%
Fixation-related behaviour	57	61%	61%
Online behaviour and online escalation	47	50%	50%
Neurodivergence/autism spectrum disorder expertise	28	30%	30%
Indicators linked to mass casualty attack risk	53	56%	56%
Working with children and young adults	3	3%	3%
Access to mental health services	27	29%	29%
Intervention planning	24	26%	26%
No major gaps identified	4	4%	4%
Other	10	11%	11%

Q15. In the 3 months between January and March 2026, did your Channel panel consider any referrals involving violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	60	64%	64%
No	30	32%	32%
Do not know	4	4%	4%

Q16. If yes, how many referrals involving violence-fixated risk did your panel consider in the 3 months between January and March 2026?

60 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
1 to 2	37	62%	39%
3 to 5	16	27%	17%
6 or more	4	7%	4%
Do not know	3	5%	3%
Not applicable	0	0%	0%

Q17. Through which routes are referrals involving violence-fixated risk received in your area? (Select all that apply)

94 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Policing	69	73%	73%
Education	72	77%	77%
Children's social care or safeguarding services	44	47%	47%
Adult social care or safeguarding services	22	23%	23%
Mental health services	36	38%	38%

Youth justice services	20	21%	21%
Probation services	12	13%	13%
Prison or other custodial settings	3	3%	3%
Do not know	5	5%	5%
Other	3	3%	3%

Q18. Overall, are the right agencies usually represented at your Channel panel?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
No	1	1%	1%
Rarely	0	0%	0%
Sometimes	3	3%	3%
Yes, usually	68	72%	72%
Yes, always	22	23%	23%
Do not know	0	0%	0%

Q19. When dealing with cases involving violence-fixated risk, how adequate is the seniority of panel members for effective decision making?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Very inadequate	1	1%	1%
Fairly inadequate	4	4%	4%
Neither adequate nor inadequate	5	5%	5%
Fairly adequate	54	57%	57%

Very adequate	29	31%	31%
Do not know	1	1%	1%

Q20. When dealing with cases involving violence-fixated risk, how adequate is the expertise of panel members for effective decision-making?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Very inadequate	0	0%	0%
Fairly inadequate	6	6%	6%
Neither adequate nor inadequate	16	17%	17%
Fairly adequate	57	61%	61%
Very adequate	15	16%	16%
Do not know	0	0%	0%

Q21. When dealing with cases involving violence-fixated risk, how adequate is the information provided to you by panel members for effective decision-making?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Very inadequate	0	0%	0%
Fairly inadequate	4	4%	4%
Neither adequate nor inadequate	15	16%	16%
Fairly adequate	51	54%	54%
Very adequate	20	21%	21%
Do not know	4	4%	4%

Q22. If relevant, which agencies are most often insufficiently represented, or not represented at the right level? (Select all that apply)

94 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Local authority education services	11	12%	12%
Child and adolescent mental health services	24	26%	26%
Forensic child and adolescent mental health services	32	34%	34%
Children's social care (including MASH and early help)	10	11%	11%
Youth justice services	9	10%	10%
Probation services	27	29%	29%
Police	3	3%	3%
Education (e.g. Designated Safeguarding Leads)	6	6%	6%
None of these	24	26%	26%
Other	9	10%	10%

Q23. In the past six months, has your Channel panel adopted any referrals where the main concern was violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	57	61%	61%
No	35	37%	37%
Do not know	2	2%	2%

Q24. When a referral involving violence-fixated risk is adopted by the Channel panel, how clear is it with regard to which agency has lead responsibility for managing risk while the case remains open?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Often unclear	9	10%	10%
Sometimes unclear	15	16%	16%
Usually clear	37	39%	39%
Always clear	20	21%	21%
Do not know	3	3%	3%
Not applicable	10	11%	11%

Q25. When a referral involving violence-fixated risk is not adopted, or an open Channel case is closed, how clear are the ongoing arrangements for lead agency responsibility and risk management?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Often unclear	10	11%	11%
Sometimes unclear	20	21%	21%
Usually clear	31	33%	33%
Always clear	16	17%	17%
Do not know	3	3%	3%
Not applicable	14	15%	15%

Q26. For referrals involving violence-fixated risk, how adequate is access to specialist mental health input?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Very inadequate	9	10%	10%
Fairly inadequate	20	21%	21%
Neither adequate nor inadequate	18	19%	19%
Fairly adequate	31	33%	33%
Very adequate	5	5%	5%
Do not know	5	5%	5%
Not applicable	6	6%	6%

Q27. When managing cases involving young persons, are there additional challenges compared to managing adult cases?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	62	66%	66%
No	25	27%	27%
Do not know	6	6%	6%
Not applicable	1	1%	1%

Q28. If yes, select all that apply

62 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Access to specialist mental health services	41	66%	44%
Complexity of safeguarding arrangements	37	60%	39%

Education-related issues	36	58%	38%
Family or carers	39	63%	41%
Transition between child and adolescent services	45	73%	48%
Limited intervention options	31	50%	33%
Unclear lead responsibility	17	27%	18%
Other	5	8%	5%

Q29. What types of intervention are most commonly available to your panel for managing referrals involving violence-fixated risk? (Select all that apply)

94 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Intervention Providers (e.g. Home Office-commissioned Channel Intervention Provider)	85	90%	90%
Local mentoring or tailored support	41	44%	44%
Mental health intervention	58	62%	62%
Safeguarding plan	68	72%	72%
Education-based intervention	56	60%	60%
Social care intervention	69	73%	73%
Police-led disruption or risk management	44	47%	47%
Online safety or digital intervention	31	33%	33%
Specialist threat-related support	5	5%	5%
Do not know	5	5%	5%
Other	7	7%	7%

Q30. Overall, how adequate are the interventions currently available to you for managing violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Very inadequate	2	2%	2%
Fairly inadequate	24	26%	26%
Neither adequate nor inadequate	19	20%	20%
Fairly adequate	38	40%	40%
Very adequate	4	4%	4%
Do not know	7	7%	7%

Q31. Compared with cases involving ideologically motivated terrorism risk, how would you define the adequacy of interventions for violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Less adequate	58	62%	62%
About the same	24	26%	26%
More adequate	3	3%	3%
Do not know	7	7%	7%
Not applicable	2	2%	2%

Q32. Are there established links in your area between your Channel panel and other local arrangements relevant to managing violence-fixated risk (e.g. Multi-Agency Public Protection Arrangements or Violence Reduction Units)? (Select all that apply)

94 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Yes, formal links	26	28%	28%
Yes, informal links	48	51%	51%
No	18	19%	19%
Do not know	9	10%	10%
Not applicable	3	3%	3%

Q33. Which other local arrangements does your Channel panel work with most often when managing violence-fixated risk? (Select all that apply)

94 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Safeguarding arrangements	77	82%	82%
Police-led partnerships	51	54%	54%
Multi-Agency Public Protection Arrangements	26	28%	28%
Mental health services	55	59%	59%
Education safeguarding arrangements	61	65%	65%
Youth justice arrangements	53	56%	56%
Violence Reduction Units	20	21%	21%
Do not know	3	3%	3%
Not applicable	6	6%	6%
Other	9	10%	10%

Q34. Overall, how suitable are the current Prevent framework and Channel Duty guidance for managing violence-fixated risk?

94 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Very unsuitable	6	6%	6%
Fairly unsuitable	35	37%	37%
Neither suitable nor unsuitable	24	26%	26%
Fairly suitable	26	28%	28%
Very suitable	3	3%	3%
Do not know	0	0%	0%

Q35. What changes would most improve the response? (Select all that apply)

94 out of 94 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Clearer national guidance	69	73%	73%
More training	53	56%	56%
Better access to specialist mental health input	36	38%	38%
Better access to specialist interventions	52	55%	55%
Stronger links with safeguarding arrangements	5	5%	5%
Stronger links with police-led partnerships	1	1%	1%
Stronger links with Multi-Agency Public Protection Arrangements	13	14%	14%
Greater clarity about lead responsibility	24	26%	26%
More resources or capacity	20	21%	21%
Other	2	2%	2%

Q36. Is there any further relevant information you would like to share with the Inquiry in relation to the topics raised in this questionnaire?

52 out of 94 respondents answered this question.

Q37. I am happy to be contacted by the Inquiry to discuss aspects of my answers further:

93 out of 94 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	19	20%	20%
No	74	80%	79%

Raw counts and percentages for CTP survey

Q1. Our organisation has a clear and shared understanding of violence-fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk.

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	0	0%	0%
Agree	7	70%	70%
Neither agree or disagree	1	10%	10%
Disagree	2	20%	20%
Strongly Disagree	0	0%	0%

Q2. Staff in our organisation can recognise early behavioural indicators of potential violence-fixation (including online and offline behaviours).

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	1	10%	10%
Agree	5	50%	50%
Neither agree or disagree	3	30%	30%
Disagree	1	10%	10%
Strongly Disagree	0	0%	0%

Q3. Which of the following best describes your area's experience in identifying potential violence-fixation cases in the past 12 months?

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
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My organisation does not record this dataset	0	0%	0%
No cases identified	0	0%	0%
Fewer than 10 cases identified	1	10%	10%
More than 10 cases identified	9	90%	90%

Q4. Staff in our organisation are confident in identifying potential violence-fixation risk at an early stage.

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	1	10%	10%
Agree	5	50%	50%
Neither agree or disagree	2	20%	20%
Disagree	2	20%	20%
Strongly Disagree	0	0%	0%

Q5. Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence-fixation risk (including working with relevant partner agencies where appropriate).

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	0	0%	0%
Agree	3	30%	30%
Neither agree or disagree	2	20%	20%
Disagree	5	50%	50%
Strongly Disagree	0	0%	0%

Q6. Staff in our area understand what actions to take when a potential violence-fixation risk is identified.

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	0	0%	0%
Agree	6	60%	60%
Neither agree or disagree	2	20%	20%
Disagree	2	20%	20%
Strongly Disagree	0	0%	0%

Q7. How long have you held this post?

10 out of 10 respondents answered this question.

Q8. To your knowledge, have Counter Terrorism Policing (CTP) officers and staff in your CTU received any training in identifying, assessing or managing non-ideological extremist or violence-fixated risk, in the context of their role as Prevent practitioner? Please include reference to wider training that addressed these issues. If training has been given, who has received this training? For example, to your knowledge has such training been provided to staff working in Prevent, the Fixed Intelligence Management Unit, CT Nominal Management or senior leadership?

10 out of 10 respondents answered this question.

Q9. Have you received training since July 2024 on any subjects relating to violence-fixated individuals (VFIs) or non-ideological risk in the context of your role as Prevent practitioner? Please include reference to wider training that addressed these issues.

10 out of 10 respondents answered this question.

Q10. How well does the training equip you to deal with VFIs within the Counter Terrorism space?

10 out of 10 respondents answered this question.

Q11. How would you rate the quality of the training?

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Very poor	1	10%	10%
Poor	4	40%	40%
Fair	2	20%	20%
Good	2	20%	20%
Excellent	1	10%	10%

Q12. Please explain why you have given this rating and provide any comments or suggestions for improvement:

10 out of 10 respondents answered this question.

Q13. How confident are you in distinguishing between those who are vulnerable to being drawn into terrorism based on (a) violence-fixation without ideology and (b) ideologically driven behaviour?

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Not confident	1	10%	10%
Slightly confident	1	10%	10%
Moderately confident	4	40%	40%
Very confident	2	20%	20%
Highly confident	2	20%	20%

Q14. In your experience, how often does your CTU encounter individuals presenting risk of serious non-ideological violence (e.g., fixation, grievance, mass violence interest)?

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Never	0	0%	0%
Rarely	0	0%	0%
Sometimes	1	10%	10%
Relatively Frequently	6	60%	60%
Very frequently	3	30%	30%

Q15. In the past 12 months, has your CTU been involved in managing any individuals who could be considered VFIs within a Prevent context?

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	10	100%	100%
No	0	0%	0%

Q16. If yes, approximately how many (estimate)?

10 out of 10 respondents answered this question.

Q17. Through which pathways are such individuals typically identified (e.g. police, probation, mental health, custodial services, from social care, referrals from education, from other youth services, referrals from family/friends)? (Select all that apply)

10 out of 10 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Wider police/public protection units	6	60%	60%

CAMHS/FCAMHS	8	80%	80%
Custodial services	1	10%	10%
Children's social care/MASH	6	60%	60%
Education (schools, PRUs, DSLs)	8	80%	80%
Secure estate/inpatient step-down	3	30%	30%
Family or self-referral	2	20%	20%
Wider youth services	3	30%	30%
Other	2	20%	20%

Q18. How frequently and to what extent do VFI cases in your experience involve online activity (e.g., fixation on mass violence content, online communities)?

10 out of 10 respondents answered this question.

Response option	n	% answered	% of total sample
Never	0	0%	0%
Rarely	0	0%	0%
Sometimes	0	0%	0%
Relatively Frequently	3	30%	30%
Very frequently	7	70%	70%

Q19. Where VFI cases are being dealt with by CTP, does CTP have the appropriate tools and powers to access and assess the online activity for the purpose of assessing risk? If so, what are they? If not, what would be valuable?

10 out of 10 respondents answered this question.

Q20. If you have encountered a potential VFI, would you engage with any of the following:

5 out of 10 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
MAPP	1	20%	10%
The Counter Terrorism Clinical Consultancy Service	4	80%	40%

Q21. (Optional) Please elaborate:

10 out of 10 respondents answered this question.

Q22. Have you experienced cases where 'ownership' or responsibility for a VFI case was unclear across agencies or frameworks?

10 out of 10 respondents answered this question.

Response option	n	% answered	% of total sample
Yes	10	100%	100%
No	0	0%	0%

Q23. If yes, briefly describe the nature of the gap (using anonymised information).

10 out of 10 respondents answered this question.

Q24. What challenges, if any has your CTU encountered when working with partner agencies to manage VFIs? (Select all that apply)

10 out of 10 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Information sharing barriers	5	50%	50%
Lack of clarity on roles/responsibilities	10	100%	100%
Delays in decision-making or action	9	90%	90%
Resource or capacity constraints	10	100%	100%

Differences in risk assessment approaches	8	80%	80%
Engagement issues with partners	7	70%	70%
Other	1	10%	10%

Q25. In your professional experience, who (whether an individual agency or an existing multi-agency framework) should be the lead agency in managing a VFI if they are not adopted by Channel?

10 out of 10 respondents answered this question.

Q26. Have you encountered any challenges in applying CTP resources and/or principles to VFI-type cases?

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	9	90%	90%
No	1	10%	10%

Q27. If yes, please describe them.

9 out of 10 respondents answered this question.

Q28. If you have encountered such challenges, are those challenges different where a VFI is aged 25 and under? How?

9 out of 10 respondents answered this question.

Q29. Which elements of CTP structures and working practices are most relevant to managing VFI-type risk?

10 out of 10 respondents answered this question.

Q30. Are CTP's structures and working practices well-suited to identifying, assessing and managing non-ideological extremist or violence-fixated risks?

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	1	10%	10%
No	9	90%	90%

Q31. If not, please explain why not.

9 out of 10 respondents answered this question.

Q32. Is CTP effective in practice at managing non-ideological VFI risk given the current framework and level of resourcing?

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	0	0%	0%
No	10	100%	100%

Q33. If not, please explain why not.

10 out of 10 respondents answered this question.

Q34. What key lessons from your CTU could be applied to improve the wider multi-agency response to violence-fixated individuals?

10 out of 10 respondents answered this question.

Q35. Is there anything further you wish to highlight regarding CTP and the management of VFI-type risk?

10 out of 10 respondents answered this question.

Q36. I am happy to be contacted by the Inquiry to discuss aspects of my answers further:

10 out of 10 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	9	90%	90%
No	1	10%	10%

Raw counts and percentages for DSL survey

Q1. Our organisation has a clear and shared understanding of violence-fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk.

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	5	15%	15%
Agree	14	42%	42%
Neither agree or disagree	7	21%	21%
Disagree	7	21%	21%
Strongly Disagree	0	0%	0%

Q2. Staff in our organisation can recognise early behavioural indicators of potential violence-fixation (including online and offline behaviours).

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	6	18%	18%
Agree	20	61%	61%
Neither agree or disagree	3	9%	9%
Disagree	4	12%	12%
Strongly Disagree	0	0%	0%

Q3. Which of the following best describes your area's experience in identifying potential violence-fixation cases in the past 12 months?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
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My organisation does not record this dataset	0	0%	0%
No cases identified	14	42%	42%
Fewer than 10 cases identified	17	52%	52%
More than 10 cases identified	2	6%	6%

Q4. Staff in our organisation are confident in identifying potential violence-fixation risk at an early stage.

33 out of 33 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	5	15%	15%
Agree	18	55%	55%
Neither agree or disagree	6	18%	18%
Disagree	3	9%	9%
Strongly Disagree	1	3%	3%

Q5. Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence-fixation risk (including working with relevant partner agencies where appropriate).

33 out of 33 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	9	27%	27%
Agree	16	48%	48%
Neither agree or disagree	3	9%	9%
Disagree	4	12%	12%
Strongly Disagree	1	3%	3%

Q6. Staff in our area understand what actions to take when a potential violence-fixation risk is identified.

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	9	27%	27%
Agree	15	45%	45%
Neither agree or disagree	7	21%	21%
Disagree	1	3%	3%
Strongly Disagree	1	3%	3%

Q7. What is your current work setting?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Primary	2	6%	6%
Secondary	5	15%	15%
Special	4	12%	12%
Alternative provision	2	6%	6%
Further Education	20	61%	61%
Higher Education	0	0%	0%

Q8. What is your Local Authority Area?

33 out of 33 respondents answered this question.

Q9. What is your current safeguarding role?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Designated Safeguarding Lead	21	64%	64%
Deputy Designated Safeguarding Lead	7	21%	21%
Other	5	15%	15%

Q10. How long have you been in this role?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
<1 year	4	12%	12%
1–3 years	11	33%	33%
4–7 years	10	30%	30%
8+ years	8	24%	24%

Q11. Please outline the structure of the safeguarding team in your organisation (including key roles, short overview of responsibilities) [250 word limit]

33 out of 33 respondents answered this question.

Q12. How familiar are you with violence fixation/non-ideological serious violence risk as a safeguarding concern?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Not at all familiar	0	0%	0%
Slightly familiar	5	15%	15%

Moderately familiar	15	45%	45%
Very familiar	8	24%	24%
Extremely familiar	5	15%	15%

Q13. Have you received any specialist training in identifying or responding to violence-fixated risk?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	9	27%	27%
No	24	73%	73%
Not sure	0	0%	0%

Q14. If yes, which types of training have you received? (Select all that apply)

9 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Formal training through your organisation	3	33%	9%
Safeguarding/multi-agency training	5	56%	15%
Prevent/counter-radicalisation training	8	89%	24%
Police-led training or briefings	5	56%	15%
Local Authority training	3	33%	9%
Online or e-learning modules	3	33%	9%
Other	0	0%	0%

Q15. If you have received training, how would you rate the adequacy of the training you have received in identifying and responding to concerns about fixation with violence?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Very inadequate	2	6%	6%
Inadequate	2	6%	6%
Average	21	64%	64%
Good	6	18%	18%
Very good	2	6%	6%

Q16. If you have received training, how would you compare the training you have received on responding to concerns about fixation on violence with training on ideological radicalisation?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Much weaker on violence fixation than ideological radicalisation	8	24%	24%
Somewhat weaker on violence fixation	7	21%	21%
About the same for both	18	55%	55%

Q17. Are you aware of any training or guidance that is currently available to you on violence fixation/targeted violence risk (even if you have not received it)? (Select all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Local Authority training or guidance	5	15%	15%
Department for Education (DfE) guidance or training	6	18%	18%
Policing-led training or briefings	7	21%	21%

In-house organisational training	2	6%	6%
Home Office/Prevent training or resources	10	30%	30%
Multi-agency training (e.g. safeguarding partnerships)	7	21%	21%
Online/e-learning modules	9	27%	27%
Written guidance or toolkits	3	9%	9%
None - I am not aware of training or guidance	17	52%	52%
Other	1	3%	3%

Q18. Have you encountered any individuals in the last 12 months whose risk could reasonably be described as violence-fixated (for example, fixation on mass violence, targeted violence ideation, grievance escalation without clear ideology)?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
No	25	76%	76%
Yes	8	24%	24%

Q19. What is the approximate number in the last 12 months?

8 out of 33 respondents answered this question.

Q20. Have you made any referrals for individuals whose risk could reasonably be described as violence-fixated during your time as DSL?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
No	22	67%	67%

Yes	11	33%	33%
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Q21. What is the approximate number in the last 12 months?

11 out of 33 respondents answered this question.

Q22. How confident are you in distinguishing between (a) violence-fixation risk without ideology and (b) ideologically driven radicalisation risk?

33 out of 33 respondents answered this question.

Response option	n	% answered	% of total sample
Not at all confident	3	9%	9%
Slightly confident	7	21%	21%
Somewhat confident	11	33%	33%
Fairly confident	8	24%	24%
Very confident	4	12%	12%

Q23. If concern about behaviours that could be considered to be violence-fixated is raised, what is (or would be if you have not encountered it) the typical internal process for triage and decision-making in your setting? Who is involved? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
DSL alone	12	36%	36%
Safeguarding team	30	91%	91%
Senior leadership team	16	48%	48%
SENCO	2	6%	6%
Mental Health lead	10	30%	30%
Other	1	3%	3%

Q24. If concern is raised, who (if anyone) would you involve externally? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
None	0	0%	0%
Local Authority safeguarding advice	25	76%	76%
Police	16	48%	48%
Prevent team	26	79%	79%
Other	1	3%	3%

Q25. If concern is raised, which guidance/policy informs your triage decision? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Keeping Children Safe in Education	20	61%	61%
Local Authority guidance	21	64%	64%
Prevent guidance	29	88%	88%
Internal policy	22	67%	67%
Other	0	0%	0%

Q26. If concern is raised, what internal steps are typically taken? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Internal risk assessment	28	85%	85%
Safeguarding meeting	29	88%	88%
Behaviour plan	16	48%	48%

Additional monitoring	27	82%	82%
Other	4	12%	12%

Q27. Which methods are used for recording concerns? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Safeguarding software	27	82%	82%
Written chronologies	23	70%	70%
Risk assessment tools	25	76%	76%
Informal notes	6	18%	18%
Other	1	3%	3%

Q28. Are your risk assessments easily shared and understood by others in multi-agency settings?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	25	76%	76%
No	1	3%	3%
Don't know	7	21%	21%

Q29. If concerns about violence-fixation behaviours are identified, which agencies do you, or would you, contact? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Multi-Agency Safeguarding Hub/Children's Social Care	27	82%	82%

Police	23	70%	70%
Child and Adolescent Mental Health Service/Health Services	14	42%	42%
Youth Services	8	24%	24%
Prevent	26	79%	79%
Educational Psychology	6	18%	18%
Special Educational Needs Services	7	21%	21%
Other	4	12%	12%

Q30. What factors would most influence your decision to make a referral to an external organisation where you have identified violence fixation? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Severity of behaviour	32	97%	97%
Evidence of impact	22	67%	67%
Advice from professionals	28	85%	85%
Mental health concerns	27	82%	82%
Risk to others	32	97%	97%
Previous history	30	91%	91%
Other	1	3%	3%

Q31. At what stage would you involve Prevent (if at all)? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Early concern	19	58%	58%

Moderate concern	10	30%	30%
Only when risk escalates	5	15%	15%
Unsure	2	6%	6%
I would not involve Prevent	0	0%	0%
Other	3	9%	9%

Q32. If you have made a referral in respect of violence fixation, how often do you receive outcomes that enable you to support the individual?

32 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Never	3	9%	9%
Rarely	1	3%	3%
Sometimes	5	16%	15%
Often	1	3%	3%
Always	1	3%	3%
Not applicable - I have not made a referral for violence-fixation	21	66%	64%

Q33. Referral outcomes — Other (please specify)

1 out of 33 respondents answered this question.

Q34. If you are involved in cases of violence-fixed risk (e.g. with Prevent/Channel), what does your role typically include? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Monitoring behaviour	24	73%	73%

Attending meetings	19	58%	58%
Supporting interventions	20	61%	61%
Information sharing	25	76%	76%
Other	5	15%	15%

Q35. In your experience, is any single agency designated as lead agency for managing risk in cases of violence fixated individuals?

33 out of 33 respondents answered this question.

Response option	n	% answered	% of total sample
No	18	55%	55%
Sometimes	9	27%	27%
Yes	6	18%	18%

Q36. If yes, which agencies most often lead? (tick all that apply)

6 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Children's Social Care	2	33%	6%
Police	3	50%	9%
Health	0	0%	0%
Prevent	3	50%	9%
Other	1	17%	3%

Q37. What factors influence the decision to appoint a particular lead agency?

33 out of 33 respondents answered this question.

Q38. Is the decision on the lead agency always communicated to you?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
Never	4	12%	12%
Rarely	2	6%	6%
Sometimes	16	48%	48%
Yes	11	33%	33%

Q39. Have you experienced cases where 'ownership' or responsibility for a violence fixated individual case was unclear across agencies or frameworks (e.g., safeguarding, youth justice, health, police, Prevent/Channel)?

33 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
No	26	79%	79%
Yes	7	21%	21%

Q40. If yes, give a brief description of the issue (please do not identify the individual or the case by name)

18 out of 33 respondents answered this question.

Q41. Have you experienced cases in the context of violence-fixation where referral outcomes were delayed or unclear, or decision making took longer than was appropriate?

32 out of 33 respondents answered this question.

Response option	n	% of answered	% of total sample
No	25	78%	76%

Yes	7	22%	21%
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Q42. If yes, which of the following applied? (Select all that apply)

7 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
The referral outcome was delayed	2	29%	6%
The referral outcome was unclear	6	86%	18%
Decision-making took longer than was appropriate	4	57%	12%
Other	0	0%	0%

Q43. If yes, what was the impact on the cases? (Select all that apply)

31 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Increased risk	6	19%	18%
Difficulty monitoring and assessing risk	6	19%	18%
Difficulties agreeing lead agency	2	6%	6%
Delays to intervention	10	32%	30%
No negative impact noted	5	16%	15%
Other	16	52%	48%

Q44. If you encounter violence fixation in an individual, what access to specialist services do you have (if any)? (Tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
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Special Educational Needs Co-ordinator/Inclusion Services	14	42%	42%
Educational Psychology	10	30%	30%
Child and Adolescent Mental Health Services	12	36%	36%
Police	28	85%	85%
Prevent	29	88%	88%
None - I don't have any	2	6%	6%
Other	4	12%	12%

Q45. How would you describe information sharing between local safeguarding or threat management agencies and the multi-agency public protection arrangements in your area? (Select the option(s) that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Very effective	1	3%	3%
Fairly effective	14	42%	42%
Neither effective or ineffective	5	15%	15%
Fairly ineffective	6	18%	18%
Very ineffective	1	3%	3%
Do not know	6	18%	18%
Not applicable	1	3%	3%

Q46. Where there are challenges in joint working, in your view, what are the main reasons for this? (tick all that apply)

33 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
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Different legal thresholds	9	27%	27%
Unclear responsibilities	18	55%	55%
Information sharing barriers	16	48%	48%
Limited capacity or resources	21	64%	64%
Different professional cultures/priorities	12	36%	36%
Limited expertise in this type of risk	16	48%	48%
Do not know	4	12%	12%
Not applicable - there are no challenges in joint working	4	12%	12%
Other	6	18%	18%

Q47. Have you changed your approach to dealing with risk in relation to violence fixation in the last 12 months?

33 out of 33 respondents answered this question.

Response option	n	% answered	% of total sample
Yes	12	36%	36%
No	21	64%	64%

Q48. If yes, what have you put in place? (tick all that apply)

12 out of 33 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Earlier identification of violence fixation	8	67%	24%
Increased referrals	3	25%	9%
Increased Prevent engagement	2	17%	6%
Improved recording	5	42%	15%

Increased training	8	67%	24%
Other	3	25%	9%

Q49. Is there any further relevant information you would like to share with the Inquiry in relation to the topics raised in this questionnaire?

19 out of 33 respondents answered this question.

Q50. I am happy to be contacted by the Inquiry to discuss aspects of my answers further:

33 out of 33 respondents answered this question.

Response option	n	% answered	% of total sample
Yes	21	64%	64%
No	12	36%	36%

Raw counts and percentages for LA practitioner survey

Q1. Our organisation has a clear and shared understanding of violence-fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk.

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	28	7%	7%
Agree	165	42%	42%
Neither agree or disagree	112	28%	28%
Disagree	80	20%	20%
Strongly Disagree	11	3%	3%

Q2. Staff in our organisation can recognise early behavioural indicators of potential violence-fixation (including online and offline behaviours).

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	55	14%	14%
Agree	268	68%	68%
Neither agree or disagree	46	12%	12%
Disagree	25	6%	6%
Strongly Disagree	2	1%	1%

Q3. Which of the following best describes your area's experience in identifying potential violence-fixation cases in the past 12 months?

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
My organisation does not record this dataset	101	26%	26%
No cases identified	55	14%	14%
Fewer than 10 cases identified	184	46%	46%
More than 10 cases identified	56	14%	14%

Q4. Staff in our organisation are confident in identifying potential violence-fixation risk at an early stage.

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	40	10%	10%
Agree	194	49%	49%
Neither agree or disagree	102	26%	26%
Disagree	58	15%	15%
Strongly Disagree	2	1%	1%

Q5. Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence-fixation risk (including working with relevant partner agencies where appropriate).

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	54	14%	14%
Agree	188	47%	47%
Neither agree or disagree	87	22%	22%

Disagree	63	16%	16%
Strongly Disagree	4	1%	1%

Q6. Staff in our area understand what actions to take when a potential violence-fixation risk is identified.

396 out of 396 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	40	10%	10%
Agree	211	53%	53%
Neither agree or disagree	89	22%	22%
Disagree	53	13%	13%
Strongly Disagree	3	1%	1%

Q7. Briefly describe the actions you would take following identification of a potentially violence-fixated individual?

396 out of 396 respondents answered this question.

Q8. How long have you been in your current role?

396 out of 396 respondents answered this question.

Response option	n	% answered	% of total sample
Less than 1 year	55	14%	14%
1-3 years	128	32%	32%
4-7 years	100	25%	25%
8 years or more	113	29%	29%

Q9. How many people does your LA have directly managing/supporting young people/children, including those who may present as individuals identified as presenting potential violence fixation risk?

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Fewer than 4 people	60	15%	15%
4-9 people	57	14%	14%
10-20 people	55	14%	14%
More than 20 people	224	57%	57%

Q10. (Optional) Please outline in fewer than 150 words the breakdown of the teams involved in directly managing/supporting young people/children?

319 out of 396 respondents answered this question.

Q11. I feel confident senior managers in my organisation understand the potential threat of individuals identified as presenting potential violence fixation risk.

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly disagree	0	0%	0%
Disagree	30	8%	8%
Neither agree nor disagree	83	21%	21%
Agree	185	47%	47%
Strongly agree	98	25%	25%

Q12. I would feel confident in raising cases of violence-fixated individuals with senior managers, particularly where there is a risk of harm to others.

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly disagree	1	0%	0%
Disagree	4	1%	1%
Neither agree nor disagree	7	2%	2%
Agree	129	33%	33%
Strongly agree	255	64%	64%

Q13. Have you received any specialist training in identifying or managing violence-fixated risk?
396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	101	26%	26%
No	267	67%	67%
Not sure	28	7%	7%

Q14. If yes, which types of training have you received? (Select all that apply)
90 out of 396 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Formal training through your organisation	13	14%	3%
Local authority training	3	3%	1%
Online or e-learning modules	2	2%	1%
Police-led training or briefings	4	4%	1%
Prevent / counter-radicalisation training	53	59%	13%
Safeguarding / multi-agency training	15	17%	4%

Q15. If you have received training, how would you rate the adequacy of the training you have received in identifying and responding to concerns regarding a violence-fixated individual?

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
I have not received training	278	70%	70%
Very inadequate	6	2%	2%
Inadequate	4	1%	1%
Average	23	6%	6%
Good	56	14%	14%
Very good	29	7%	7%

Q16. If you have received training, how would you compare the training you have received on responding to concerns about fixation on violence with training on ideological radicalisation?

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Much weaker on violence fixation than ideological radicalisation	78	20%	20%
Somewhat weaker on violence fixation	63	16%	16%
About the same for both	233	59%	59%
Somewhat stronger on violence fixation	14	4%	4%
Much stronger on violence fixation	8	2%	2%

Q17. Are you aware of any training or guidance that is currently available to you on violence fixation or violence-fixated individuals? (Select all that you are aware of)

377 out of 396 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
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Department for Education (DfE) guidance or training	7	2%	2%
Home Office / Prevent training or resources	102	27%	26%
In-house / organisational training	11	3%	3%
Local Authority training or guidance	55	15%	14%
Multi-agency training (e.g. safeguarding partnerships)	18	5%	5%
None- I am not aware of training or guidance	148	39%	37%
Online / e-learning modules	12	3%	3%
Policing-led training or briefings	15	4%	4%
Written guidance or toolkits	9	2%	2%

Q18. I am aware of who the key partners are and how to contact them, for support, in the identification and management of an individual with violence-fixation or vulnerable to being drawn toward violence-fixated harm?

396 out of 396 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly disagree	8	2%	2%
Disagree	21	5%	5%
Neither agree nor disagree	51	13%	13%
Agree	220	56%	56%
Strongly agree	96	24%	24%

Q19. Outline the key partner agencies or multi-agency processes that you might contact or refer to, following the identification of an individual with violence-fixated risk?

384 out of 396 respondents answered this question.

Q20. If you encounter violence fixation in an individual, what access to specialist services do you have? (Tick all that apply)

322 out of 396 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Child and Adolescent Mental Health Services	66	20%	17%
Educational Psychology	18	6%	5%
No access to specialist services	3	1%	1%
Police	78	24%	20%
Prevent	115	36%	29%
Special Educational Needs Co-ordinator/inclusion services	42	13%	11%

Q21. How would you describe information sharing between you and relevant agencies in your area? (Select the option(s) that apply)

393 out of 396 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Very effective	122	31%	31%
Fairly effective	250	64%	63%
Neither effective nor ineffective	20	5%	5%
Fairly ineffective	12	3%	3%
Very ineffective	0	0%	0%
Do not know	3	1%	1%
Not applicable	0	0%	0%

Q22. Where there are challenges in joint working, in your view, what are the main reasons for this? (Select all that apply)

396 out of 396 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Different legal thresholds	171	43%	43%
Unclear responsibilities	147	37%	37%
Information sharing barriers	131	33%	33%
Limited capacity or resources	238	60%	60%
Different professional cultures or priorities	151	38%	38%
Limited expertise in this type of risk	163	41%	41%
Do not know	6	2%	2%
Not applicable - there are no challenges in joint working	19	5%	5%
Other	25	6%	6%

Q23. Are you confident that partners would share information with you, necessary for the effective identification and management of individuals identified as violence-fixated or at risk of becoming violence-fixated? (Select the option(s) that apply)

396 out of 396 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Yes	282	71%	71%
No	41	10%	10%
Don't know/not sure	82	21%	21%

Q24. (Optional) Briefly outline any experiences you have had in sharing or receiving information with or from partner agencies in relation to cases involving violence-fixated individuals?

257 out of 396 respondents answered this question.

Q25. Is there any further relevant information you would like to share with the Inquiry in relation to the topics raised in this questionnaire?

392 out of 396 respondents answered this question.

Q26. I am happy to be contacted by the Inquiry to discuss aspects of my answers further:

396 out of 396 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	284	72%	72%
No	112	28%	28%

Raw counts and percentages for LA senior leader survey

Q1. Our organisation has a clear and shared understanding of violence-fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk.

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	4	3%	3%
Agree	41	32%	32%
Neither agree or disagree	45	35%	35%
Disagree	37	29%	29%
Strongly Disagree	0	0%	0%

Q2. Staff in our organisation can recognise early behavioural indicators of potential violence-fixation (including online and offline behaviours).

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	4	3%	3%
Agree	67	53%	53%
Neither agree or disagree	45	35%	35%
Disagree	11	9%	9%
Strongly Disagree	0	0%	0%

Q3. Which of the following best describes your area's experience in identifying potential violence-fixation cases in the past 12 months?

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
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My organisation does not record this dataset	53	42%	42%
No cases identified	9	7%	7%
Fewer than 10 cases identified	51	40%	40%
More than 10 cases identified	14	11%	11%

Q4. Staff in our organisation are confident in identifying potential violence-fixation risk at an early stage.

127 out of 127 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	0	0%	0%
Agree	50	39%	39%
Neither agree or disagree	56	44%	44%
Disagree	21	17%	17%
Strongly Disagree	0	0%	0%

Q5. Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence-fixation risk (including working with relevant partner agencies where appropriate).

127 out of 127 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	3	2%	2%
Agree	68	54%	54%
Neither agree or disagree	24	19%	19%
Disagree	31	24%	24%
Strongly Disagree	1	1%	1%

Q6. Staff in our area understand what actions to take when a potential violence-fixation risk is identified.

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	0	0%	0%
Agree	79	62%	62%
Neither agree or disagree	33	26%	26%
Disagree	15	12%	12%
Strongly Disagree	0	0%	0%

Q7. Which Local Authority Teams contributed to this response?

127 out of 127 respondents answered this question.

Q8. Did you seek any input from any external safeguarding partners? If so, which partners were consulted?

127 out of 127 respondents answered this question.

Q9. What sources of information were used to compile this return (e.g. case management records, multi-agency safeguarding hub (MASH) logs/referrals, education safeguarding information)?

127 out of 127 respondents answered this question.

Q10. Have teams in your area received training relevant to identifying or assessing violence fixated risk?

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
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Yes	35	28%	28%
No	70	55%	55%
Do not know	19	15%	15%
Not applicable	3	2%	2%

Q11. In the 3 months from January to March 2026, have teams in your area managed any individuals whose risk could be reasonably be described as violence-fixated?

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
My organisation does not record this dataset	34	27%	27%
No	28	22%	22%
Yes	65	51%	51%

Q12. If yes, how many such individuals have been managed in the 3 months from January to March 2026?

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
1-2	40	31%	31%
3-5	16	13%	13%
6 or more	4	3%	3%
Not applicable	67	53%	53%

Q13. In the last 12 months, if your LA has had experience with individuals presenting with violence fixated tendencies, can you describe the process by which they are triaged and managed?

126 out of 127 respondents answered this question.

Q14. Does your organisation have established guidance, processes and systems for the identification and management of behaviour or early risk indicators that is used or adapted for VFIs? If yes can you describe: - What behaviours or early risk indicators are included in this assessment? - What process or guidance is in place to assess them? - What process or guidance is in place to manage them?

127 out of 127 respondents answered this question.

Q15. How confident are you that frontline staff (e.g., schools, social workers, early help practitioners, youth justice staff) can recognise and act on early warning signs in individuals who could be considered as violence-fixated?

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
Not at all confident	4	3%	3%
Not very confident	28	22%	22%
Fairly confident	91	72%	72%
Very confident	1	1%	1%
Do not know	3	2%	2%

Q16. Is any single agency designated as lead agency for managing risk from cases of violence fixated individuals? If so, which agency has been given the lead in such cases, and how is that decision made and communicated to other agencies involved?

127 out of 127 respondents answered this question.

Q17. Have you experienced cases where 'ownership' or responsibility for a violence fixated individual case was unclear across agencies or frameworks (e.g., safeguarding, youth justice, health, police, Prevent/Channel)?

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
No	86	68%	68%
Yes	41	32%	32%

Q18. If Yes, briefly describe the issue (please do not identify the individual or case by name):
80 out of 127 respondents answered this question.

Q19. What access does the Local Authority have to specialist input to support assessments where neurodivergence may interact with violence risk (including education/SEND expertise and health/CAMHS input)?

127 out of 127 respondents answered this question.

Q20. Where early indicators are present but statutory thresholds are not met, how do your services sustain oversight and engagement/support?

127 out of 127 respondents answered this question.

Q21. Does your Local Authority run a MASH?

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	110	87%	87%
No	17	13%	13%

Q22. If yes, what organisations are members of your MASH?

104 out of 127 respondents answered this question.

Q23. If no, please describe the alternative arrangements that are adopted instead of a MASH.

16 out of 127 respondents answered this question.

Q24. What links does your MASH have to wider local partners relevant to serious violence risk (e.g., police, CAMHS/health, Prevent, youth justice, education)? a) How do practitioners know how to contact these partners when required? b) How is information shared across agencies for these types of concerns, and how reliable are current information-sharing arrangements? c) Are agencies who refer individuals to the MASH informed of the outcome of the referral?

126 out of 127 respondents answered this question.

Q25. Is your organisation/service a member of the local Prevent or Channel panels?

127 out of 127 respondents answered this question.

Response option	n	% answered	% of total sample
Yes	125	98%	98%
No	2	2%	2%

Q26. If yes, can you describe your risk management arrangements for children engaged with Prevent and/or who are subject to Channel support?

125 out of 127 respondents answered this question.

Q27. How effective do you consider working arrangements and relationships with key partners to be in managing VFI-type cases?

127 out of 127 respondents answered this question.

Response option	n	% answered	% of total sample
Not effective – partnerships do not work well	1	1%	1%
Partially effective – some are stronger than others	105	83%	83%
Fully effective with all partners	21	17%	17%

Q28. Where there are challenges in joint working, in your view, what are the main reasons for this? (Select all that apply)

127 out of 127 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Different legal thresholds	56	44%	44%
Unclear responsibilities	61	48%	48%
Information sharing barriers	34	27%	27%
Limited capacity or resources	75	59%	59%
Different professional cultures or priorities	50	39%	39%
Limited expertise in this type of risk	79	62%	62%
Do not know	2	2%	2%
Not applicable - there are no challenges in joint working	8	6%	6%
Other	12	9%	9%

Q29. Does your organisation/service have an escalation policy if there are disagreements between organisations?

127 out of 127 respondents answered this question.

Q30. Has your organisation made any changes to its safeguarding structures or multi-agency approach in the past 12 months relevant to VFI-type cases? (If yes please set out what these are)

127 out of 127 respondents answered this question.

Q31. Are there any improvements you would like to see made to Local Authority systems for identifying, assessing, and managing early violence-fixation risk?

126 out of 127 respondents answered this question.

Q32. Are you aware of any examples of best practice (within your Local Authority or elsewhere) in engaging with children and young people vulnerable to violence fixation?

124 out of 127 respondents answered this question.

Q33. Is there any further relevant information you would like to share with the Inquiry in relation to the topics raised in this questionnaire?

126 out of 127 respondents answered this question.

Q34. I am happy to be contacted by the Inquiry to discuss aspects of my answers further:

127 out of 127 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	99	78%	78%
No	28	22%	22%

Raw counts and percentages for MAPPA survey

Q1. Our organisation has a clear and shared understanding of violence-fixation (including violence-fixated individuals), and how this differs from ideologically motivated risk.

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	0	0%	0%
Agree	13	43%	43%
Neither agree or disagree	6	20%	20%
Disagree	11	37%	37%
Strongly Disagree	0	0%	0%

Q2. Staff in our organisation can recognise early behavioural indicators of potential violence-fixation (including online and offline behaviours).

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	1	3%	3%
Agree	13	43%	43%
Neither agree or disagree	12	40%	40%
Disagree	4	13%	13%
Strongly Disagree	0	0%	0%

Q3. Which of the following best describes your area's experience in identifying potential violence-fixation cases in the past 12 months?

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
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My organisation does not record this dataset	7	23%	23%
No cases identified	1	3%	3%
Fewer than 10 cases identified	12	40%	40%
More than 10 cases identified	10	33%	33%

Q4. Staff in our organisation are confident in identifying potential violence-fixation risk at an early stage.

30 out of 30 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	1	3%	3%
Agree	11	37%	37%
Neither agree or disagree	13	43%	43%
Disagree	5	17%	17%
Strongly Disagree	0	0%	0%

Q5. Our area has clear and effective processes in place for managing and responding to individuals identified as presenting potential violence-fixation risk (including working with relevant partner agencies where appropriate).

30 out of 30 respondents answered this question.

Response option	n	% answered	% of total sample
Strongly Agree	0	0%	0%
Agree	11	37%	37%
Neither agree or disagree	8	27%	27%
Disagree	11	37%	37%
Strongly Disagree	0	0%	0%

Q6. Staff in our area understand what actions to take when a potential violence-fixation risk is identified.

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Strongly Agree	0	0%	0%
Agree	12	40%	40%
Neither agree or disagree	7	23%	23%
Disagree	11	37%	37%
Strongly Disagree	0	0%	0%

Q7. How long have you been involved in your local multi-agency public protection arrangements?

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Less than 1 year	3	10%	10%
1 year to less than 3 years	9	30%	30%
3 years to less than 5 years	2	7%	7%
5 years or more	16	53%	53%
Prefer not to say	0	0%	0%

Q8. To your knowledge, have partner agencies in your area received training relevant to identifying or assessing violence-fixated risk?

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
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Yes	3	10%	10%
No	10	33%	33%
Do not know	17	57%	57%
Not applicable	0	0%	0%

Q9. How confident are you that partner agencies in your area can identify violence-fixated risk?
30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Not at all confident	4	13%	13%
Not very confident	12	40%	40%
Fairly confident	13	43%	43%
Very confident	1	3%	3%
Do not know	0	0%	0%

Q10. In the 3 months between January and March 2026, have the multi-agency public protection arrangements in your area managed any individuals whose risk could reasonably be described as violence-fixated?

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
My organisation does not record this dataset	4	13%	13%
No	4	13%	13%
Yes	22	73%	73%

Q11. If yes, how many such individuals have been managed in the 3 months from January to March 2026?

22 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
1 to 2	16	73%	53%
3 to 4	3	14%	10%
6 or more	2	9%	7%
Not applicable	1	5%	3%

Q12. Through which routes are these individuals identified in your area? (Select all that apply)

26 out of 30 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Don't know	2	8%	7%
Mental health services	1	4%	3%
Police	16	62%	53%
Prison or other custodial settings	1	4%	3%
Probation services	6	23%	20%

Q13. As far as you are aware, are there individuals known to local agencies who present a high risk of serious violence but do not meet the threshold for management under the multi-agency public protection arrangements?

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	20	67%	67%
No	4	13%	13%
Do not know	6	20%	20%

Q14. If yes, which arrangements are used to manage such individuals? (Select all that apply)

20 out of 30 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Police-led public protection arrangements	17	85%	57%
Safeguarding arrangements	12	60%	40%
Mental health services	10	50%	33%
Counter-terrorism arrangements (e.g. Prevent multi-agency arrangements or police-led partnerships)	13	65%	43%
Youth justice arrangements	12	60%	40%
Do not know	0	0%	0%
Not applicable	0	0%	0%
Other	6	30%	20%

Q15. Are there established links in your area between the multi-agency public protection arrangements and other relevant local arrangements for managing violence-fixated risk? (Select the option(s) that apply)

30 out of 30 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Yes, formal links	16	53%	53%
Yes, informal links	11	37%	37%
No	3	10%	10%
Do not know	5	17%	17%
Not applicable	0	0%	0%

Q16. If yes, which other local arrangements are these links with?

27 out of 30 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Counter-terrorism arrangements	7	26%	23%
Do not know	2	7%	7%
Not applicable	5	19%	17%
Police-led threat or risk management arrangements	7	26%	23%
Safeguarding arrangements	6	22%	20%

Q17. In the past 12 months, have any individuals in your area been managed at the same time under the multi-agency public protection arrangements and one or more other local arrangements relevant to violence-fixated risk? (Select the option(s) that apply)

30 out of 30 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Yes	8	27%	27%
No	9	30%	30%
Do not know	14	47%	47%
Not applicable	0	0%	0%

Q18. If yes, how would you describe joint working between the multi-agency public protection arrangements and those other local arrangements in managing violence-fixated risk?

8 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Very poor	0	0%	0%
Poor	0	0%	0%
Unsure	0	0%	0%
Good	5	62%	17%

Very good	3	38%	10%
Not applicable	0	0%	0%

Q19. How would you describe information sharing between the multi-agency public protection arrangements in your area and other key local safeguarding or threat management processes?

30 out of 30 respondents answered this question.

Response option	n	% answered	% of total sample
Very ineffective	0	0%	0%
Fairly ineffective	1	3%	3%
Neither effective nor ineffective	1	3%	3%
Fairly effective	21	70%	70%
Very effective	6	20%	20%
Do not know	1	3%	3%
Not applicable	0	0%	0%

Q20. Where there are challenges in joint working, what are the main reasons for this? (Select all that apply)

30 out of 30 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Different legal thresholds	11	37%	37%
Unclear responsibilities	16	53%	53%
Information sharing barriers	10	33%	33%
Limited capacity or resources	23	77%	77%
Different professional cultures or priorities	11	37%	37%
Limited expertise in this type of risk	14	47%	47%

Do not know	1	3%	3%
Not applicable - there are no challenges in joint working	0	0%	0%
Other	0	0%	0%

Q21. In cases involving violence-fixated risk, how clear is it regarding which agency has primary responsibility for coordinating risk management while the case is being managed under the multi-agency public protection arrangements?

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Often unclear	3	10%	10%
Sometimes unclear	10	33%	33%
Usually clear	9	30%	30%
Always clear	6	20%	20%
Do not know	2	7%	7%
Not applicable	0	0%	0%

Q22. When a case is closed to MAPPA or support for an individual ends, how clear are the arrangements for any ongoing lead agency responsibility and risk management?

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Often unclear	1	3%	3%
Sometimes unclear	6	20%	20%
Usually clear	15	50%	50%
Always clear	4	13%	13%

Do not know	3	10%	10%
Not applicable	1	3%	3%

Q23. Which aspects of the multi-agency public protection arrangements are or could be most useful in managing violence-fixated risk? (Select all that apply)

30 out of 30 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Multi-agency oversight	22	73%	73%
Risk management planning	26	87%	87%
Information sharing	27	90%	90%
Senior oversight or escalation	18	60%	60%
Use of statutory powers	17	57%	57%
Clear allocation of responsibility	23	77%	77%
Do not know	0	0%	0%
Not applicable	0	0%	0%
Other	0	0%	0%

Q24. How suitable is the current framework of the multi-agency public protection arrangements for managing individuals whose risk is driven mainly by fixation, grievance, or obsession rather than ideology?

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Very unsuitable	1	3%	3%
Fairly unsuitable	6	20%	20%
Neither suitable nor unsuitable	13	43%	43%

Always suitable	7	23%	23%
Very suitable	1	3%	3%
Do not know	2	7%	7%

Q25. In your view, should the multi-agency public protection arrangements play a greater role in managing people who present a high risk of serious violence but do not meet traditional offender-based criteria?

30 out of 30 respondents answered this question.

Response option	n	% answered	% of total sample
Yes	19	63%	63%
No	5	17%	17%
Unsure	6	20%	20%

Q26. If yes, which changes would be important for enabling multi-agency public protection arrangements to manage VFIs effectively? (Select all that apply)

19 out of 30 respondents selected at least one option for this question.

Response option	n	% of answered	% of total sample
Additional training	3	16%	10%
Changes to thresholds	1	5%	3%
Legislative change	4	21%	13%
More resources or capacity	2	11%	7%
National guidance	8	42%	27%
Other	1	5%	3%

Q27. Is there any further relevant information you would like to share with the Inquiry in relation to the topics raised in this questionnaire?

17 out of 30 respondents answered this question.

Q28. I am happy to be contacted by the Inquiry to discuss aspects of my answers further:

30 out of 30 respondents answered this question.

Response option	n	% of answered	% of total sample
Yes	21	70%	70%
No	9	30%	30%

Appendix 2. Frequency tables for thematic coding analysis

This appendix sets out the number of times each thematic code (as described in the Methodology section) was applied to open-text responses, broken down by the valence recorded for each application: Positive, Mixed, Uncertain, Negative, Descriptive/Factual, or Not Applicable. A single response may have more than one code applied where it raised more than one distinct theme. Code definitions are set out in the Methodology section of this report.

Overall thematic code frequency across all open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/Factual	Not Applicable	Total
Multi-Agency Structures/Panels	91	50	0	126	511	0	778
Operational Casework Actions	0	0	0	0	390	0	390
Information-Sharing Between Agencies	72	36	0	65	150	0	323
Training Availability/Adequacy	18	32	0	120	138	1	309
Suggested Improvements	16	27	0	92	153	3	291
Wider Contextual Factors	23	20	1	76	166	2	288
Service/Intervention Provision	26	32	0	138	70	1	267
Definition of VFI	2	27	1	92	88	3	213
Organisational Guidance/Governance	17	5	0	33	156	0	211
Assessment Tools/Frameworks	14	15	0	50	114	1	194

Lead Agency Responsibility	8	22	0	116	45	1	192
Recognition of Early Indicators	16	25	0	64	63	0	168
Reported Case Experience	11	27	0	24	69	33	164
Workforce Capacity/Resourcing	3	17	0	113	23	3	159
Statutory/Legal Thresholds	8	17	0	47	70	1	143
Legislative Change Views	1	21	1	59	50	5	137
Mental Health Act Powers Scope	0	13	0	23	6	38	80
Escalation/Flagging to Line Manager	0	1	0	0	76	1	78
MAPPA Eligibility Criteria Fit	6	6	0	10	32	0	54
Strategic Data Monitoring	7	2	0	12	27	0	48
CAMHS/FCAMHS Role Interface	1	9	0	20	0	1	31
CT Policing as Institutional Home	0	3	0	23	1	1	28
Frontline Personal Safety	1	0	0	1	24	0	26
Strategic Partnership Arrangements	3	1	0	3	19	0	26
Channel Panel Capacity	0	1	0	22	0	0	23
MAPPA/Prevent-Channel Overlap	1	3	0	11	4	0	19

Ideological Element Requirement	0	3	0	14	1	0	18
FCAMHS Regional Consistency	0	1	0	12	1	0	14
Age Threshold Appropriateness	1	0	0	5	2	0	8

Thematic code frequency for CAMHS open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/ Factual	Not Applicable	Total
Mental Health Act Powers Scope	0	6	0	20	6	37	69
Training Availability/Adequacy	3	12	0	43	7	0	65
Service/Intervention Provision	1	8	0	40	1	1	51
Lead Agency Responsibility	2	6	0	31	3	1	43
Multi-Agency Structures/Panels	3	5	0	25	4	0	37
Suggested Improvements	4	5	0	15	10	2	36
Definition of VFI	2	7	0	17	5	1	32
Recognition of Early Indicators	3	6	0	15	3	0	27
Legislative Change Views	1	5	0	11	4	5	26
Workforce Capacity/Resourcing	0	2	0	21	0	0	23
Reported Case Experience	2	9	0	3	5	1	20
CAMHS/FCAMHS Role Interface	1	6	0	12	0	1	20
Assessment Tools/Frameworks	0	3	0	8	3	0	14
Wider Contextual Factors	0	2	0	11	0	1	14
Information-Sharing Between Agencies	3	1	0	9	0	0	13

FCAMHS Regional Consistency *	0	0	0	8	1	0	9
Statutory/Legal Thresholds	0	1	0	5	2	0	8
Channel Panel Capacity *	0	0	0	1	0	0	1
Escalation/Flagging to Line Manager	0	0	0	0	0	0	0

Thematic code frequency for FCAMHS open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/ Factual	Not Applicable	Total
Legislative Change Views	0	11	0	7	0	0	18
Definition of VFI	0	2	0	13	1	0	16
Service/Intervention Provision	0	2	0	13	1	0	16
Lead Agency Responsibility	0	1	0	14	0	0	15
Workforce Capacity/Resourcing	0	4	0	9	0	2	15
Training Availability/Adequacy	0	2	0	11	0	0	13
Reported Case Experience	0	4	0	2	6	1	13
CAMHS/FCAMHS Role Interface *	0	3	0	8	0	0	11
Mental Health Act Powers Scope *	0	7	0	3	0	1	11
Multi-Agency Structures/Panels	0	3	0	6	0	0	9
Recognition of Early Indicators	0	1	0	7	0	0	8
Assessment Tools/Frameworks	0	2	0	5	0	1	8
Suggested Improvements	0	3	0	3	0	0	6
Statutory/Legal Thresholds	0	0	0	2	1	1	4
FCAMHS Regional Consistency	0	1	0	3	0	0	4
Information-Sharing Between Agencies	0	0	0	3	0	0	3

Wider Contextual Factors	0	0	0	2	0	0	2
Escalation/Flagging to Line Manager	0	0	0	0	1	1	2
Ideological Element Requirement *	0	1	0	0	0	0	1
Channel Panel Capacity *	0	0	0	1	0	0	1
CT Policing as Institutional Home *	0	0	0	1	0	0	1
FCAMHS Specialist Remit Clarity	0	0	0	0	0	0	0

Thematic code frequency for Channel open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/ Factual	Not Applicable	Total
Definition of VFI	0	1	0	14	1	0	16
Assessment Tools/Frameworks	0	2	0	12	0	0	14
Reported Case Experience	0	3	0	3	5	0	11
Multi-Agency Structures/Panels	0	0	0	10	0	0	10
Suggested Improvements	0	3	0	6	0	1	10
Ideological Element Requirement	0	2	0	7	1	0	10
Channel Panel Capacity	0	1	0	9	0	0	10
Lead Agency Responsibility	0	3	0	6	0	0	9
Recognition of Early Indicators	0	1	0	6	1	0	8
Training Availability/Adequacy	0	0	0	6	1	1	8
Workforce Capacity/Resourcing	0	1	0	6	0	1	8
CT Policing as Institutional Home *	0	1	0	5	1	1	8
Wider Contextual Factors	0	0	0	4	1	0	5
Statutory/Legal Thresholds	0	2	0	2	0	0	4
Service/Intervention Provision	0	0	0	2	0	0	2

Age Threshold Appropriateness *	0	0	0	2	0	0	2
Information-Sharing Between Agencies	0	0	0	0	0	0	0
Legislative Change Views	0	0	0	0	0	0	0
Escalation/Flagging to Line Manager	0	0	0	0	0	0	0

Thematic code frequency for CTP open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/ Factual	Not Applicable	Total
Lead Agency Responsibility	0	1	0	25	0	0	26
Workforce Capacity/Resourcing	0	0	0	21	0	0	21
Multi-Agency Structures/Panels	0	1	0	16	1	0	18
CT Policing as Institutional Home	0	1	0	17	0	0	18
Service/Intervention Provision	0	0	0	13	0	0	13
Reported Case Experience	0	1	0	10	1	0	12
Statutory/Legal Thresholds	0	1	0	10	0	0	11
Assessment Tools/Frameworks	0	1	0	10	0	0	11
Legislative Change Views	0	1	0	10	0	0	11
Definition of VFI	0	2	0	8	0	0	10
Training Availability/Adequacy	0	1	0	9	0	0	10
Channel Panel Capacity *	0	0	0	10	0	0	10
Recognition of Early Indicators	0	3	0	6	0	0	9
Suggested Improvements	0	0	0	9	0	0	9
Wider Contextual Factors	0	1	0	5	1	0	7
Ideological Element Requirement *	0	0	0	7	0	0	7

Age Threshold Appropriateness	1	0	0	3	2	0	6
MAPPA Eligibility Criteria Fit *	1	1	0	1	1	0	4
Information-Sharing Between Agencies	0	0	0	2	1	0	3
MAPPA/Prevent-Channel Overlap *	0	0	0	3	0	0	3
FCAMHS Regional Consistency *	0	0	0	1	0	0	1
Escalation/Flagging to Line Manager	0	0	0	0	0	0	0

Thematic code frequency for DSL open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/ Factual	Not Applicable	Total
Multi-Agency Structures/Panels	1	2	0	3	30	0	36
Reported Case Experience	0	3	0	0	9	1	13
Lead Agency Responsibility	1	2	0	6	1	0	10
Training Availability/Adequacy	0	4	0	2	3	0	9
Suggested Improvements	0	2	0	3	1	0	6
Recognition of Early Indicators	0	1	0	2	1	0	4
Assessment Tools/Frameworks	0	1	0	1	1	0	3
Service/Intervention Provision	0	1	0	1	0	0	2
Wider Contextual Factors	0	1	0	1	0	0	2
Escalation/Flagging to Line Manager	0	1	0	0	1	0	2
Definition of VFI	0	1	0	0	0	0	1
Statutory/Legal Thresholds	0	0	0	1	0	0	1
Workforce Capacity/Resourcing	0	0	0	1	0	0	1
Channel Panel Capacity *	0	0	0	1	0	0	1
CT Policing as Institutional Home *	0	1	0	0	0	0	1

Information-Sharing Between Agencies	0	0	0	0	0	0	0
Legislative Change Views	0	0	0	0	0	0	0
Scope of Education's Role	0	0	0	0	0	0	0
Education Setting Constraints	0	0	0	0	0	0	0

Thematic code frequency for LA practitioner open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/ Factual	Not Applicable	Total
Multi-Agency Structures/Panels	49	25	0	36	292	0	402
Operational Casework Actions	0	0	0	0	390	0	390
Information-Sharing Between Agencies	59	30	0	46	105	0	240
Wider Contextual Factors	8	9	0	33	101	1	152
Training Availability/Adequacy	7	6	0	31	63	0	107
Service/Intervention Provision	5	10	0	40	27	0	82
Escalation/Flagging to Line Manager	0	0	0	0	74	0	74
Reported Case Experience	9	1	0	4	29	17	60
Definition of VFI	0	9	0	16	33	1	59
Assessment Tools/Frameworks	4	2	0	6	43	0	55
Statutory/Legal Thresholds	3	9	0	13	28	0	53
Recognition of Early Indicators	6	7	0	12	19	0	44
Workforce Capacity/Resourcing	1	7	0	32	4	0	44
Suggested Improvements	3	8	0	15	11	0	37
Lead Agency Responsibility	2	4	0	14	15	0	35

Frontline Safety	Personal	1	0	0	0	23	0	24
MAPPA Criteria Fit *	Eligibility	3	4	0	3	9	0	19
Legislative Views	Change	0	4	0	10	2	0	16
MAPPA/Prevent-Channel Overlap *		1	1	0	1	4	0	7

Thematic code frequency for LA senior leader open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/ Factual	Not Applicable	Total
Multi-Agency Structures/Panels	38	14	0	29	184	0	265
Organisational Guidance/Governance	17	5	0	33	156	0	211
Suggested Improvements	9	5	0	38	131	0	183
Wider Contextual Factors	15	7	1	20	63	0	106
Training Availability/Adequacy	8	7	0	17	64	0	96
Service/Intervention Provision	20	9	0	24	41	0	94
Assessment Tools/Frameworks	10	3	0	7	67	0	87
Definition of VFI	0	5	1	23	48	1	78
Recognition of Early Indicators	7	5	0	15	39	0	66
Legislative Change Views	0	0	1	20	44	0	65
Information-Sharing Between Agencies	10	5	0	4	44	0	63
Statutory/Legal Thresholds	5	3	0	14	39	0	61
Strategic Data Monitoring	7	2	0	12	27	0	48
Lead Agency Responsibility	3	2	0	15	26	0	46
Workforce Capacity/Resourcing	2	2	0	18	19	0	41

Reported Case Experience	0	3	0	2	14	13	32
MAPPA Eligibility Criteria Fit *	2	0	0	4	22	0	28
Strategic Partnership Arrangements	3	1	0	3	19	0	26
Frontline Personal Safety *	0	0	0	1	1	0	2
Escalation/Flagging to Line Manager	0	0	0	0	0	0	0

Thematic code frequency for MAPPA open-text responses

Code	Positive	Mixed	Uncertain	Negative	Descriptive/ Factual	Not Applicable	Total
MAPPA/Prevent-Channel Overlap	0	2	0	7	0	0	9
Lead Agency Responsibility	0	3	0	5	0	0	8
Service/Intervention Provision	0	2	0	5	0	0	7
Workforce Capacity/Resourcing	0	1	0	5	0	0	6
Suggested Improvements	0	1	0	3	0	0	4
Reported Case Experience	0	3	0	0	0	0	3
MAPPA Eligibility Criteria Fit	0	1	0	2	0	0	3
Recognition of Early Indicators	0	1	0	1	0	0	2
Assessment Tools/Frameworks	0	1	0	1	0	0	2
Definition of VFI	0	0	0	1	0	0	1
Information-Sharing Between Agencies	0	0	0	1	0	0	1
Statutory/Legal Thresholds	0	1	0	0	0	0	1
Training Availability/Adequacy	0	0	0	1	0	0	1
Legislative Change Views	0	0	0	1	0	0	1
Multi-Agency Structures/Panels	0	0	0	1	0	0	1

Wider Contextual Factors	0	0	0	0	0	0	0
Escalation/Flagging to Line Manager	0	0	0	0	0	0	0