Title: Practitioner perspectives on service users' experiences of targeted violence and hostility in mental health and adult safeguarding in England, UK

Abstract:

People with lived experience of mental distress experience high rates of targeted violence and hostility based on their mental health status. This user-led study explored practitioners' perceptions and experiences of supporting service users in these challenging situations and considered the role of adult safeguarding. Six focus groups with practitioners (n=46) enabled them to respond to data documenting service user's experiences. This process facilitated knowledge exchange between the research team and practitioners on the ground. The findings illuminate a complex picture where lack of effective structures and processes mitigate against service users in these difficult situations. Practitioners need to invest in trusting relationships, to optimise resources and actively help service users with lived experience of mental distress to find their own solutions. These should involve collaborative empowerment whereby feelings of isolation and rejection can be replaced with hope, a sense of agency and belief in personal control.

Keywords: Mental health; mental distress; hate crime; adult safeguarding; professional practice; co-production.

Introduction

Violence, hostility and discrimination against people with lived experience of mental distress are human rights issues of global concern (UN Human Rights Council, 2017). The limited research available shows that they are at high risk of being victims of hate crime (Emerson & Roulstone, 2014; Mikton et al. 2014). This paper reports findings from a qualitative study conducted in England (2017-2018) which explored the issue of targeted violence and hostility towards people with lived experience of mental distress from the perspectives of those involved in reporting and responding to it. Building on what we know about 'hate crimes', within the context of English legal and policy reforms (Whitelock, 2009; Schwehr, 2010), the research examined how these experiences connected with adult safeguarding as defined within the Care Act (HM, 2014). The Care Act provides a legal framework for local authorities (LAs) and its partners to identify and protect adults at risk of abuse or neglect. It asserts that an asset and strengths-based approach is required to emphasise prevention and community engagement (Stevens et al, 2018). Whilst safeguarding is everyone's business, LAs hold a key responsibility to establish a Safeguarding Adults Board in their area, develop and publish their plans with local people, make enquires in conjunction with their partners and review and learn lessons from their work (DHSC, 2014; Cooper and Bruin, 2017; Penhale et al, 2017). Analysis of critical features or variables which distinguish between different models of safeguarding organisation in England therefore reflects an iterative process between research evidence and developments in practice. Practitioners are still learning how to meet statutory requirements and work in person-centred ways as promoted in the Care Act guidance (Graham et al, 2017).

Despite policy and legal provisions, little is known about how best to prevent and respond to people experiencing targeted hostility, violence and abuse due to their mental health status. At an international level there are variations in police enforcement of hate crime laws and inconsistent engagement of care professionals' specifically social work in these areas

(Pollack, 2015). Our scoping review (Carr et al, 2017) revealed a degree of thematic consistency on the types and quality of evidence of mental health service user experiences of targeted violence and hostility and their help-seeking. It provided important insights into direct experiences of ‘disability hate crime’ involving mental health and addressed some gaps in knowledge. Importantly, the review revealed tentative findings about the relationship of services and professionals to these issues. Mental health professionals, social workers, police or family and friends were commonly identified as sources of referral or help and good quality advocacy, liaison or joint working between involved services is thought to improve responses.

How practitioners deploy power in these situations may be influenced by the culture and power of the organisation within which they work (Norrie et al, 2017). The use of ‘co-operative power’ (Tew, 2006:44) can facilitate working alliances with service users and an approach to using protective power in a more inclusive way. Models for enabling resolution and recovery, in safeguarding practice include ‘family meetings’, ‘Family Group Conferences’ and other strengths-based approaches. Making Safeguarding Personal (MSP) an English sector-led safeguarding initiative, has helped further to develop these outcome-focused responses (LGA, 2017). Formal evaluation of MSP revealed that the process takes no longer and leads to better outcomes, savings in time and resources including fewer revolving doors or repeated investigations (Lawson, 2017; Cooper et al, 2018). These approaches particularly draw on social work knowledge and skills and are welcomed by both professionals and those they work with (Manthorpe et al., 2014; Cooper et al., 2015; Pike and Walsh, 2015). Challenges to application can be enhanced by training, supervision and peer support mechanisms underpinned by compassion, respect and understanding of the impact that interventions have on people who use care services (Cooper et al, 2018). Less is known however about how these interventions have converged in mental health safeguarding since the Care Act (Whittington, 2016a; 20016b). We know however that social workers potentially play a significant role in delivering opportunities for people to take more power and control (Hamilton et al, 2015; Tew et al, 2015; Khoury, 2015).

Study design

The national study reported here, addressed this important gap in research and practice knowledge relating to adult safeguarding, ‘disability hate crime’ and targeted violence and abuse against people with lived experience of mental distress. Two key research objectives were addressed through empirical enquiry;

- to explore service users perspectives and concepts of abuse including aspects of help-seeking, prevention, protection and resilience (Phase 1).
- to explore and investigate Phase 1 findings with practitioners and providers who could potentially address them and their relevance to and relationship with safeguarding practice (Phase 2).

The study was user-led and co-produced. The research team comprised both researchers with and without lived experience of mental distress. This was significant for investigating a highly sensitive and potential distressing topic and led to high recruitment and retention rates and improvement in data quality (Faulkner et al, 2019). The findings were grounded in service-users’ perspectives to help inform their practical application (Nichols et al, 2003; Faulkner, 2004). The findings from phase 1 are published elsewhere (Carr et al, 2019), as are

the detailed methodological aspects of this user-led study (Faulkner et al, 2019). This paper reports solely on findings from Phase 2.

Methodology

In phase 1, in-depth qualitative interviews were conducted with service users (n=23) with experience of mental health targeted violence and hostility by researchers with experience of living with mental distress. Being open about these commonalities was a key feature of the research approach (Faulkner et al, 2019). The summative themes resulting from this data are in Table 1.

Place Table 1 near here

In phase 2 we engaged relevant professionals and practitioners to explore these themes from a wide range of expertise and experience. Focus groups were used to facilitate a process of embedded knowledge exchange between the themes that encapsulated service user's reported experiences, the research team and practitioners on the ground. Focus groups were conducted by researchers with both practice and lived experience. Participants received a full summary of the above themes from the data in advance of the focus groups accompanied by some broad overarching questions for their consideration. At the beginning of each group discussion, these were reiterated with some illustration of the actual service user narratives to bring these to life in the form of a short presentation. The research team used a topic guide to structure the subsequent discussion. This addressed:

- How participants understand and align themselves with the service users' own experiences and definitions of mental health related abuse, violence and neglect?
- How participants see abuse, hate crime and neglect experienced in mental health in the context of person-centred adult safeguarding?
- What could improve person-centred approaches for the study population and how adult safeguarding might reach into mental health services including inpatients?

This exploratory approach offered a means of enriching our understanding of this data against the original key research questions through interpretation from key individuals and organisations from the assessment and provider context. The consistency of themes were assessed through a process of triangulation. These enabled co-production in understanding the process for responding, the implications for current and future practice, for service design and capacity building and to identify further opportunities for knowledge acquisition.

Sample

A combination of purposive, opportunistic and snowball sampling recruitment methods were achieved by reaching out to relevant networks and organisations in the English South East region and Midlands. Target participants for the focus groups comprised of social workers with delegated statutory responsibilities for adult safeguarding and professional expertise in mental health, plus practitioners represented in the proxy range of agencies and organisations identified in the service user interview transcripts. Six focus groups (n=46) took place over

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twelve weeks, ranging from 30-90 minutes in length. Participants provided basic details on their background and experience. An overview of the sample reached is in Table 2.

Place Table 2 near here

Data collection and analyses

Group discussions were digitally recorded and transcribed. The facilitators debriefed after each focus group and made short contextual and reflective notes together.

The Framework Method (Ritchie and Lewis, 2003) was used to analyse the focus group data alongside the service user interview data obtained in Phase 1. A coding framework to manage and organise the data was derived from the codes established for the service user interviews. These were developed and adapted for the focus group topics. Four team members analysed seven transcripts. Firstly, individuals familiarised themselves with the content and then coded each transcript manually. One member of the team moderated all of the coding to identify the main codes and categories, to ensure consistency and to note and account for any differences. Each member wrote memos on the transcript to aid any interpretive concepts or propositions that described or explained aspects of the data. Again these were moderated and key themes further developed by interrogating data categories through comparison between and within ‘cases’ (Richie and Lewis, 2003). Cases consisted of professional disciplines, settings, legislation and policies referred to and practice issues. This inductive and co-produced approach to data analysis contributed richness in perspectives achieved through service user analysis of practitioner discourses and everyday accounts (Nicholls et al, 2003; Author 3 et al, 2019).

Categories identified in the data covered the nature of mental health-related crime, practitioners’ views on perpetrators/location and views/observations about factors increasing vulnerability. They captured participants’ perspectives’ on responding, taking responsibility for and resolving incidents, the relationship to adult safeguarding, identifying cultural, organisational and systemic issues. They identified sources of support and recommendations for change and improvement. This facilitated thematic analysis across both sources in phases 1 and 2, utilising different sources of expertise (Gale et al, 2013; Faulkner 3 et al, 2019).

Ethics

Ethical approval was granted by **Middlesex University**. Research conduct was informed by the SRA Code of Practice for the Safety of Social Researchers, which covers physical and emotional safety (http://the-sra.org.uk/wp-content/uploads/safety_code_of_practice.pdf) and the Ethics of Survivor Research (Faulkner, 2004). The process embodied ethical principles of user-led research regarding transparency, respect, flexibility, accessibility, empowerment, a commitment to change, clarity about the underlying theoretical approach employed, accountability and financial compensation for participants' time and support needs (Beresford and Croft, 2012). All researchers in the team had group and peer supervision, in the form of reflective research practice, and opportunities for post-interview debriefing in phases 1 and 2. Flexibility in the budget facilitated any additional support needed (i.e. following a distressing

interview). The research team reviewed the ethical conduct of the research on an ongoing basis (Faulkner et al, 2019).

Findings

We discuss four thematic areas from phase two. Firstly, **recognition and interpretation of service users reported experiences of mental health related abuse** in the context of practitioners' experiences. This surfaced descriptions of diminishment, helplessness and complacency and barriers to justice for people with mental distress in complex systems. The second theme concerned **professional and service user status and power relations** played out in responses to abusive scenarios and how these were positioned within power structures. Participants described tensions in taking a rights-based approach outside of the mainstream criminal justice system. Significant conflicting structural issues highlighted grey areas in people's rights to access support when things went wrong. Thirdly, practitioners identified **key issues in responding to victimisation, abuse and hate crime**. User involvement was a core principle missing in safeguarding practice. Fourthly, the **reframing of practitioners contributions** identified suggestions for moving forward. This theme articulated the need to empower individuals in decision making by making meaningful connections and alliances. Participants asserted the need to work tenaciously with complex, often cross-disciplinary and cross-agency issues to ensure all stakeholders, particularly in health and criminal justice, play their full role in adult safeguarding.

Recognising the significance of mental health related abuse

Participants' responses to the user narratives ranged from expressions of shock and sadness to lack of surprise. Some practitioners expressed desensitized or defensive reactions accompanied by feelings of helplessness. They provided many practice examples of people vulnerable to targeted hostility and violence based on mental health status. These echoed stigma and stereotypes about how and why abuse occurred and its normalisation. One advocate conducting community-based mental health first-aid training reported;

... some of the questions that would come out....well are these people going to destroy our neighbourhood and why would you let mad people out...a phrase they used "these dogs"...hearing some of these comments was really quite disturbing. (Community advocate)

Practitioners gave examples of colleagues who diminished experiences of abuse through the use of language which described victims as 'hard to engage' or 'difficult' and suggested that abuse was fabricated. Service users lacked the right spaces to articulate abuse, had low expectations due to sustained poor experience of services. Inpatients were seen to experience the most challenging situations due to increased vulnerability. One manager cited local research where a third to half of people admitted with mental distress had a history of childhood abuse.

So I wasn't shocked. I'm part of mental health services.....you will find that abuse patient to patient, patient to staff, visitors to staff and staff to patients happens, it's one of the highest numbers of incidents that occurs in mental health wards that's the reality (Mental health practitioner)

The environment posed risks from mixed gender wards where patients may be *'sexually disinhibited'* and the staff *'too busy'* to supervise, resulting in unchallenged sexual violence between patients, patients and visitors, patients and staff, including same-sex abuse. These scenarios were compounded by poor supervision of people who lacked capacity and the complete lack of consultation or advice on how people could mitigate risks and protect themselves.

The use of terminology to describe incidents of targeted violence, hostility and abuse were seen as significant in reporting them. The term *hate crime* was questioned as being too dramatic a description in some circumstances. Service users were reluctant to infer criminality for fear of reprisals or because they did not consider their situation to be *'that bad'*. As mental health is not often specified within the formal categorisation of hate crimes, this led to its lack of determination. Incidents involving mental health were often categorised as a *'disability hate crime'*. However for those who see disability in very conventional terms these also went unrecorded. For example, the police noted complex issues around recording sexual crimes in instances where people with mental distress had been targeted. Police crime reporting therefore did little in highlighting prevalence and trends of different types of crimes against people due to their mental health status despite efforts to tighten this up.

National adult safeguarding leads observed a tendency towards a *'hierarchy of abuse'*, where *'low level hate crime'* became marginalised due to the volume of work. They identified the important role of Safeguarding Boards in developing strategies to address these unmet priority areas. Parallels were made with work done to combat fraudulent schemes such as *'scamming'* where professionals worked together to pick up the implications for safeguarding and to promote prevention. They cited the value of evaluating research evidence from care settings on types of abuse arising from mental health status. This approach could stimulate improved partnership working and inform wider commissioning, safety and service improvement in provider services.

Positioning responses and power relationships

A dynamic and challenging picture emerged of how professionals responded to targeted violence and hostility towards people with mental distress. There was a clear narrative of feeling unable to resolve issues particularly where scenarios were downgraded, diminished and seen as intransigent. Strong themes emerged on buck-passing between partner agencies. There were perceived barriers and boundary issues and lack of clarity around threshold criteria for taking action. It was here that practitioners described grey areas in legislation, policies and practice relating to criminal justice and safeguarding compounded by a lack of confidence in being able to advocate, intervene and assert accountability. The lack of resources were a significant contributory factor when assessing the needs of individuals seeking support.

Within the community, buck-passing was common:

I remember a transgender person experiencing mental health that was being managed, but um this person was really targeted because of you know status and um it was by a neighbour

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3 *and there was no support from Housing. There was just no support from anywhere, it was a*
4 *real kind of helpless situation and kind of compounded the person's mood and depression*
5 *and ... So it's very difficult. (Mental health practitioner)*
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8 Another described making a referral to a local authority '200 times' in a crisis involving co-
9 occurring problematic substance use in which no-one accepted responsibility. Buck-passing
10 was described by the police requiring timely help from in-patient medical practitioners when
11 obtaining statements about mental capacity assessments **were needed** to make an application
12 to the Criminal Prosecution Service. This worked more effectively **where staff were** the
13 victim of assault rather than the patient:
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17 *just to get something as simple as a doctor to sit there and say at the time that person*
18 *assaulted that person they did have some form of capacity and therefore we think you can*
19 *take them to court.... whether they did have capacity or not is down for the court to decide.*
20 *All we want to do is get them through the door (police).*
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23 On the other hand, social workers in community mental health teams described how the issue
24 of mental capacity enabled staff to opt out of treating a situation as a crime:
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26 *Within our team if someone is assessed and determined to have capacity... then it kind of feels*
27 *almost that they are to blame for that if these things are happening to them (social worker).*
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30 Colleagues were cited as openly stating 'this person is really hard work' or 'they're playing
31 the victim for attention' and/or using austerity as an excuse not to phone and follow through
32 issues following disclosure of abuse. They failed to initiate collaborative ways of responding
33 or behaving in a 'more professional empathic practical way'. Withholding power through
34 instances of victim blaming were compounded by unspoken thresholds for responding to
35 reports of harm:
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38 *I've called the police ten times and the police said to me, I'm not coming out, we've been out*
39 *ten times, we're not going out eleven times, we've investigated. It's kind of like there's this*
40 *threshold that professionals feel you know that they are not resolving it, but there's kind of*
41 *like this idea that you can only do it so many times... (Social worker).*
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45 Time pressures and management expectations led to social workers processing situations
46 either out of their own domain, or to another agency. There was little evidence of investing in
47 enquiries from a position of curiosity. An example was given of a homeless person rehoused
48 but not able to live in his home due to victimisation by a local 'drug gang'. He was afraid to
49 disclose this vulnerability and persistently presented with other issues at the housing
50 department. It was only following a home visit that legal action was taken. The combination
51 of poor housing environments with local drug dealing and problematic substance use featured
52 significantly in abusive situations:
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56 *(She) got herself in quite a difficult position with local drug dealers, which kind of*
57 *deteriorated and now they're kind of harassing her sexually, threatening her because they*
58 *can't access her home anymore to supply drugs (Social worker).*
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Other scenarios illustrating agency control and power involved practitioners and advocates sharing information with a service users' psychiatrist. This resulted in the service user having their medication increased to address psychiatric symptoms rather than dealing with the source of the problem. For inpatients, limited or no access to a telephone or advocate led to untimely responses and the loss of valuable evidence. Sometimes the patient called the police, the police then called the ward who said they would deal with it, with nil action:

I've been to some inpatient wards you know during my time and I have to say I don't feel safe as a worker going in to visit a client or attend a review meeting.....you are literally just going to put a sticking plaster over people... (Independent advocate).

Oversight of abuse occurring in the community was often lost following hospital admission or led to abuse continuing in the new setting. This was illustrated in the following example of ongoing financial abuse:

.. There's confusion where um this visitor or family has been abusing the person in the community and then when they are admitted they still keep on visiting. So it's not being able to differentiate whether this person actually supporting this patient..... (Social worker).

Mental health practitioners referred to the patient advocacy liaison service as the go-to support for in-patients. They referred to their own lack of confidence in knowing what to do. Combined with buck passing, they expressed frustration in being unable to get sufficient support for situations they were dealing with:

I think it probably down to me not driving it and insisting that we do have a professionals meeting, because the police have shut down the investigating, housing are like, well no she needs to call the police, you know she can change her number, she can do all of these things, but we're not moving her. She is desperate to be moved. It kind of feels like I don't really know what to do, if these guys aren't really interested in having a further discussion or exploration as to how we can maintain her safety in her community, my hands are tied (social worker).

This notion of a person being trapped and unsure of who to turn to or not knowing who could help, was therefore not just confined to service users' experiences. This worker acknowledged her tendency to blame the service user for not acting on the advice given on how to keep herself safe and her own lack of vigilance in responding to the service user when she was distressed.

Practitioners described 'mate crime' where people would appear to befriend, and then take advantage or perpetrate abuse. In the absence of alternative community services or as a result of service reductions, service users became dependent on 'mates' for support. They were forced to balance the making of a complaint about the abuser with the potential of being left in complete isolation or experiencing escalated abuse and reprisals. Those living with learning disability and/or sensory impairments were particularly susceptible. National safeguarding leads echoed these themes from a strategic standpoint based on evidence from

their Serious Case Reviews where austerity frequently underpinned these examples within the theme of dependency and powerlessness.

Many accounts illuminated the lack of mental health awareness generally. For example, if people expressed delusional thoughts or beliefs, this could result in staff accounts being privileged over service user accounts and preventing unbiased and thorough investigations. The police gave an example of retrospective ‘sampling’ of investigations in one in-patient setting which was used to challenge inaction. As many public enquiries have shown, practitioners saw colleagues on the frontline becoming desensitised to service user distress and to the impact of power relations within institutional settings. Participants with lived experience and from community organisations described how such powerful institutional structures and cultures shaped professionals interactions and overshadowed service users own voices. The scenarios described by practitioners highlighted power dynamics, not only between service users and professionals but between different professionals themselves. Practitioners needed to be highly skilled and knowledgeable in how the experience of abuse might manifest when people present with complex situations.

Even within their own services social workers observed contrasting hierarchies around safeguarding in adult mental health and children’s services. In integrated settings social workers saw themselves at the bottom of the hierarchy, which diminished their leadership of safeguarding practice. They held generic roles as care coordinators with pressure to close ‘cases’ quickly. Therefore following up enquiries became a personal burden and were seen as ‘extra or unnecessary’ by other disciplines. Managers avoided accountability and in comparison to children’s services, staff tended to hold little procedural knowledge in relation to their legal powers or were less involved in structures and processes common to safeguarding enquiries which aid good decision making, such as in the use of independent roles. Children’s practitioners however were perceived as having smaller workloads, better leadership from the social work profession and their knowledge, skills and expertise valued.

There were further complexities for people transitioning from children to adult services or where the assessment involved children with parents with mental distress. One children’s social worker talked about the limitations and hazards of specialist roles. Her example was revealing:

..One incident where I was in the home and this parent had said to me that if I didn’t remove these children she would kill herself. Well I’m primarily here for these two small children and I need to focus on them....when I tried to contact the mental health team the worker said to me ‘well why didn’t you just talk her down’. I was saying hold on a minute, actually isn’t that your responsibility? Can’t you come to this situation and offer some advice? It’s not my area.....it was just left there and nobody was kind of really stepping up on it. Nobody seemed to do any kind of extra (social worker).

In summary, there were many issues concerning status such as professional identities and the status of working in mental health itself. Lack of status impacted on being able to hear and enable service users own voices. Practitioners connected the lack of awareness and

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stigmatising attitudes with an overpowering lack of coordination and collaboration. These were in turn impaired by poor infrastructure, problem-solving, demand management and role hierarchies. None of these were flexible enough to meet the needs of service users. Austerity also impacted on increased use of agency staff mitigating the need for a reliable, stable workforce, equipped to meeting both the needs of mental health in-patients and those in community settings.

Key issues and boundaries between hate crime and safeguarding when responding to victimisation and abuse

Many issues around responding and resolving targeted hostility and violence in adult mental health reflected inequalities across adult safeguarding and mental health hate crime. Participants reiterated how the impact of categorising people presenting with issues associated with their mental health were reinforced by service separations. A more flexible and coordinated response was needed. The lack of awareness of safeguarding within integrated mental health settings made it difficult to assess threshold significance with potentially dire consequences. One social worker described a woman being harassed constantly by her neighbours which had been reported on many occasions:

..nothing really has come out of that which is really quite frightening. She's worried that one day she will step out her front door and have acid thrown in her face, because you know they can do that and get away with it because the police aren't really taking it seriously. So this is something that I really do understand and I feel really sympathetic with, but I kind of feel tied (social worker).

Safeguarding procedures within mental health trusts appeared to be ineffectual when staff had little experience outside of the hospital setting. Reporting was not prioritised or joined-up enough to respond to issues across the community/ hospital divide. Practice was dominated by a medical perspective and the role and experience of the social worker in the Community Mental Health Team was generally undervalued:

It's all up on the wards, posters and stuff, I don't think people, you talked about perception, I don't think people think of it as safeguarding. (Social worker).

Knowing the 'language of safeguarding' had been described in the service user data. Practitioners agreed that this enabled service users to articulate and communicate their experience of abuse and access help. Practitioners felt that identifying targeted violence and hostility as a safeguarding issue was a positive one. They thought it important for developing more appropriate services. This also contrasted with other data however from service users where they tended to self-blame or perceive their problem not to be serious enough and lowered self-esteem.

It is difficult because, 'making safeguarding personal', you have to ask the person what do you want, do you want someone to do something? And unfortunately they do have that choice of saying no, particularly when it's financial abuse and its family (social worker).

Echoing earlier themes on recognising or naming criminal behaviour, practitioners spoke about barriers in the criminal justice system where people were rarely successful in meeting thresholds for prosecution. One participant with lived experience talked about the adversarial court system which undermined her own advocacy and those she was supporting. People found it difficult to get their cases heard in the first place and when they did, their mental health was used to discredit evidence. This was both contradictory and frustrating.

The police reflected on the importance of building kudos in the police force for those with expertise in mental health and stated that the *'average police officer tends to avoid situations'* where mental health was involved. Officers lacked confidence on the ground if the situation was complex combined with the sheer amount of time it can take to process a situation which in turn was not seen by them as *'real policing'*:

Uniform officers out there on the streets, would much prefer to go to a suspect on a burglary, or a robbery....I mean unless you're arresting someone, it's not worth investigating it (police).

In relation to drawing on relatively new legislation and guidelines, one social worker stated:

'um adhering to the Care Act, I think people don't really know how to use it properly and I certainly don't feel confident like using the safeguarding planning meetings and strategy meetings to really you know push her case forward, because other agencies who could be supporting and doing their bit, aren't really interested in helping.'

This response conveys doubt about how to best meet the needs of someone and confusion about the practical way forward. It reveals more emphasis on legislation and structures than advocacy or engagement in problem solving. At an individual level, some practitioners reflected on the function of safeguarding procedures, in terms of raising an alert and involving the person in any investigation or subsequent planning. However, they questioned how this informed change at the organisational, service or structural level. The latter is far more complex. The political reality such as bed availability and poor physical environments for example impacted directly on effective co-ordination of safety for inpatients. Practitioners felt unable to be critical about the quality of services being commissioned or endorsed. One participant with lived experience however was more optimistic about the opportunities:

There's a system failure going on and I think for me, in terms of the solutions, I think this is the way things are very slowly going is around the peer support stuff. It's about people kind of actually getting together and sharing experiences and working together. I think that's where the strength and potential lies (peer support worker).

High staff turnover threatened the process of engagement, trust, communication, affecting staff retention, morale, esteem, confidence and a blame culture. Increasing reliance on agency staff and transient settings caused structural weaknesses within organisations when implementing safeguarding policy. Geographical differences influenced the ratio of permanent staff to agency staff and impacted on work practices and patient experience. Not all participants agreed that resources were entirely to blame. The 'humanness' of

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practitioners, the need to be self-aware, ethical practice, knowledge and skills in working with trauma and challenging their own expectations about what an individual can actually cope with, were all frequently cited. Many examples of strengths-based practice were given such as working in a ‘good group of staff’. Working with people with lived experience encouraged a grass-roots approach to problem solving.

Reframing of practitioners contributions and finding ways forward

This theme returned to the importance of knowing the language, developing capacity for partnership working and building expertise and clarity around criteria and thresholds for support at different levels in this challenging area of practice. Practitioners revealed a diverse range of good practice examples such as the role of dedicated liaison and initiatives targeting intransigent issues. Whilst promising, these initiatives were not always sustainable due to changing operational structures and reductions in spending.

The police described emerging systems for improving the reporting of hate crimes. In one area, they created a full time mental health liaison officer linked to a central mental health team. One participant described his role in liaison work, planning, risk assessment and pre-planned mental health assessments to manage and target situations more confidently. Examples were given of a pilot street triage involving mental health nurses and a dedicated police phone line. The police identified the lack of nuance in the system to capture incidents towards improved hate crime reporting. This echoed concerns in the service user data, where the categorisation of incidents prevented accurate monitoring and service users were more commonly reported as protagonists rather than as victims of anti-social behaviour. The police gave an example of targeting a hospital with a high rate of serious incidents over five years, and developed a scheme with a named police officer for the local inpatient mental health unit. This officer utilised his own lived experience of family mental health. This enabled situations to be more sensitively and quickly resolved and was beginning to help the police achieve an overview of weaknesses in the system. The police talked about taking a more curious stance following a shift in culture resulting from recent public exposure of abuse occurring in institutions:

....we’ve got to go there within an hour, you know, very irritating. But....they saw the patient, they looked at the CCTV, bosh, and there you see a suspect has gone into the room as you described and committed an assault....from taking a different approach to victims in these settings has brought out a successful prosecution..... We have got cultures issues that we need to overcome... (Police).

Strategic leadership

A national safeguarding lead spoke about the importance of leadership at the organisational level to scrutinise complaints, provide consistent follow-up on outcomes and speed of response. She called for higher standards on investigating and ensuring proper consultation and checking satisfaction with the process. At the board level reviewing themes on choice and safety were pertinent. Identifying, recognising and reporting hate crime in situations where the perpetrator also has lived experience of mental distress was essential. This requires

a multi-level approach which deals with anti-social behaviour and provides support in reporting as well as in monitoring incidents. Participants spoke of the need for accountability and holding perpetrators to account. They noted the potential to learn from developments in domestic abuse.

Participants in management roles spoke about the role of the Care Quality Commission in following mental health hate crimes in their key lines of enquiry and for managers in reviewing trends in their services. They reiterated fundamental rules on communicating incidents and the challenges faced where there are closed care environments. Whilst taking time to embed, positive changes had been introduced by the Care Act such as in the new statutory footings for adult safeguarding boards and their membership to include the police and people with lived experience.

Prevention

Solutions involved radical and earlier interventions, with named champions and the building of relationships with the voluntary sector. Investment was a major barrier to prevention and needed good strong community liaison where resources were stretched. Positive working relationships and local connections with service users were currently focused on dealing with crises. Safeguarding was not seen as an end in itself but a trigger for coordinating an assessment and programme of support. Most issues were not easily fixed. Making a 'safeguarding referral' was not seen as having any teeth beyond sharing some information but could be useful for highlighting the need for help and in achieving sustained coordination around service users' needs:

It's like okay now we've passed them onto safeguarding, they've been safeguarded...there has to be that buy in from all partners to say actually okay what's happened, how can we move this person forward and let's put some commitment to it, not just the case of we've safeguarded that person now, it's all okay.... it's frustrated our frontline crews who are all safeguard trained, and well aware of what to look out for inside someone's home, what someone might disclose to them and more often than not they will come to me and say look, I've put this safeguarding referral in because this lady really does need it ...and then 8-9 weeks later they have had no feedback, no comeback (Fire service).

There was little evidence of mental health being represented in adult safeguarding forums and participants noted that it was rare to have a mental health representative in Multi-Agency Safeguarding Hubs (MASH). From a strategic standpoint, the police were able to comment on the integrity of crime data and how useful this could be to help them serve populations living with mental health in their communities. They were committed to sharing high profile situations and working together to keep people safe. Safeguarding leads noted the need for Boards to undertake an impact assessment of major reorganisations and changes which led to reduced support for individuals in the community. The broader picture reflected how adults with learning disabilities and mental distress experiencing hate and mate crime were not embedded in these structures. Recommendations from local serious case reviews needed to inform better systemic working:

I'm sitting here and trying to work out what's the added value of safeguarding then? if it's actually joining up some conversations between advocacies, voluntary organisations, the actual health providers and the individuals, that could be a possibility. But the CQC should be visiting these inpatient wards and picking things up (Chair of Safeguarding Board).

Peer advocacy, and grass roots peer support

Practitioners spoke extensively about the value of peer advocacy and peer support in walking people through a process. In closed care cultures, these provided services with eyes and ears cultures.

Peer workers are a brilliant, brilliant addition, so I think we have to politically stand up and fight for some things to be protected (Safeguarding lead).

Those in advocacy roles gave examples of initiatives being cut, at the risk of closing, or skimming the surface. So whilst user involvement and peer support were deemed ideal and effective, few examples were given of active schemes.

To homogenise it as a hate crime in a way? The flip side of that, I mean I've just come from the human library, we created a human library and the idea is to break down prejudice and discrimination around labels and people who have experienced prejudice and discrimination (service user advocate).

Others referred to tapping into the lived experience of their staff with mental health and the importance of learning from other marginalised or stigmatised communities where targeted consultation and advisory work had impacted well. Some initiatives involved creative commissioning to ensure that people who come into regular contact with the community had their issues identified earlier and reported more proactively. These helped local services to be more aware about issues becoming problematic. The Fire Service had appointed a *vulnerable person officer* role, who had been upskilled and specially trained about the Care Act, mental capacity, mental health and disability. This flexible role provided additional visits to a particular property or particular person, in response to individual needs:

'finding the teeth almost I suppose, there's some real key ones in particular, to try and hold all agencies and pull all agencies together, to really make a difference, make an impact'.

There was an appetite to work differently with support that *'ties up even higher'* (Safeguarding lead). Working with faith groups for example helped to guide those delivering services on what good care should look like and how best to consult. Most participants stressed the ongoing importance of engaging with service users from mental health in their training and education.

Discussion

This unique study explored practitioners' perspectives, knowledge and practice about targeted violence and hostility in mental health based on data emerging from direct dialogue with service users about the shocking levels of abuse against people with mental distress

perpetrated by a range of people and compounded by consistent failure of authorities to deal with these incidents effectively. We wanted to know what could be done to address abuse and how to promote help-seeking, resilience, protection and prevention by those whose role it is to support service users (Henderson, 2002). Victims did not always describe their experience as a mental health related ‘hate crime’, and professionals may also not classify or recognise it as such (Williams and Keating, 2000). The research however revealed a lack of faith among mental health service users *and* services in existing procedures to keep them safe. Discrimination in the criminal justice system and a systemic lack of engagement with the principles and practice of adult safeguarding can deny people with mental distress equal access to justice and poses a risk to their human rights (see also Whitelock, 2009).

For service users, the research raised potentially distressing and difficult issues for individuals to discuss or disclose. Participants with practice knowledge however were familiar and spoke of them freely. Notwithstanding, all stakeholders recognised the way in which hate crime manifested and the complexity of the issues and factors which increase ‘vulnerability’ (Copperman, 2011). Both sources gave concrete example of the devastating impact of hate crime and the wide variety in which it affects people including intersecting factors such as structural and environmental factors combined with lifecourse experiences (Williams and Keating, 2000; Matheys, 2015). These make hate crime hard to detect and confront. Whilst practitioners referred to ‘holistic approaches and interdisciplinary working’, these did not accord with service users definitions. For them, ‘holistic’ approaches meant the use of alternatives to diagnostic, and medical models of distress which offered alternative remedies, therapies and culturally-based approaches that were independent of statutory work. These were hardly addressed (Whitelock, 2009; Wallcraft, 2012).

Differences in organisational culture and structures within services where safeguarding concerns occurred affected the implementation of policy and legislation. Some practitioners in mental health integrated teams for example described a lack of ownership of individual roles and responsibilities and partnership working in the scenarios they shared which failed people. Whilst social workers tended to be more hands on, their work was frustrated by strong role boundary maintenance exercised by other agencies. Distinguishing whether a service user is the victim of a hate crime or in need of adult safeguarding is therefore a grey area in interpreting policy (Hewitt, 2009; Carr et al, 2019). In contrast, the data from the service user interviews focused and prioritised the importance of the qualities which professionals bring to their interactions and their commitment to listening and recognising people’s own perspectives on the problems. Giving this role to people with lived experience represents a significant reversing of the traditional hierarchy around risk rather than professionals’ being the ones to decide whether you are at risk or present a risk to others (Faulkner, 2017).

The knowledge exchange facilitated in phase 2 of this study exposed the need to address the causal role of abuse in psychological distress and disturbance and the perpetuation or replication of abuse in services. This means drawing upon experience gained from community alternatives. Williamson and Keating (2000) caution against placing too much initial reliance upon the safeguarding paradigm, but recommend explicit consideration of the

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troubled relationship between mental health services and oppression within our society (Hafford-Letchfield and Carr, 2017) as so clearly evidenced in this study.

At an operational level, practitioners own sense of disempowerment led to inevitable worse case scenarios because of the limitations of some service interventions in providing preventative measures and support for clients that fall within the safeguarding criteria. There is insufficient mental health representation within Adult Safeguarding forums and structures contributing to the lack of successful implementation of safeguarding policy provision. These highlight the need to further develop best practice for practitioners and service recipients through co-productive means (Cooper and Bruin, 2017). A major shift from the medical model engrained within practice, to the social, recovery model would enable a mirroring of approaches when working in multi-agency partnerships. The findings therefore have much to offer in theoretical frameworks used to analyse power relationships around service integration and the practical implementation of cross-disciplinary policy themes.

Limitations

Housing issues were prominent within the service user data, but securing participation from housing representatives remained challenging despite several efforts. The sample was biased towards practice in urban rather than rural areas. Further, small sample sizes did not permit nuanced understanding of different professional roles in safeguarding particularly for those working in specialist mental health.

Conclusions

There is an urgent need to agree and promote the language used to describe mental health targeted violence and hostility to convey the need for intervention which utilises both hate crime and adult safeguarding. Whichever intervention, they need to engage with service users own experiences and needs. Whitelock (2009) reminds us that abuse is no lesser an offence than other crimes and following the history of domestic violence, the police already have clear operating procedures to deal with perpetrators and prosecute them. Decisions to intervene should be made on a case-by-case basis that weighs up people’s human rights and builds up expertise.

This study highlights inequalities experienced by people with lived experience of mental distress. Targeting mental health in Adult Safeguarding strategies could provide better leverage. Moving from concepts of neighbourhood nuisance to hate crime would also promote recognition with robust engagement of housing in the debate about anti-social behaviour and mental health. More sharing of information and pooling of resources combined with improvement of data collection processes could provide better intelligence on problems, across agencies, and the responses or lack thereof. These key principles have currency at an international level.

At a local level practitioners need to address needs holistically and focus on strength-based approaches which enhance safety planning and recognise service users own resilience (Cooper et al, 2018). We recommend a safeguarding lead within agencies working with mental health plus service user and mental health representation on wider safeguarding structures and processes. Opportunities for third party reporting to the police with a wider

range of community members could be engaged as first responders to identify people at risk, gain access and give advice and information and pass on concerns. The establishment of local drop-ins could also contribute to prevention. We call for the improvement of monitoring and review systems for measuring incidents such as the use of flags on police crime reporting where mental health is involved,

Challenging power relations in institutions where there are sexual safety issues and people lacking capacity must include willingness to bring in new procedures to address these, more openness about personal professional shortcomings and suiting systems to victims instead of trying to make victims fit systems. Valuing the contribution of peer support and peer advocacy are clearly ways forward and involving people with lived experience in designing and providing services. Training that enables service users to be supported to keep themselves safe could follow examples of co-production in other areas of public services. It is essential to target perpetrators of abuse alongside a national campaign to tackle inpatient violence and reporting.

The impact of user-led research

The methods used in this study demonstrated that people with lived experience are well equipped to advise on risk and conduct user-led peer research (Faulkner et al, 2019). This gave voice to their experiences and then brought these to the fore in focus groups with practitioners. User-led research ensured that service user participants had a space to explore their mental health without some of the fears, barriers and constraints that characterise many of their other experiences. Powerful findings emerged from this approach (Faulkner et al, 2019). Participants in phase 1 told researchers with lived experience that they rarely had space to discuss non-psychiatric understandings of mental distress and had limited opportunities to influence services individually, or strategically. As choice and control for people who use services are policy imperatives, room for such discussions on both individual and collective levels needs to be made, including the challenging of discourses of abuse as defined in policies and legislation? Systems may be slow to change but initiatives such as peer support encompasses a personal understanding of the frustrations experienced with the mental health system. These serve to reframe targeted violence and hostility, make sense of what has happened and move on, rather than focusing on definitions of dysfunction in mental health. It is through this trusting relationship and optimising resources, which offers companionship, empathy and empowerment. Feelings of isolation and rejection can be replaced with hope, a sense of agency and belief in personal control. How far the changes wanted by participants can and will be achieved, is a huge challenge for politicians and practitioners alike.

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Table 2: Summative themes from the service user data

Theme headings	Sub-themes
Understandings and experiences of risk and vulnerability	<p><i>Determined by a person’s situation, environment, diagnosis and/or relationships.</i></p> <p><i>Socioeconomic effects of austerity may exacerbate for some and increase the risk of crisis, visibility and exposure to targeted violence and abuse by family, friends or neighbours.</i></p> <p><i>Poor housing or unsafe supported accommodation and deprived neighbourhoods</i></p> <p><i>Significant risks due to in-patient conditions on psychiatric wards including neglect by mental health services and staff</i></p> <p><i>Risk of abuse, assault (including sexual) or theft from staff as well as fellow service users in closed environments such as wards and supported housing.</i></p> <p><i>Living in fear of violence and abuse and feeling unsafe were common.</i></p> <p><i>The majority of mental health service users interviewed did not know about adult safeguarding, their rights and protections or how to use safeguarding language to raise alerts. They are unlikely to identify incidents of targeted violence and abuse as disability hate crime.</i></p>
Reporting, self-worth and ‘psychiatric disqualification’	<p><i>Recognition and reporting of targeted violence and abuse can be compromised by being seen as inevitable; not feeling or being believed because of their mental health status (the “unreliable witness”); not feeling they are “worth it”; and believing services will not respond appropriately or in ways that are additionally harmful.</i></p> <p><i>“burden of proof” characterised service users as problems rather than perpetrators.</i></p> <p><i>Forced to leave their homes, or to move house several times as a result of violence, abuse or victimisation</i></p>
Life histories, trauma and abuse	<p><i>Nearly all participants recounting mental health related targeted violence and abuse had a lifetime history of experiencing violence and abuse which was ‘normalised’ in their lives and some emerged</i></p>

	<p><i>from histories of trauma as part of their narrative, with a quarter mentioning childhood sexual abuse.</i></p> <p><i>Many reported additional multi-factorial abuse and discrimination impacting on mental health, such as racism, sexism, homophobia and discrimination or abuse based on disability and gender identity from neighbours, family, colleagues, mental health practitioners and in society.</i></p>
<i>Positive survival strategies, resourcefulness and perseverance</i>	<p><i>Negative responses such as isolation, deterioration in mental health and loss of trust, the majority of service users interviewed used positive strategies to cope and seek help using creativity, resourcefulness and perseverance.</i></p> <p><i>Many used or intended to use their experiences to help others or to inform change or to participate in the study</i></p>
<i>Experiences of mental health and adult safeguarding responses</i>	<p><i>Just under half had direct experience of adult safeguarding but few found it satisfactory because of poor response.</i></p> <p><i>Others had not heard of adult safeguarding, or thought it did not apply to them, either because of their perception of abuse</i></p> <p><i>Those who reported incidents of targeted violence or abuse found services to be “fragmented” and responses “haphazard” leading to loss of trust and faith in services, reducing likelihood of seeking help, disengagement and further exposure to harm.</i></p> <p><i>The police were generally the first point of contact with some satisfaction. Social workers were experienced as inconsistent or inflexible; focused on eligibility, were uninformed about adult safeguarding and/or had inappropriate responses to requests for help.</i></p> <p><i>GPs, therapists, advocates (including Independent Mental Health Advocates) in community and inpatient settings, user-led organisations and independent support groups were generally reported as being helpful, Being listened to and believed, even with limited power to act was valued</i></p>

<i>Service user recommendations for change and improvement</i>	<i>Being listened to and believed; accountability, and ownership, pursuit of justice. Independent advocacy and peer support to provide person-centred and consistent support for navigating complex mental health, adult safeguarding and criminal justice processes to resolution stage</i>
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For Peer Review Only

Table 2: Focus group and participant profiles (N=46)

Composition of each Focus Group	<p>Focus Group 1</p> <p>Focus Group 2</p> <p>Focus Group 3</p> <p>Focus Group 4 plus one individual interview</p> <p>Focus Group 5 & 6</p>	<p>Social workers with adult safeguarding experience</p> <p>Mental health social workers and nursing</p> <p>National Safeguarding leads</p> <p>Police</p> <p>Third sector, emergency services, advocates, people with lived experience</p>
Professional background	<p>Social work (adults)</p> <p>Social work (children's)</p> <p>Social work (specialist Mental Health)</p> <p>Police</p> <p>Mental Health Nursing (CPN/RMN/Critical Care)</p> <p>Youth Justice</p> <p>Adult Safeguarding Lead</p> <p>Voluntary sector (Community Development/Advocacy/Employment)</p> <p>Peer Support/User-led Organisation</p> <p>Housing (Health Liaison/Neighbourhood)</p> <p>Civil service</p> <p>Fire service</p> <p>Senior managers in Patient experience/Forensic Mental Health/CEO.</p> <p>Participants with lived experience</p>	<p>n=14</p> <p>n=2</p> <p>n =5</p> <p>n=4</p> <p>n=3</p> <p>n=1</p> <p>n=3</p> <p>n=5</p> <p>n=2</p> <p>n=2</p> <p>n=1</p> <p>n=1</p> <p>n=3</p> <p>n=3</p>
Length of experience	<p>Range = 6 months – 35 years</p> <p>Mean = 14.5 years</p>	<p>(7 people did not respond to this question)</p>
Working directly with mental health services or service users	<p>Yes</p> <p>No</p> <p>Not sure/no response</p>	<p>n=21</p> <p>n=20</p> <p>n=9</p>