

# Keeping control: Exploring mental health service user perspectives on targeted violence and abuse in the context of adult safeguarding

## RESEARCH FINDINGS

Living in fear of abuse and feeling unsafe in all settings was common across the service users interviewed

Neglect by mental health staff can be experienced as targeted abuse by services users

Staff reported feeling disempowered, afraid to take responsibility, lacking in confidence to advocate for individuals or to “speak out” about bad practice in such a system and in mental health or social work “blame cultures”

There should be more emphasis on user-led prevention and protection, with safety planning and safeguarding outcomes agreed with the service user when care planning

Service users report they need mental health and adult safeguarding practitioners, police and housing officers to listen and believe them; be accountable and responsible; to take ownership of the issue; and help them pursue justice



# BACKGROUND

Many people living with mental health problems are at high risk of targeted violence and abuse. Most adult safeguarding research in mental health has focused on service and practitioner perspectives.

Set in England, this research was a qualitative exploration of service user experiences and concepts of targeted violence and abuse (often termed 'hate crime') on the grounds of mental health status. It also aimed to capture mental health and adult safeguarding practitioners and stakeholder responses to these mental health service user experiences and concepts..

The Care Act 2014: Statutory Guidance on Making Safeguarding Personal reforms aim to make adult safeguarding person-centred and outcomes-focused. The study sought to inform policy implementation and practice development from a mental health service user perspective.



## Methods

The study used interconnected work streams with different methods:

- a literature scoping review;
- user-controlled interviews with self-selecting mental health service users with experience of targeted violence and abuse recruited through user-led organisations and networks (n=23, 92% women, 2 proxy carer respondents);
- practitioner-led adult safeguarding and mental health practitioner and stakeholder focus groups discussing preliminary service user interview findings (n=46);
- practitioner-led discussion of findings via two sessions on Twitter using @MHChat in December 2016 (n=585) and June 2017 (n=139); and
- a 'sense making' stakeholder event (n=42) facilitated discussion of implications of the findings for adult safeguarding in mental health.

The study was mental health service user led. Over half the team identified as service user or survivor researchers, including the Principal Investigator. It was co-produced with two practitioner researchers in a team working to a set of shared principles and methods derived from survivor and emancipatory research.



# FINDINGS

## SERVICE USER INTERVIEWS

The majority of service users interviewed were women, so these findings relate predominantly to women's reported experiences and concepts.

### Understandings and experiences of risk and vulnerability

Living in fear of violence and abuse and feeling unsafe were common themes across the interviews. Abusers, including some mental health staff, were thought to target victims in situations where individuals are vulnerable.

Risk and vulnerability can be experienced and conceptualised by mental health service users who have been victims of targeted violence and abuse in ways that are different to adult safeguarding practitioners.

Levels of vulnerability, risk from others and feelings of powerlessness can be determined by a person's situation, environment, diagnosis and/or relationships. The broader effects of austerity may exacerbate this for some. Reductions in support packages, absence of preventative support and difficulties with accessing services can increase the risk of crisis, visibility and exposure to targeted violence and abuse by family, friends or neighbours.

Poor housing or unsafe supported accommodation; deprived neighbourhoods with high crime; poor conditions on psychiatric wards; loss of trust in people and services; bullying and social isolation; and certain stigmatising diagnoses can expose people with mental health problems to the risk of targeted abuse or neglect in community, workplace, family and mental health service settings.

Neglect by mental health services and staff can be experienced as targeted abuse by services users. This can include ward staff who "don't want to see things and to help patients". They can also be at 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.

### Reporting, self-worth and 'psychiatric disqualification'

Service users reported that recognition and reporting of targeted violence and abuse can be compromised by them feeling it is an inevitable part of their life; 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.

Some felt that the "burden of proof" was on them. Many felt that they, rather than the perpetrators, were characterized as the problem. Several had been forced to leave their homes, or to move house several times as a result of violence, abuse or victimisation.

# FINDINGS

## Life histories, trauma and abuse

Nearly all the participants who recounted a specific incident of mental health-related targeted violence and abuse (including sexual and gender-based violence against women) had a lifetime history of experiencing violence and abuse. The majority reported a degree of normalisation of abuse in their lives and recounted lifetime histories of trauma as part of their narrative, with a quarter mentioning childhood sexual abuse.

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.

## Positive survival strategies, resourcefulness and perseverance

As well as reporting negative responses such as isolation,

deterioration in mental health and loss of trust, the majority used positive strategies to cope and seek help using creativity, resourcefulness and perseverance. They often had to find both positive and negative ways to cope in the absence of adequate responses from services or safeguarding.

Many were using, or intended to use their experiences to help others or to inform change, with several citing this as a reason for volunteering to be interviewed.

## Experiences of mental health and adult safeguarding responses

Just under half had direct experience of adult safeguarding but very few had found it satisfactory because alerts were not followed up or practitioners said the issue was “not in their remit”. Others had not heard of adult safeguarding, or thought it did not apply to them, either because of their perception of abuse or because they

believed safeguarding was for other service user groups (e.g. children or people with learning disabilities).

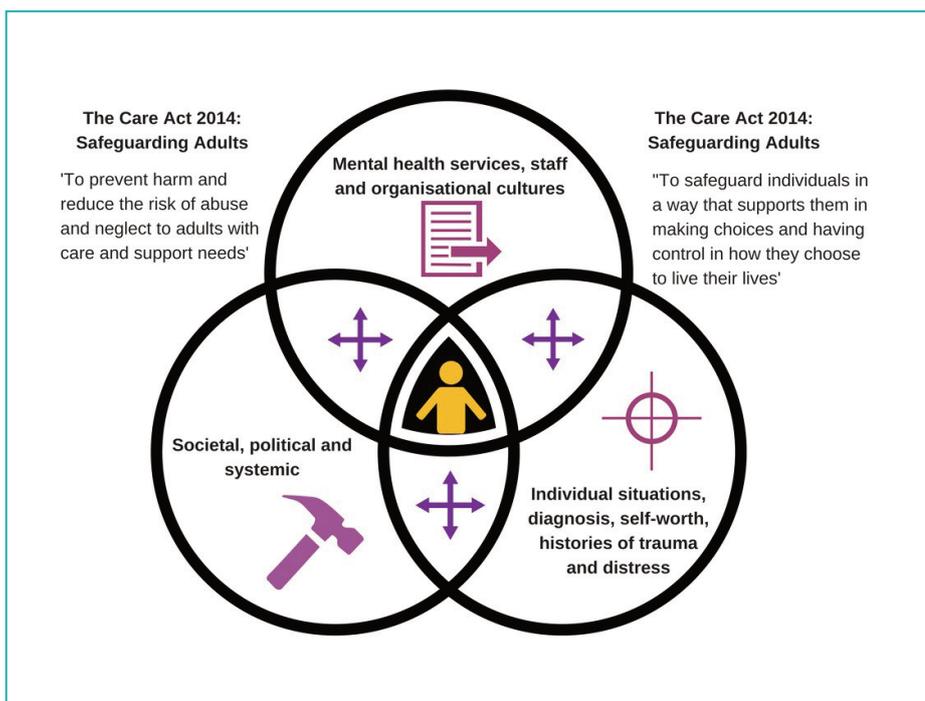
Generally, participants were unclear about the role and remit of adult safeguarding in mental health, with one reporting “even doctors don’t seem to know about it”.

Those who reported incidents found services to be “fragmented” and responses “haphazard”. They said that health and social work professionals sometimes “pass the buck” resulting in long response delays and lack of support. This could then lead to a loss of trust and faith in services, reducing likelihood of reporting and help seeking in the future and increasing the likelihood of disengaging and risking exposure to harm.

“We just want someone to accept responsibility.”

“There was no one to walk with me through it all...we need empathy and viewing the person as the person is first and it should be foremost.”

## Risk and vulnerability factors for targeted violence, abuse and neglect against people with mental health problems



The police were generally reported as first point of access in help seeking, with several participants reporting satisfaction with police responses as they felt “taken seriously”, and many had immediate responses focusing on their safety.

Participants said social workers did not help if they were inconsistent or inflexible, focused on eligibility, were uninformed about adult safeguarding and/or had inappropriate responses to requests for help. However, one said her social worker was affirming and believed her which she found very helpful.

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,

mainly because individuals were listened to and believed, even if the practitioners or organisations had limited power to act within the safeguarding or criminal justice context.

## **MENTAL HEALTH AND ADULT SAFEGUARDING PRACTITIONER AND STAKEHOLDER FOCUS GROUPS**

### **Views on vulnerability and risk**

Consistent with the literature, practitioners generally perceived risk from others as being about coercive control by family or friends, abuse by neighbours and financial exploitation. 'Mate crime' was seen as difficult to address as individuals may rely on the people who are exploiting or abusing them, and therefore reluctant to report the abuse or pursue a criminal case.

Adult safeguarding leads and police respondents said that under-reporting led to a lack of data on victimization of people with mental health problems.

Focus group participant responses to service user interview findings ranged from despairing to desensitized, with some noting that violence or abuse on wards was often seen as a "hazard" rather than a crime.

Participants agreed that closed environments such as wards, poor supported accommodation or housing, deprived neighbourhoods, social isolation and disconnected communities were circumstances that increased vulnerability to targeted violence and abuse. Sexual safety for women on mixed wards was also mentioned, along with the risks posed by high staff turnover and the use of agency staff on wards.

The reduction in or lack of access to mental health care and support was recognised as increasing vulnerability to targeted violence and abuse from neighbours and others. The

institutionalisation and desensitization of mental health ward staff was seen by some as risking the safety of patients, with police respondents citing difficulties in accessing wards and gathering evidence in response to patient reports of crime.

### **Views on professional roles and responsibilities**

Data from focus groups confirmed the reports from service users about systematic "buck passing" between professionals and agencies, with lack of follow up after incident reporting or a complaint. There was a specific example of professional boundary setting by a children and families social worker, when the parent with mental health problems was being targeted for abuse by neighbours: "I was expected to be master of it all...and I was saying to her [the victim], it's not my area".

Practitioners reported difficulties in taking individual responsibility for responding to reports of targeted violence and abuse in fragmented systems and structures where there are unclear lines of reporting and management. Several cited "blame cultures" in mental health and social work can mean that practitioners are afraid to take responsibility or whistle blow for fear of reprisal. Defensive practice was also highlighted as a difficulty.

Many respondents reported staff desensitization to targeted violence and abuse, particularly towards female service users with a history of trauma, multiple needs and unstable lives, which could result in individual blaming, refusal of services or lack of referral adult safeguarding.

### **Experiences of adult safeguarding and mental health**

A number of systemic, structural, resourcing and cultural issues in mental health and adult safeguarding were identified in the focus groups.

Respondents concurred that austerity and cuts to all services and support used by people with mental health problems was affecting service user and carer safety, including reduction in care packages, high staff turnover, understaffing and increased use of "unqualified and agency staff".

Several observed that ineffective management of partnership working in mental health and adult safeguarding can mean that "nobody takes ownership". Some reported lacking confidence or a sense of powerlessness in using safeguarding meetings and processes because they felt that other agencies would not "do their bit" or that safeguarding meetings were held to make plans that resulted in no action, with a fire services respondent remarking that "safeguarding is not an end process in itself."

Inequalities in adult safeguarding were identified, with many saying that it was better for older people, and people with learning disabilities than for people with mental health problems. Inequalities were also highlighted with the way child protection functions. Reasons included greater awareness of safeguarding for these groups among professionals, service users and the public and perceptions that victim protection was prioritized in children's safeguarding.

Police respondents said that a mental health equivalent of the domestic violence multi-agency risk assessment conference (MARAC) is needed, while a number of social workers reported that they have no mental health representatives on their local multi-agency safeguarding hub (MASH). Several social workers reported the importance of "safety planning" and "safeguarding outcomes" as part of care planning.

# CONCLUSIONS & IMPLICATIONS

Mental health service users' experiences and concepts of risk from others, vulnerability and neglect should be central to adult safeguarding. Their reported experiences of targeted violence and abuse should contribute to defining disability hate crime. An increased awareness of what adult safeguarding is in relation to 'hate crime' is required.

Histories of trauma; multi-factorial abuse; living with fear and stigma as well as mental distress; psychiatric disqualification characterised by "not being believed" or "worth it"; and individual blaming should be addressed in adult safeguarding practice in mental health.

Complex situations in people's lives do not require complicated or fragmented responses from adult safeguarding, mental health and other services which mean the person becomes "lost in the process", risking distress and disengagement, potentially increasing the risk to the victim. Staff said they can feel disempowered, afraid or lacking in confidence to "speak up" or advocate for individuals in such a system.

Powerful and influential independent advocates/peer advocates may be an approach for supporting service users who have experienced abuse or neglect, especially in mental health services: "A civil, social working advocate of some sort."

Mental health service users and carers need information and awareness about adult safeguarding and raising alerts, rights and protections and hate crime so they can access support and hold professionals to account. There should be more emphasis on user-led prevention and protection, with "safety planning" and "safeguarding outcomes" agreed with the service user when care planning.

Adult safeguarding, particularly police and housing partners, need to be accessible and respond quickly to service users reporting incidents of targeted violence or abuse and crime in closed mental health environments, such as wards or supported housing.

Service users (and carers) with experience of targeted violence and abuse and/or adult safeguarding should be members of local adult safeguarding boards, with equal power and influence.

Establishing collective and individual responsibility between agencies and individual practitioners, sharing information, developing a common language and open cultures are needed if adult safeguarding is to be person-centred, accessible and effective for people with mental health problems who are at risk or victims of targeted violence and abuse, and staff feel supported and confident to take responsibility, raise concerns and challenge bad practice.

## FACILITATED @MHChat DISCUSSIONS

Two Twitter discussions took place with practitioners to explore findings.

### December 2016: Responses to initial service user interview findings (n=585)

Largely confirmed themes identified; additional and expanded points were:

- Service users have to live with and manage fear and stigma, as well as mental distress.
- Isolation, loneliness, homelessness or neglect by family and friends are risk factors for victimisation.
- "Being different" or "not belonging" can lead to the victimisation of people with mental health problems.
- Trauma of previous abuse can be replayed in mental health services and supported accommodation.
- Austerity and political victim blaming may be creating a permissive culture for abusing people with mental health problems.
- The invalidating effects of diagnoses such as "personality disorder" and being "written off" by services posing a risk of exposure to targeted violence and abuse.
- The importance of a safe home and supportive network for protection and prevention.

### June 2017: Responses to initial mental health and adult safeguarding focus group findings (n=139)

Largely confirmed themes identified; additional and expanded points were:

- The possibility of individuals having histories of trauma and abuse should be accounted for in adult safeguarding in mental health.
- Individuals and situations not fitting 'criteria' for support can put them in vulnerable positions.
- Practitioners and services need to respond quickly to reports of targeted violence and abuse, otherwise there is a risk of disengagement and further harm.
- Service users, carers and staff can all feel "lost in the process", confused and disempowered.
- People who "speak up" can fear reprisal.

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