

At risk, yet dismissed

The criminal victimisation of people with mental health problems

Bridget Pettitt | Sian Greenhead | Hind Khalifeh | Vari Drennan | Tina Hart |
Jo Hogg | Rohan Borschmann | Emma Mamo | Paul Moran

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Foreword



Javed Khan

Chief Executive, Victim Support

This report is as timely as it is disturbing. That some of the most vulnerable people become so often victims of crime and yet feel so frequently let down is nothing short of a national scandal. There is an emerging consensus that urgent change is needed to protect those with mental health problems who find themselves in custody or crisis. This research shows how critical it is that the same energy and focus is brought to bear on the plight of victims who have mental health problems. These are people whose stories are ignored or disbelieved, their needs left unmet, their psychological scars left unhealed.

Once again, the criminal justice system has been shown to be ill equipped to respond to a vulnerable group. Once again, the solution is bigger than one agency or organisation.

We need a national debate involving all of us to consider how best to respond to these findings and when we do so, we must humbly learn from the lessons of the past. To make a real and sustained difference, changes to policy and working practices must have a clear goal in sight, must be strategic and must be focused on those in greatest need of help. Change must be urgent yet coordinated, across agencies and across sectors to ensure progress in one area is not wasted or undermined by inaction in another.

At Victim Support we look forward to working with others to ensure this report does not just mark the end of a piece of research, but the beginning of a process of lasting reform.



Paul Farmer

Chief Executive, Mind

At Mind, we believe people with mental health problems have the same rights to justice and equality as anyone. Our *Another Assault* campaign in 2007 aimed to tackle the barriers people with mental health problems face when accessing justice, and achieved key policy changes within the Criminal Justice System including new training and guidance within the police and Crown Prosecution Service.

Five years on, this research still paints a stark reality of the situation for people with mental health problems. It gives concrete evidence that people with mental health problems are at risk of all types of crime, are being repeatedly attacked and are far more likely to be victims of a crime than those without a mental health problem. Far too many people are not being believed, and are receiving a poor service when they try to get the support they need. As one described in the report, they feel like "they are being thrown out to the wolves".

This research is a call to action for all services to improve the way we respond to people with mental health problems who have been victims of crime. As one in four of us will experience a mental health problem in any given year, this is an issue that can't be ignored or dismissed.

Mental Health and Justice Researchers group

The researchers group is made up of six people who have personal experiences of victimisation and mental health problems. We are a passionate group of people from various backgrounds and walks of life and getting involved has meant taking time away from our lives to contribute to this very worthwhile piece of research. We joined at the start of the study and have met regularly to provide guidance and to ensure that experiences of people with mental health problems is at the heart of this work.

People with mental health problems are too often silenced or ignored. This role has helped us try and redress some of the injustices we encountered when we were victims of crime and to try to build something positive out of very difficult times in our lives. Drawing on our own experience, we have raised concerns, shared positive practice and talked directly to key professionals. We hope we have helped to establish a positive dialogue which will lead to improvements for people with mental health problems when they are victims of crime.

The findings of this study are shocking but not surprising to us. They confirm what we already knew from experience: we are at greater risk, we are more affected by this and we find it harder to get support and be taken seriously. It is bad enough to be a victim of crime in the first place, but to then not be believed or to be denied access to support and justice on the basis of your mental health diagnosis, is a double blow.

Whilst it is promising to read about some victims having good experiences it is noticeable how much of a lottery it is for people with mental health problems when they report or seek help in terms of the responses they receive. The challenge now is to try and implement positive changes so that people consistently receive good support from the services and individuals they go to for help.

The research has shown that this is not just about one service upping their game, but that improvements are needed across the board, from criminal justice agencies, to mental health services, to voluntary and community sector services to housing services.

The effects of crime are long lasting and far reaching. They cut across all areas of a person's life and therefore the responsibility for supporting victims with mental health problems is everyone's business.

Executive summary

Background

Public perception is that people with mental health problems are offenders, and historically, policy, research and clinical practice has focused on the risk they pose to others. However, in recent years a body of work has explored the victimisation of people with mental health problems and the impact it has on them. This research was conducted by a partnership of Victim Support, the Institute of Psychiatry at King's College London, Mind and St George's University of London and Kingston University, in collaboration with University College London, funded by the Big Lottery Fund and the Medical Research Council.

The study

This study was designed to understand experiences of victimisation and engagement with the criminal justice system among people with mental health problems. The main questions the study sought to answer were:

- What proportion of people with severe mental illness had been a victim of violent or non-violent crime in the past year, and how does that compare to the general population?
- What are the barriers and facilitators for people with mental health problems, who have been victims of crime, in reporting crime, progressing through the criminal justice process, and accessing support?

The study was conducted in two main parts, a quantitative survey and qualitative interviews and focus groups. The survey used a modified version of the Crime Survey for England and Wales (CSEW) with a random sample of 361 people with severe mental illness (SMI) using community mental health services in London. The findings from this sample were compared with those from the general population who took part in the CSEW survey over the same time period in London. We also gained information from clinical notes, and professionals involved in the participants' care. (See appendix 1 for details).

For the qualitative research we interviewed 81 individuals who had mental health problems and had been victims of crime in the last three years. The profile

of these interviewees was slightly different, with a broader range of mental health problems, and a third were not using community mental health services. The interviews explored their experience of crime, its impact and their engagement with the criminal justice system. We also conducted focus groups and individual interviews with 30 relevant professionals from a range of different backgrounds including police officers and mental health care coordinators.

Experience of crime

The findings of the survey showed that people with mental health problems experienced high rates of crime, and were considerably more likely to be victims of crime than the general population.

- Forty-five percent of people with severe mental illness (SMI) were victims of crime in the past year.
- One in five people had experienced a violent assault; a third were victims of personal crime and a quarter were victims of a household crime.
- People with SMI were five times more likely to be a victim of assault, and three times more likely to be a victim of household crime, than people in the general population, after taking into account socio-demographic differences. Women were 10 times more likely to be assaulted.
- They reported very high rates of sexual and domestic violence, with 40% of women reporting being a victim of rape or attempted rape in adulthood, and 10% being a victim of sexual assault in the past year.
- Victims with SMI were up to four times more likely to be victimised by their relatives or acquaintances than those from the general population.
- Nine percent of the victims described crimes in psychiatric inpatient settings.

Impact of crime

It took two months to recover from [being assaulted] because I was having nightmares and stuff and I was finding it hard to sleep as well.

[Int21, male, assault]



Compared to victims who did not have mental health problems, victims with SMI were more likely to suffer social, psychological and physical adverse effects as a result of the crime, and were more likely to perceive the crime as serious. The impact of domestic or sexual violence was particularly serious with 40% of women and a quarter of men who experienced this having attempted suicide as a result.

In the qualitative interviews, participants explained how being a victim of crime affected many aspects of their lives including: their financial and material situation; personal relationships and behaviour; physical health; housing situation; emotional well-being; and mental health. The most common negative effect of crime was on their emotional well-being. Many described their mental health deteriorating as a result, with some individuals going into crisis and being admitted into hospital.

Risk factors

One of the aims of this study was to find out who, among people with SMI, was most at risk. We found there were three key risk factors: less engagement with services, drug misuse and a history of being violent. Compared to those with good service engagement, people with medium and poor engagement had a five-fold and seven-fold higher risk of victimisation

respectively. Drug misuse and violence perpetration were associated with a two to three-fold higher victimisation risk which is similar to those reported in the general population in other published studies.

The perceived association between mental health and victimisation

In the qualitative interviews, many participants felt that having a mental health problem was a factor in their victimisation. They gave examples of perpetrators picking up on visible signs of vulnerability and distress, and known perpetrators preying on them when they were unwell and less able to protect themselves. Some felt perpetrators targeted them because they understood that people with mental health problems are more easily discredited and commonly disbelieved when they report. A few said they felt perpetrators were motivated by hatred and hostility towards their mental health status. The nine participants victimised in psychiatric inpatient wards described the environment as unsafe and a place where they felt both under threat from staff and other patients as well as less able to access other sources of help.

The survey supported this sense of people being targeted for their identity, where 37% felt the incident was motivated by their identity and 25% felt this was specifically because of their mental health status.

Engagement with the criminal justice system

Reporting to the police

Victims with SMI were as likely to report their experiences to the police and to progress through the criminal justice system as general population victims, but they were much less satisfied with the police and less likely to report fair or respectful treatment.

In the qualitative interviews, participants described factors that helped or motivated them to report to the police. The influence of friends, family and professionals could be instrumental in helping them to report a crime. They were more likely to report crimes they felt were serious, or when a situation had escalated. Some were motivated to report from a desire to protect others. Police being easily accessible was another factor reported as helpful, for example when the police had a presence in their local communities and at other key locations such as hospitals.

Participants also described barriers to reporting crime to the police. Most of the qualitative sample had some previous experience with the police either as a victim, witness, offender or when being detained under the Mental Health Act. Where these prior experiences were poor, individuals were reluctant to contact the police again.

Participants described not reporting crimes because they feared a negative response from the police. They feared being blamed for causing the incident, not being believed or taken seriously and these fears were often grounded in previous experiences. Participants were very conscious of how having a mental health problem might be used as a basis for discrediting and disbelieving them, and many people feared that they might be sectioned if they tried to report a crime against them.

In some cases the impact of the crime also prevented them from reporting to the police, because of feelings of shame or embarrassment or feeling too overwhelmed, distressed or confused in the aftermath of the crime. The actions of, or fear of, perpetrators as well as loyalty to them, were also factors described as preventing reporting.

I wasn't in a right state to make a phone call direct to the police because I was in shock. And I just couldn't speak for myself.

[Int41, female, burglary and family violence]

Positive experiences of the police

She probably treated me better because I had mental illness. [...] The way she was kind, considerate and stuff. She was alright.

[Int5, female, assault and partner violence]

Participants in the qualitative interviews described both positive and negative experiences, with many experiencing both on different occasions. The way in which police officers responded when they became aware that the participant had a mental health problem was key in this. Participants valued empathy and understanding coupled with appropriate action to investigate the crime and signposting to other services for additional support.

People appreciated police officers who were friendly, respectful and compassionate, and who spent time listening to them, acknowledging their feelings and believing them. This was reported as particularly important at times when the participant might feel very distressed such as when the police first arrived at the scene or when they were taking a statement.

Interviewees valued receiving follow-up from the police, being kept informed of the progress on their case, and having a named officer assigned to them. Follow-up support was also praised, for example providing help and information about staying safe and securing their homes. There were a few examples where police liaised with a participant's existing formal network of support (with their consent), encouraging a joined up approach to support.

As with any victim, taking the incident seriously and taking action was a high priority for this group.

Negative experiences of the police

Many qualitative interviewees expressed dissatisfaction with some aspect of the way they were treated by the police. Poor responses to finding out that a participant had mental health problems were described by a third of participants and this included: a lack of empathy and understanding; attitudes indicating prejudice: for example, being told they were an unreliable witness because of their mental health problem; and insensitive reactions to distress.

Other negative experiences reported by participants in their engagement with the police were: not being



believed when they reported crimes; being blamed for the incident; being perceived as unreliable or not credible; and not being taken seriously. Some participants associated this poor treatment with the police having attitudes of prejudice or being misinformed about mental health problems. Others felt they were treated poorly because of other identity attributes, for example their gender or their sexual orientation, ethnicity, or because of several of these attributes.

The police failing to take action was another common complaint and this included: delays in attending incidents; not pursuing the perpetrator; not following up or collecting evidence; letting incidents escalate; and leaving the participant in dangerous situations. A few participants also said they felt the police dropped their case because they had mental health problems.

Participants also commented on poor communication from the police after they had reported a crime, for example finding it difficult to gain information about the progress of their case or being provided with incorrect information, and this caused anxiety and frustration.

A number of participants said they would not report to the police again in the future because they'd had such a poor experience, either in the way they were treated or because the overall outcome had been unsatisfactory.

Experience of court

Ten of the interviewees in the qualitative research had cases that went to court. Those who went to court to give evidence described it as very stressful. Factors which improved the experience for them included preparation for going to court, such as pre-trial visits and receiving information. This helped to reduce anxiety and put them more at ease. Help on the trial day from the Witness Service was also appreciated, as was access to special measures (such as screens or giving evidence by video link) when they gave evidence. Cross-examination in court was difficult and some participants said they were comforted when judges or magistrates intervened in a supportive manner.

Participants also talked about the things which worsened their experience of court. A few participants were extremely distressed when they came into contact with the perpetrator (or their supporters) at court. Several found being cross-examined by the defence barrister very difficult, feeling like they were being attacked or mocked, or frustrated that they were not able to convey their version of events. In one case a participant had his mental health history used against him by the defence barrister to discredit his testimony. Few of the participants had heard of special measures or been provided with them when they gave evidence in court. Lengthy waiting times before the case went to court, or before giving evidence on the day of court, could be unnerving and stressful.

Seeking help

Of the survey sample, a third of victims did not disclose their experiences of being a victim of crime to any professional. This was higher with sexual and domestic violence, where 70% of male victims of sexual assault did not disclose their experience at all. Whilst all of the survey participants were receiving support from community mental health teams 40% did not disclose their experience to a mental health professional.

Victims with SMI were more likely to receive help than those in the general population group. However, while they were more likely to receive talking and practical help, none received crime prevention advice compared to 35% of the general population group. Nearly half of SMI victims said they wanted further help and the greatest unmet needs were for practical or financial help, talking help and help with accessing the criminal justice system.

Few victims had contact with Victim Support (10% of those with and without SMI), but most of the people who did were satisfied with the help they received.

Experiences of seeking help from non-criminal justice agencies

In the qualitative interviews participants described seeking help and support from a range of individuals and services after being a victim of crime, from friends, family and neighbours, to housing officers, General Practitioners (GPs) and mental health professionals.

Having a pre-existing support network, either from informal sources like friends and family or from services such as community mental health teams (or both), facilitated help seeking as they said they felt more able to go to those they already knew and trusted. Those they were close to were able to spot signs that something was wrong and asked about it. The detrimental effects of the crime on their lives were described as triggers for them to seek help. Feeling frightened, unsafe, and the escalation of violence and the worsening of their mental health problem were powerful motivators for seeking help.

There were a number of factors that prevented participants from seeking help. Several said they were particularly reluctant to tell mental health professionals for fear the experience would be interpreted as a sign of their deteriorating mental health problem and trigger additional medical intervention. Many of these were similar to barriers to reporting to the police, and as with the police, some were put off by previous poor

responses. Participants feared they would be blamed or not believed; and worried that telling others would make the situation worse. In some cases the worsening of their mental health problem or the emotional impact of the crime made them feel like they weren't strong enough to ask for help.

Participants also faced problems in accessing help because of the barriers in the services themselves. They described services as simply not existing or being so overstretched that they were unable to offer them the support when they needed it, as well as services having strict limitations on the type or amount of support they were able to offer. This left some participants managing relationships with multiple services, something which caused them stress during a time when they felt very vulnerable.

Positive experiences of seeking help

In the qualitative interviews, when describing the experiences of seeking help, people referred to both good and bad experiences. With the positive experiences, both the type of help and the manner in which it was provided were important. They valued responses which were empathetic and validating, being treated as an individual with a unique set of needs and having their opinions and wishes respected. They appreciated services that were responsive to their request for help, taking steps to investigate or resolve issues or offering support, as well as staff who had specific expertise and knowledge about mental health problems and/or the nature and impact of victimisation.

Half of the qualitative respondents appreciated gaining practical help to deal with the consequences of the crime such as advocacy support, assistance with housing and childcare, financial help and support with safety. Referral or signposting to other more specialist services that could provide help was also valued, particularly when the referrer took extra care to ensure they accessed that service, for example by accompanying them to their first meeting.

Negative experiences of seeking help

In the qualitative interviews, half of the participants described negative experiences of seeking help either because of the nature of the individual response or problems with the services themselves. Poor individual responses included: those which lacked empathy or understanding; responses which invalidated the participant's experience and their emotional response to it, for example not believing them or minimising their experience; blaming the participant for being a victim of

crime; and displaying attitudes of prejudice towards the participant because they had mental health problems or because of other identity attributes, for example gender.

In the qualitative interviews, a quarter of participants described services that were poor quality, insufficient, or unresponsive to their needs. Interviewees described instances where services ignored them, showed reluctance to get involved, were slow to respond or did not take any action. There were also examples of inappropriate support being provided, such as a female rape victim being examined by a male doctor against her wishes. Several participants described punitive or disempowering responses, for example being evicted when they reported antisocial behaviour, or being threatened to have their children taken into care if they did not agree to a specific course of action.

There were few examples of services working in an effective joined up manner. More commonly participants reported going from one service to the next, being unable to gain the help they needed and becoming increasingly frustrated and distressed as a result. In some cases the victimisation experience and its effects on the participant were very complex and intersected with other difficulties in their lives, requiring support from several different services. The consequences of receiving poor support (or no support at all) were therefore considerable and in some cases exacerbated the distress people were already experiencing as a result of the crime.

Professionals' perspectives

The perspectives of the professionals who participated in the interviews reflected those of the people with mental health problems. They considered that isolation and social exclusion contributed to the increased risk of victimisation. Several, particularly mental health professionals, noted that victimisation could have a very serious impact, sometimes triggering crisis or admission into inpatient facilities. They highlighted the challenges they felt victims of crime with mental health problems faced, including many of the experiences the victims identified themselves. The court process was highlighted as being extremely stressful and in some cases this might mean that a victim preferred to drop the case rather than go to court, and some gave examples of cases being dropped by the Crown Prosecution Service (CPS) or other professionals because victims with mental health problems were viewed as unreliable witnesses.

Professionals echoed some of the experiences shared by interview participants about barriers to accessing

services. Most professionals also said that a lack of effective multi-agency working was problematic and that the reluctance of services to get involved or take ownership of cases could leave victims unsupported and more distressed. Different working practices and organisational cultures, as well as a lack of understanding between different services about job roles and responsibilities and poor systems for information sharing were viewed as contributing to this.

Professionals also talked about the challenges they faced themselves when trying to support victims of crime with mental health problems including: difficulties engaging with some individuals, particularly where the cases were very complex and the people were facing multiple difficulties in their lives; victims having unrealistic expectations about what a service could provide to them; victims not providing the professional with the full information about their case; and victims underplaying their mental health problems.

Professionals provided illustrative good practice and effective multi-agency collaboration, for example care coordinators supporting victims to engage with the police or police officers ensuring protective measures were in place to enable victims to go to court. The police also highlighted some new initiatives being developed to try to improve the way they work with people with mental health problems including a triage service where a police officer and an approved mental health practitioner work together to respond effectively to individuals with mental health problems.

Conclusion

This research paints a stark picture of the risks to people with mental health problems in the community, and the barriers they face in getting the support and help they need. Contrary to popular perceptions, people with mental health problems are more likely to be victims of crime than perpetrators. The impacts of crime for this group were wide ranging and devastating for some individuals. The problems identified in this research are complex, and there is no one simple solution, nor can one particular agency alone resolve these issues. However, that said, many of the actions people valued involved some simple changes and sharing and utilising already known good practice. This research is a call to us all to actively listen, believe, validate and take action to support people with mental health problems who have been victims of crime and empower them to take action to prevent further victimisation.

1 | Introduction

1.1 | Background

Nearly one in four people are estimated to have a mental health problem.¹ In England and Wales, an estimated one million people had contact with secondary mental health services in 2011; of whom 265,000 had severe and enduring mental health problems and received intensive support from community mental health teams.² Some people with long-term mental health problems are supported only by primary health care services.^{3,4}

Public perception is that people with mental health problems are offenders, and historically, policy, research and clinical practice focused on the risk of violence that patients with severe mental illness (SMI) pose to others.⁵ In recent years, a growing body of evidence has demonstrated that people with SMI are vulnerable to being victims of violent and non-violent crime.^{6,7} Whilst both men and women with SMI are at higher risk of violence than the general population, women with SMI are particularly vulnerable.^{8,9,10}

The effect of crime on an individual can show in multiple aspects of their life: physical, emotional, financial, practical and social.¹¹ The impact varies with the type of crime, the individual's circumstances, resources and levels of resilience.¹² The negative emotional and mental consequences of crime for adults have been reported for both non-violent crime in the United Kingdom (UK) and violent crime.^{13,14,15,16} The continuing psychological distress over time, including post-traumatic stress disorder (PTSD) has been reported by victims of street crime, and those of physical and sexual assaults in the UK.^{17,18} The high rates of childhood physical and sexual victimisation in adults with severe mental health illness are well documented.^{19,20,21} There is some evidence of the negative effect of victimisation on well-being and clinical outcomes for people with severe mental illness in the USA and the UK.^{22,23} People with pre-existing mental illness surveyed in the Crime Survey for England and Wales (CSEW) 2009/2010 were significantly more likely to report adverse mental health effects than the general population or people with other types of disability.²⁴

People with mental health problems, who are victims of crime, are not explicitly recognised within the UK criminal justice process and policies (*See Box A*) that are designed to support, guide and protect victims and in particular those who are vulnerable.^{25,26,27} In the UK, as in many societies, mental illness is often viewed negatively and stigmatising opinions are widely held,²⁸ leading to discrimination.^{29,30} In the UK, the Equality Act 2010 makes it unlawful to discriminate against a person disabled either mentally or physically. Organisations providing services or public functions are required to make reasonable adjustments to overcome substantial disadvantages that a disabled person may experience in using its services compared to someone who is not disabled.

A survey by Mind suggested that there was a low rate of reporting crime by people with mental health problems and that many of their respondents were dissatisfied with the response from the criminal justice system.³¹ Subsequent discussions with groups of people who had experienced mental health problems suggested there was considerable tension with the police in part because of the powers the police have under the Mental Health Act 2007 to remove people who have a mental disorder to a place of safety if they are in need of immediate care and control. In addition the police were reported to view people with mental health problems as unreliable witnesses causing their cases to be dropped before reaching court.³²

Over the last few years there has been an increased focus on the experiences of victims (and witnesses) with mental health problems and their engagement with the criminal justice system. This includes research by the Crown Prosecution Service (CPS) into their own decision-making in cases involving victims and key witnesses with mental health problems and/or learning disabilities,³³ research commissioned by the Ministry of Justice investigating the court experiences of adults with mental health problems, learning disabilities and limited mental capacity³⁴ and the recently published findings from the Independent Commission on Mental Health and Policing which reviewed the way the Metropolitan Police Service deals with incidents involving people with mental health problems.³⁵ These pieces of work have

Box A: Relevant policies and initiatives

A number of initiatives have been developed by the government and key criminal justice agencies over the last 15 years to improve the treatment of victims and witnesses when they come into contact with the criminal justice system. This includes *Speaking up for Justice*³⁶ in 1998 which reviewed the treatment of vulnerable and intimidated witnesses in the criminal justice system; the subsequent legislation for 'special measures' in 1999³⁷ designed to help vulnerable and intimidated witnesses give their best evidence in court and to relieve some of the stress of giving evidence; the introduction of Victim Personal Statements in 2001³⁸ giving victims the opportunity to explain how the crime has affected them; and the 2003-4 *No Witness, No Justice* pilot aimed at improving provision for witnesses, which led to the establishment of Witness Care Units.³⁹

In addition, the introduction of the *Prosecutors' Pledge*,⁴⁰ the *Code of Practice for Victims of Crime*⁴¹ and the *Witness Charter*⁴² between 2005 and 2008 set out the standards of service that victims and witnesses could expect from the range of criminal justice agencies. Currently, the government is consulting on provision for victims and witnesses, with the stated aim of remedying weaknesses in the existing systems of support. As part of this consultation, both the Victims' Code and Witness Charter are being reviewed and revised.⁴³

Individual criminal justice agencies have produced a variety of policy and practice guidance designed to improve the way they work with vulnerable victims and witnesses, including those with mental health problems. This includes *Guidance on Responding to People with Mental Ill health or Learning Disabilities*⁴⁴ produced by the National Policing Improvement Agency (NPIA) on the behalf

of the Association of Chief Police Officers (ACPO) in 2010 which aimed to improve operational responses to individuals with mental health problems and learning disabilities; *Victims and witnesses who have mental health issues and/or learning disabilities: Prosecution Guidance*⁴⁵ produced by the CPS and updated in 2011; and the CPS public policy statement *Supporting Victims and Witnesses who have Mental Health Issues* published in 2009.⁴⁶

Following on from the changes made by section 146 of the Criminal Justice Act 2003 (CJA), which imposed a duty upon courts to increase the sentence for any offence aggravated by hostility based on the victim's disability, criminal justice agencies have also produced guidance and policy statements outlining their commitment and approach to tackling disability hate crime, for example the *CPS Policy for Prosecuting Cases of Disability Hate Crime* produced in 2007.⁴⁷

Mind has worked in collaboration with several criminal justice agencies to produce guidance designed to improve the way they respond to victims and witnesses with mental health problems. This includes *Police and mental health: how to get it right locally*⁴⁸ which outlines examples of good practice initiatives designed to improve relations between police and people with mental health problems in England and Wales and is endorsed by the Police Federation and the Association of Chief Police Officers (ACPO), as well as *Achieving justice for victims and witnesses with mental distress: a mental health toolkit for prosecutors and advocates*,⁴⁹ supported by the CPS, the Bar Council and the Law Society, and providing practical information and advice about mental distress and its implications and outlining best practice to try and ensure victims and witnesses have equal access to justice.



highlighted shortcomings in the way the criminal justice system responds to people with mental health problems and has emphasised (among other things) the need for better awareness and training for staff on mental health problems, the importance of early identification of victim and witness needs and the need for more effective multi-agency working and information sharing.

In addition to this there is also a body of work focused on better understanding and responding to disability hate crime which incorporates the experiences of people with mental health problems. This includes the publication of *Hidden in Plain Sight*⁵⁰ in 2011 which revealed the pervasiveness and severity of disability-related harassment, along with the failings by agencies to respond, compounded by a 'culture of disbelief' when incidents were reported, the subsequent *Manifesto for Change*⁵¹ which provided recommendations for improvements as well as a commitment to evaluating the impact of the inquiry; *Living in a Different World: Joint Review of Disability Hate Crime* investigating the way the police, Crown Prosecution Service (CPS) and probation trusts deal with disability hate crime⁵² and which highlighted problems of poor identification and recording across agencies as well as under-reporting of the crimes. A number of initiatives are currently underway to try to better understand who perpetrates hate crime and their motivations for doing so, including research recently published by the Welsh Government and carried out by Cardiff and Manchester universities.⁵³

1.2 | About the study

This study is a partnership between Victim Support, the Institute of Psychiatry at King's College London, St George's, London and Kingston University, and Mind. It is conducted in association with University College London and has been funded by the Big Lottery Fund and the Medical Research Council. It is a mixed methods study combining quantitative and qualitative approaches.

This study was designed to understand experiences of victimisation and engagement with the criminal justice system in greater depth primarily from the perspective of people with mental health problems, but also to explore the perspective of those in services supporting people with mental health problems and those working within the criminal justice process.

The quantitative study is the first UK survey on crime against people with SMI compared with crime against the general population. It aimed to answer the following questions:

- What proportion of people with severe mental illness has been a victim of violent or non-violent crime in the past year, and how does that compare to the general population after taking into account socio-demographic differences?
- What is the nature and impact of crime against people with SMI?

- What are the risk and protective factors for victimisation among people with SMI?
- How often do victims with SMI report their experiences to the police and mental health professionals, and how satisfied are they with the response?
- What are the key unmet needs of victims with SMI?

The qualitative study aimed to answer the following questions:

- What are the barriers and facilitators for people with mental health problems, who have been victims of crime, in reporting crime, and also progressing through the criminal justice process and accessing support?
- What strategies could services employ which might enhance the reporting of crime and progression through the criminal justice process and accessing support for victims?

1.3 | Methods

Quantitative study

This study used a modified version of the Crime Survey for England and Wales (CSEW). The CSEW is an annual national survey run by the Office for National Statistics (ONS) which measures experiences of recent crime victimisation in the general population.

We recruited a random sample of people with severe mental illness under the care of community mental health teams (CMHTs) in the London boroughs of Lewisham, Lambeth, Southwark, Croydon, Camden and Islington, covering a population of 1.5 million people. We interviewed them using a modified version of the ONS-CSEW questionnaire. We kept the survey format and wording as close to the original as possible.ⁱ We compared findings from our sample of people with SMI with findings from general population controls who took part in the ONS-CSEW survey over the same time period who live in London. We explored the extent to which people were a victim of personal, household crime, and domestic or sexual violence in the last year. We also explored experiences and attitudes towards the police. For people who reported victimisation we explored the nature, impact and reporting of crime, and victims' unmet needs.

For the survey of people with SMI we gained information from the clinical notes of 300 (83%) participants, and interviewed mental health professionals involved in the care of 184 (51%) participants. This provided us with clinical information, and information on the recording or knowledge of crime victimisation and perpetration.

Qualitative study

The study design drew on interpretive social science approaches which emphasise the multiple experience and interpretations of individuals in social interactions.⁵⁴ Qualitative data collection was undertaken in two phases: semi-structured interviews with people with mental health problems and focus group interviews with those employed in health care, support and criminal justice services.⁵⁵ A user group was recruited of six people who had experience of victimisation and mental health problems. They met throughout the project and advised on the research.

For the semi-structured interviews, participants were recruited via invitations to participate circulated in local Mind and Victim Support services as well as community mental health teams and other voluntary organisations. The focus group participants were initially invited to participate via partner networks and Advisory Group members. The analysis from the two phases of the study was then compared and contrasted and synthesised as appropriate ensuring the experiences of the people with mental health problems were privileged in the reporting.

ⁱ | We modified it by omitting sections that were not relevant to our research aims.

2 | Findings from the quantitative survey

Comparing our sample of people with SMI with the 'control' group

We compared the victimisation experiences of people with and without severe mental illness. People with SMI tend to have greater socio-economic deprivation, and tend to live in more deprived areas, than those without SMI. A greater degree of deprivation is associated with a greater risk of being a victim, so any differences between those with and without mental illness could have been due to differences in the level of deprivation between the two groups; rather than to mental illness itself. We wanted to estimate the excess risk of victimisation for people with SMI after taking into account (or adjusting for) differences due to demographics, personal deprivation and area deprivation. We did this using the statistical technique of multivariate logistic regression. This estimates the relative likelihood of being a victim in a group of people with and without mental illness, after taking into account a number of other factors that differ between the groups. In this study we adjusted our main analyses for the following variables: age, sex, ethnicity, marital status, living alone, educational attainment, employment status, housing tenure and local area deprivation. The relative likelihood of victimisation was then reported as an 'adjusted odds ratio'.

Interpreting odds ratios

An adjusted odds ratio shows the likelihood of an outcome in one group compared to another, after taking into account (or adjusting for) a number of other factors. In general, an odds ratio greater than 1.0 means that the outcome is more likely to occur in the group of interest relative to the comparison group. An odds ratio less than 1.0 means that the outcome is less likely to occur in the group of interest relative to the comparison group. An odds ratio of 1.0 means that there is no difference in the likelihood of the outcome occurring in the two groups.

2.1 | About our sample

Our sample is made up of 361 people with severe mental illness (SMI)ⁱⁱ and our comparison sample is made up of 3,138 people aged 18-65 living in London.ⁱⁱⁱ Our sample was more likely to be male and of Black/Black British ethnicity. As expected, our sample had greater personal and area deprivation: 72% (vs. 43%) were single, 79% (vs. 9%) were unemployed/long-term sick, 63% (vs. 21%) were council housing tenants and 52% (vs. 27%) lived in the most deprived areas (see Table 1 and Figure 1).

In terms of clinical characteristics, around 60% had schizophrenia, and a further 20% had bipolar affective disorder or a depressive disorder (see Figure 2). The majority had been ill for more than 10 years, and more than half had been admitted to hospital under the Mental Health Act.

Table 1: Sample demographics for people with SMI and controls

	People with SMI (n=361) %	Control ⁱ * (n=3138) %
Age: mean	42	41
Sex		
Male	56.2	46.0
Female	43.8	54.0
Ethnicity		
White	41.6	63.4
Asian/Chinese/other	35.2	23.0
Black/Black British	23.0	13.4

ii | See glossary for our definition of severe mental illness

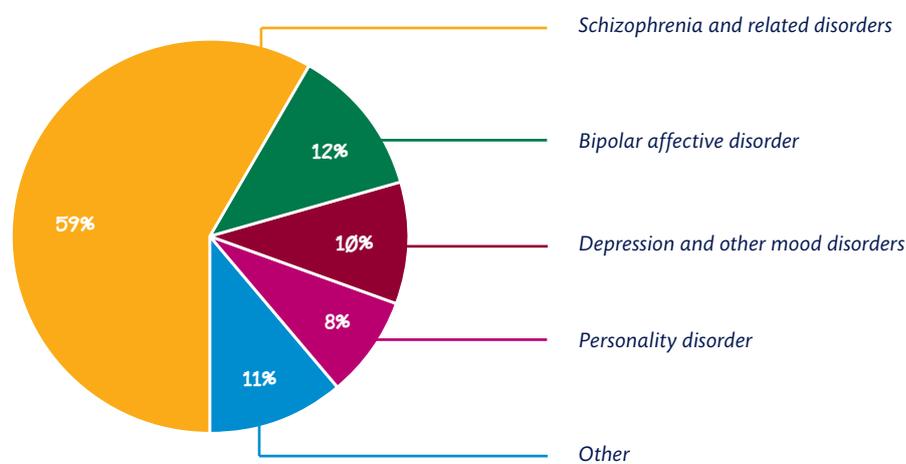
iii | See appendix 3 for data tables

* the control group was made of people aged 18-65 living in London, excluding 86 (2.4%) who reported a disabling mental illness.

Figure 1: Marital, employment and tenancy status of our sample
 People with SMI (n=361) Controls (n=3138)



Figure 2: Survey participant diagnosis (n=353)



2.2 | Victimization in the last year

In the survey, all participants took part in a face-to-face interview on whether they had been a victim of crime in the past year. This included questions on domestic and sexual violence. In addition, about 70% of participants filled out a more detailed self-completion questionnaire on domestic and sexual violence (the others refused or were unable to do so). In this section we report on findings from the main face-to-face interview, and in the next section we report on findings from the self-completion questionnaire. It is worth noting that many people who reported domestic and sexual violence in the self-completion questionnaire did not report these experiences in the face-to-face interview, so the findings reported in this section will underestimate the prevalence of this type of violence in both people with SMI and controls.

The prevalence of crime among our sample was higher for all areas of crime (see Figure 3). Around 45% of people with SMI were victims of (any) crime in the preceding year (compared to 16% of London residents). Nearly a fifth, 18% (vs. 3%), were victims of an assault; and 23% (vs. 8%) were victims of a household theft or criminal damage.

After taking into account demographics, social deprivation and area characteristics, people with SMI were around three times more likely to be a victim of any crime, and five times more likely to be victims of an assault than the general population (see Figure 4). The risks were particularly high for women with SMI, who were 10 times more likely to be victims of an assault than general population women (whilst men with SMI were three times more likely to be assault victims than

general population men). People with SMI were 40% more likely to be victims of a mugging or theft from crime and two to three times more likely to be victims of household crime than the general population.

People with mental health problems are very vulnerable to repeat victimisation, of different types of crime. Forty-three percent experienced more than one type of crime in the past year, and they were seven times more likely to experience three or more different types of crime in a year than the general population (see Figure 5).

Victims with SMI were less likely to be victimised by strangers but three to four times more likely to be victimised by their relatives or acquaintances. After taking into account personal, household and crime type differences, victims with SMI were three times more likely to have misused substances at the time of the incident.

Targeted crime

Forty-three percent felt that the crime was motivated by the offender’s attitude towards the victim’s race, religion, age, sex, sexual orientation or disability (hate crime), eight times more likely than the control group. A quarter of people with SMI described their experience as hate crime specifically related to their mental illness (see Figure 6).

The majority of the crimes for both people with SMI and the control group occurred in the home, followed by public places. Nine percent of the people with SMI described an incident happening in a mental health facility.

Figure 3: Prevalence of crime victimisation in past year (%)



2.3 | Domestic and sexual violence

In a separate self-completion part of the survey, participants were asked about any domestic or sexual violence they had experienced since the age of 16, and in the past year. For this part of the analysis we did not have access to individual data for the general population sample.^{iv} Instead, we compared our sample of people with SMI to published CSEW findings on all participants living in England and Wales who completed the self-completion questionnaire.^v All analyses were completed separately for men and women.

The prevalence of adulthood domestic and sexual violence was extremely high among women with SMI: 40-62% of women with SMI reported this compared to 10-24% of control women. 42% of women with SMI reported being the victim of adulthood rape or attempted rape. And 22-35% of SMI men (compared to 3-13% of control men) reported adulthood domestic or sexual victimisation (see Figure 7).

In the past year, 10-16% of SMI women reported being the victim of domestic or sexual violence, compared to 2-8% of control women; 3-9% of men with SMI (compared to 0.2-4% of control men) reported these experiences (see Figure 8).

We could not directly adjust for demographic and social differences between the people with SMI and control groups. We used data, where available, from the groups of CSEW participants that were most similar to our

^{iv} | As this is not available to researchers without special permission, in order to protect participant confidentiality.
^v | See appendix 1 for details.

Figure 4: Likelihood of being a victim of crime in last year*



Figure 5: Likelihood of experiencing three or more types of crime*



Figure 6: Likelihood of perceiving crime as targeted at them (hate crime)*



* Based on adjusted odds ratios

Figure 7: Lifetime domestic and sexual abuse

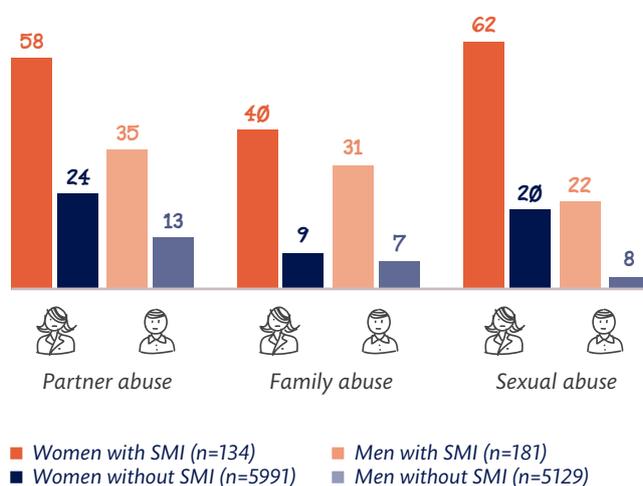
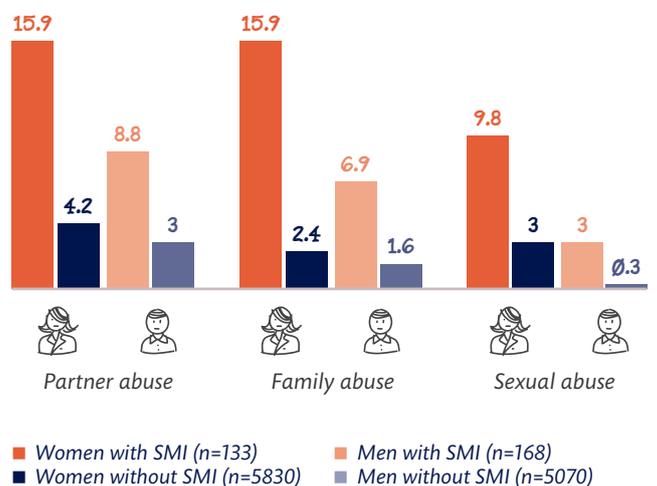


Figure 8: Past year domestic and sexual abuse



sample, for example London residents, and participants living in council housing. These indirect comparisons indicate that people with SMI are between two and 10 times more likely to be victims of domestic or sexual violence as the general population. This excess risk holds even when comparing those with SMI to the subgroup of CSEW participants who live in council housing and who are at relatively high risk of domestic and sexual violence.

2.4 | Impact of victimisation

The impact of victimisation was greater for people with SMI, both in how serious they perceived the crime to be, and the social and emotional effects. A high number of those who experienced domestic and sexual violence said that they attempted suicide as a result of the victimisation.

To get an idea of how serious people felt the incident was, we asked them to rate it on a scale of one (theft of a milk bottle) to 20 (murder). Victims with SMI were more likely to perceive their experience as serious than those without SMI, even taking into account the nature of the crime. They were five times more likely to rate it as 16-20 than the control group (see Figure 9).

Nearly all our sample, 98% (ie all but three who answered this question), said that they had emotional or mental health problems as a result of the victimisation, and were more likely to have social problems as a result too (eg financial loss or relationship breakdown). They were also more likely to be affected emotionally by their experience; they were three times more likely to be 'very much affected' than the control group, even taking the seriousness of the crime into account (see Figure 10).

People with SMI who were assault victims were three times more likely to be injured but 70% less likely to seek medical help than general population victims.

Figure 9: Likelihood of perceiving the crime as most serious (based on adjusted odds ratios)

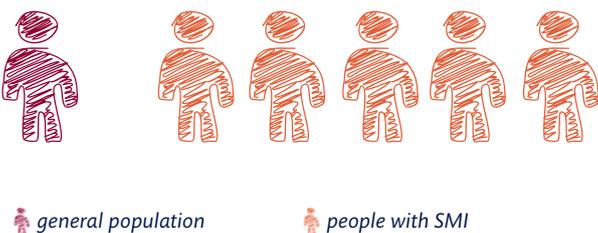


Table 2: Suicide attempt following domestic or sexual violence among people with SMI

	Men with SMI		Women with SMI	
	total no.	%	total no.	%
Any domestic or sexual violence	91	23	106	38
Partner violence	56	21	73	32
Family violence	54	13	53	26
Sexual violence	32	22	74	37

The majority of people with SMI who experienced domestic or sexual violence suffered adverse physical and psychosocial effects. Table 2 shows that around 40% of female victims and a quarter of male victims of domestic or sexual violence reported that they attempted suicide as a result of this victimisation, with particularly high risk following sexual violence.

2.5 | Disclosure of victimisation

The survey measured whether the victim or someone else reported victimisation to the police. The police came to know about the incidents for around half of all victims (with and without SMI). Nearly half (45%) of victims with SMI informed the police themselves, compared to 35% of the control group – this is not a statistically significant difference.

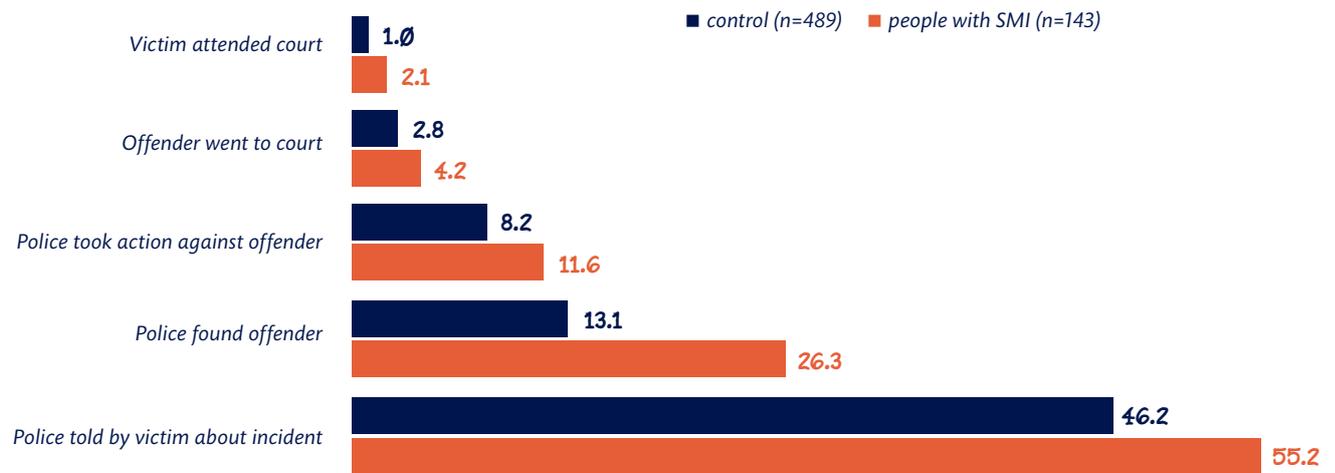
There was no difference between victims with SMI and those without SMI in their progress through the criminal justice system (CJS) (see Figure 11). However, the victims with SMI were much less satisfied with police, and less likely to describe the police as fair or respectful (see Figure 12).

All the survey participants with SMI were receiving support from the community mental health teams

Figure 10: Extent of emotional effect of crime (%)



Figure 11: Progress through criminal justice system (%)



but 40% of them did not disclose their experience to a mental health professional, and a third did not disclose their experiences to either mental health or criminal justice professionals.

In the case of domestic violence, a third of female victims and half of male victims did not disclose their experiences to anyone (including their informal social network, professional or voluntary bodies). For sexual assault half of female victims and 70% of male victims did not disclose their experiences to anyone.

Few victims had contact with Victim Support (10% of those with and without SMI), but most who did were satisfied with the help they received.

2.6 | Help received and wanted: unmet needs

Victims with SMI were around 13 times more likely to receive help than those without SMI. Whilst victims with SMI were much more likely to receive talking and practical help, none received crime prevention advice (compared to 35% of the control group). Only 16% were helped to access other services (see Figure 13). Victims with SMI were significantly less likely to make changes to prevent future victimisation than other victims.

People with SMI received the majority of their help from mental health services and family and friends. They were less likely than controls to receive help from the police or voluntary sector agencies (see Figure 14).

Nearly half (45%) of SMI victims wanted further help regardless of whether or not they had received any help. The greatest unmet needs for SMI victims were for practical or financial help (60%), talking help (40%) and help with accessing the CJS (40%) (see Figure 15).

Figure 12: Satisfaction with police (%)

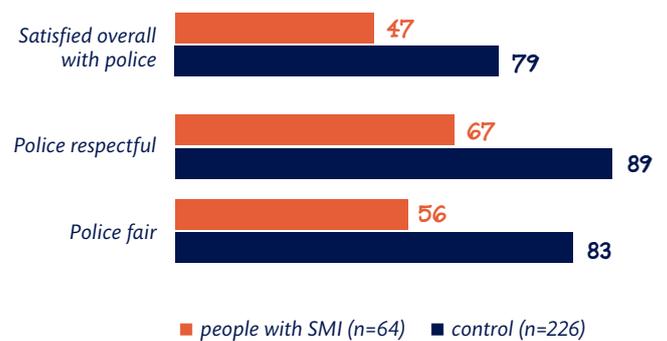


Figure 13: Type of help received by people with SMI (%)

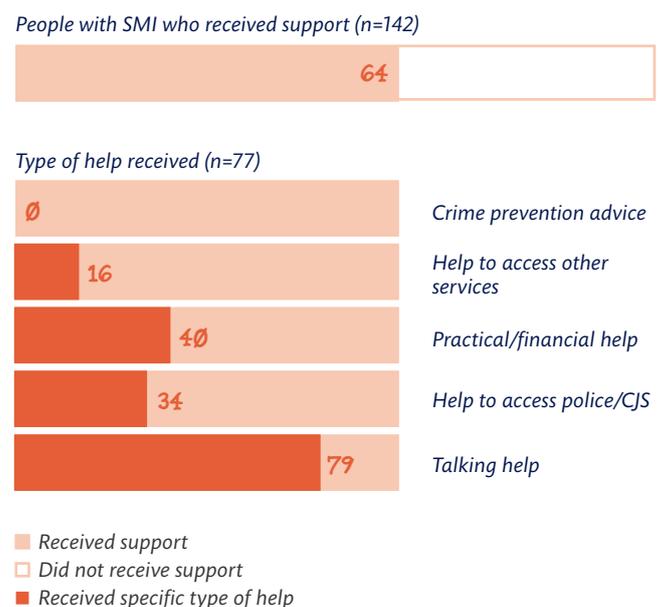


Figure 14: Help givers for people with SMI

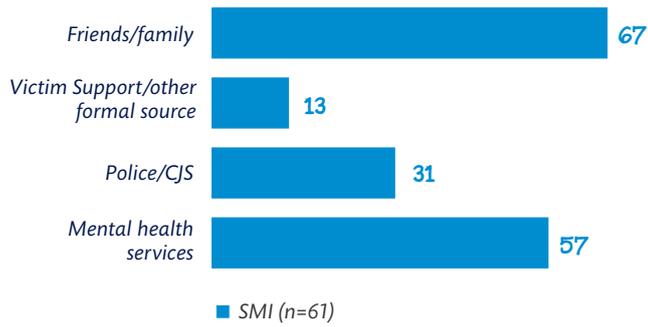
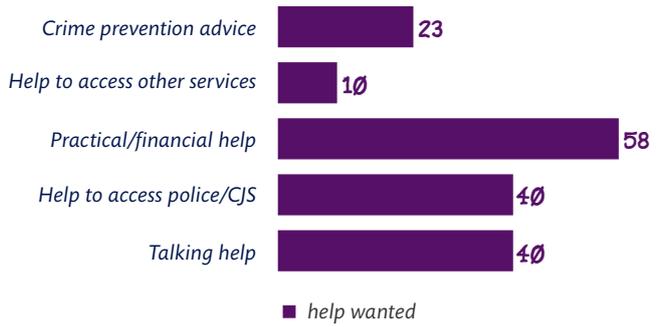


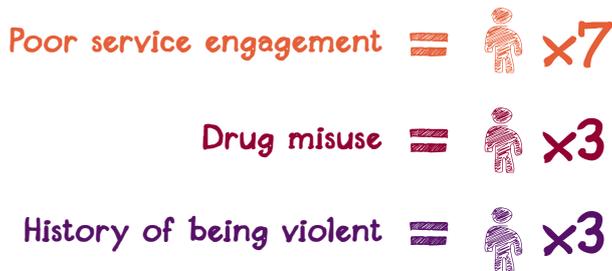
Figure 15: Type of help wanted by people with SMI (%) (n=48)



2.7 | Risk factors for victimisation among people with SMI

One of the aims of this study was to find out who, among people with SMI, was most at risk; for example whether any social factors (such as social support) or clinical factors (such as diagnosis) were associated with a greater risk of victimisation among people with SMI. We assessed nearly 30 demographic, socio-economic, social, developmental, behavioural and clinical factors that could be related to risk of victimisation among people with SMI, but only three were independently correlated with this outcome: service engagement, drug misuse and a history of being violent.

Figure 16: Likelihood of being a victim of crime



Service engagement

Service engagement had the strongest independent correlation. In this study, service engagement was assessed using a modified version of the Service Engagement Scale which measures how easy it is for the people with SMI to arrange appointments, accept professional advice, ask for help and adhere to prescribed medications. Compared to those with good engagement, people with medium and poor engagement had a five-fold and seven-fold higher risk of victimisation respectively.

Drug misuse and violence perpetration

Drug misuse and violence perpetration were associated with a two to three-fold higher victimisation risk. There was no independent association with alcohol misuse. These associations are similar to those reported in the general population in published studies, and not unique to people with SMI.

2.8 | Fear of crime and feelings of safety

The fear of crime had a greater effect on quality of life among people with SMI, who also tended to feel less safe if out walking alone at night or in the daytime. However, after taking into account differences in the risk of victimisation for people with and without SMI, there was little difference between the two groups on these measures. This indicates that the excess fear of crime among people with SMI is explained by their higher risk of having experienced actual victimisation.

2.9 | Attitudes towards the police

Attitudes towards the police were measured for all participants (whether or not they were victims of crime). People with SMI had more negative attitudes: they were twice as likely to report that they thought the police were unfair (18% vs. 5%); disrespectful (32% vs. 14%); and to have no overall confidence in the police in their local area (24% vs. 10%). This attitude and experience of the police is explored in the next section where we report on the qualitative findings.



3 | Findings from the qualitative research

3.1 | About the sample

A total of 81 participants took part in an interview about their experiences of being a victim of crime in the last three years. The majority (82%) of the sample lived in London and the rest lived in a variety of locations elsewhere in the UK. We interviewed slightly more women than men (57% vs. 43%) and the majority of participants (78%) were aged between 25 and 54 years. Just over half the participants described themselves as White British, 22% as Black or Black British, 9% as Asian or Asian British and 5% as White other or White non-British. The majority of participants described themselves as heterosexual, 17% described themselves as gay, lesbian or bisexual.

Approximately a third of the sample described having another type of disability as well as their mental health problem. 9% had a learning disability while 23% described having a physical disability or a serious illness, such as epilepsy or diabetes, which significantly affected their life.

As with the quantitative survey, the majority of the sample were not economically active with only a fifth in work. Just over half described themselves as long-term sick/ill or temporarily sick/ill and a fifth as unemployed.

This reflects statistics produced by the Office for National Statistics showing low employment rates for those with mental health problems and recent research which suggests that the gap in unemployment rates between those with mental health problems and those without has significantly widened following the onset of the recession.^{56 57}

Mental health problems experienced

We asked our sample to describe the mental health problems they experienced in their own words.

Table 3 shows the number of people who described experiencing each type of mental health problem. (The number does not add up to the sample total of 81 because the majority of participants described experiencing more than one type of mental health problem.)

Approximately half of the sample said they experienced depression, just over a third experienced an anxiety disorder and a third reported experiencing psychosis as part of their mental health problems.

Two thirds of the sample reported that they were accessing support from community mental health services.

Table 3: Types of mental health problems experienced by sample

Type of mental health problem	Number	%
Depression	40	49
Anxiety disorder	28	35
Schizophrenia	15	19
Bipolar disorder	14	17
Personality disorder	10	12
Depression with psychosis	9	11
Post-traumatic stress disorder (PTSD)	8	10
Schizoaffective disorder	4	5
Total	128	
Sample size	81	

Table 4: Experience of crime by gender and crime type

Crime type	Female		Male		All	
	No	%	No	%	No	%
Assault	23	22%	31	39%	54	29%
Threats and harassment	13	12%	12	15%	25	14%
Theft from person	15	14%	9	11%	24	13%
Sexual violence	19	18%	2	3%	21	11%
Antisocial behaviour	10	10%	9	11%	19	10%
Burglary	8	8%	9	11%	17	9%
Partner violence	11	11%	3	4%	14	8%
Family violence	5	5%	0	0%	5	3%
Fraud	1	1%	4	5%	5	3%
Total	105	100%	79	100%	184	100%

Experiences of abuse as a child

A fifth of the sample disclosed experiencing abuse as a child. Participants raised this issue spontaneously rather than being asked systematically by the researcher and therefore it is likely to underestimate the proportion of the sample that experienced child abuse. This reflects other research which shows a link between childhood physical and sexual victimisation in adults with severe mental health illness,^{58 59 60} as well as research suggesting that experiences of abuse in childhood increases the risk of re-victimisation in adulthood.^{61 62}

3.2 | Types of crime

Participants reported experiencing a range of different crimes over the three-year period (*see Table 4*). Multiple experiences of victimisation were common with three quarters of the sample reporting experiencing more than one crime and 41% experiencing three or more crimes. These were often unrelated and perpetrated by different individuals, but there were also examples of severe and enduring crimes which were related, such as cases of domestic violence.

A total of 184 experiences of crime were reported by the 81 participants and these have been divided by crime type and gender in Table 4. The most commonly

reported crime for both male and female participants was assault, double that of the next most common: threats and harassment. Men and women reported similar crimes, but women reported more sexual and domestic violence.

The crimes occurred in a range of settings including in the home, in public or community spaces and on transport. Nine participants reported being victims of crime when they were inpatients in psychiatric settings, and in some of these cases the offenders were staff members.

3.3 | Perpetrators

As outlined in Table 5, participants described a range of individuals who perpetrated the crimes they experienced. Three fifths of the crimes participants experienced were perpetrated by people they knew and had existing relationships with. This included people they were close to such as friends, family, partners and flatmates, those who were less close but still well known such as neighbours and acquaintances, and those who were providing services or support to them, like mental health professionals. Out of the types of known perpetrators reported by participants, neighbours, acquaintances and partners were most frequently mentioned. This reflects the findings of the prevalence

Table 5: Perpetrators of crimes as indicated by participants

Perpetrators	Female		Male		All	
	Number	%	Number	%	Number	%
Neighbour	16	15%	11	14%	27	15%
Acquaintance	17	16%	5	6%	22	12%
Partner or ex-partner	14	13%	4	5%	18	10%
Family	7	7%	1	1%	8	4%
Friend	5	5%	2	3%	7	4%
Nursing staff in psychiatric ward	4	4%	2	3%	6	3%
Flatmate	2	2%	4	5%	6	3%
Patient in ward	4	4%	1	1%	5	3%
Landlord	0	0%	3	4%	3	2%
Mental health professional	2	2%	0	0%	2	1%
Non-clinical staff in psychiatric ward	2	2%	0	0%	2	1%
Police	1	1%	1	1%	2	1%
Transport worker	1	1%	1	1%	2	1%
Work colleague	1	1%	0	0%	1	1%
Legal professional	1	1%	0	0%	1	1%
Service provider	0	0%	1	1%	1	1%
Unidentified	28	27%	43	54%	71	39%
Total	105	100%	79	100%	184	100%

survey which shows that victims with severe mental health problems were three to four times more likely to be victimised by relatives or acquaintances.

There are some differences between the types of perpetrators reported by male and female participants. Women were more likely to know the perpetrator, and experienced more victimisation from partners, family members and acquaintances than men.

3.4 | Impact of crime

The participants interviewed as part of the qualitative study also described how their experiences of victimisation adversely affected their lives in a multitude of ways including attempting suicide. This reflects the survey findings (Section 2.4) showing how people with mental health problems are strongly affected emotionally and socially by their experience of crime (see Figure 17).

The emotional and mental health effects of crime were raised most commonly by participants, and this included shock, anger, fear, anxiety and upset. For some these reactions were short-lived but for many the emotional impact of the crime was enduring.

Straight away I just sat down and I felt like my world had caved in. I felt intruded upon. I was certainly very upset and mad and angry because that's how I express myself.
[Int29, female, sexual violence, assault, burglary]^v

^v | Quotes from participants are identified by their study identification number, gender and the criminal acts they had experienced.

It took two months to recover from [being assaulted] because I was having nightmares and stuff and I was finding it hard to sleep as well.
[Int21, male, assault]

Many described how the experience of victimisation caused their existing mental health problems to deteriorate. The worsening of mental health problems caused some to develop physical symptoms like heart palpitations:

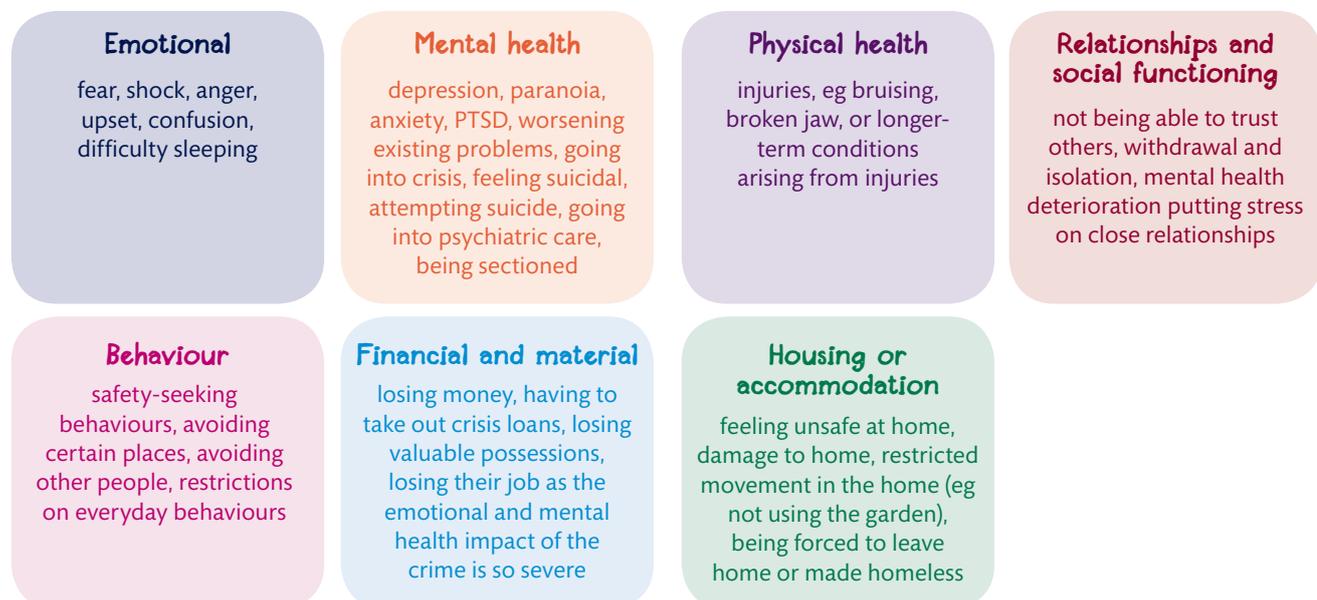
I was severely depressed and I was getting a lot of anxiety. And it started to affect my health. I started getting stomach cramps and my sleep was disturbed and [I had] things like palpitations.
[Int42, female, antisocial behaviour]

Some developed new symptoms, for example obsessive compulsive disorder (OCD), or those related to post-traumatic stress disorder for example flashbacks, sleep disturbances, hyper-vigilance and exaggerated startle responses. A few were diagnosed with post-traumatic stress disorder by mental health professionals.

It affected me mentally a lot [...] I couldn't sleep, I used to be scared at night time [...] Still I cannot sleep without the light on.
[Int22, female, theft from person]

Anybody that makes any sudden movements near me, even my partner, sometimes I jump, you know. [...] make a sudden movement and automatically I jump.
[Int75, female, sexual violence, burglary and antisocial behaviour]

Figure 17: Area of impact with examples





Some participants were so severely affected by the crime that they went into crisis. Examples included self-harming by participants, increased dependency on drugs and alcohol, experience of manic episodes.

I found that I was self-harming as a way of releasing the tension sometimes. And this has led to physical health problems for me. [...] I ended up doing things like drinking bleach.

[Int63, female, antisocial behaviour, threats and harassment and family violence]

Eight participants (10% of the sample) said that they attempted suicide as a direct consequence of their victimisation experience.

I cut my wrists, all because of the beatings. [...] And [perpetrator] said to me, "Why are you doing it?" I said, "Because I was sick of you controlling me and beating me. I preferred to kill myself than let you kill me because one day you will."

[Int81, female, assault and partner violence]

In most of these cases it was not simply the experience of the crime that caused the crisis, but also the difficulties they faced trying to access support after the crime. For example, in this case, on being told that he did not have an appointment and no-one could see him:

At this moment, I don't know, something just went wrong with my head, seriously wrong. The next thing I realise I was in a train track with three trains around me and the police. [So you tried to commit suicide?] Yeah.

[Int49, male, assault, theft from person, threats and harassment and partner violence]

Some participants described the cumulative impact and said they were affected more seriously by recent experiences of crime because they had endured previous (and often multiple) experiences over their lifetime. This, combined with a lack of support, reduced their resilience in coping with crime and could leave them feeling hopeless:

I'm already dealing with, so much in my experiences. But I've been a victim of crime all my life. And I'm not being funny but it's probably why I've got bipolar now. [...] There hasn't been no justice for me to be honest and I'm still soldiering on with mental health problems. And it does have an impact.

[Int29, sexual violence, assault, burglary]

And it's just, you know, you pick yourself up, you're booted, you're booted in, you're booted down again. You try and pick yourself up, you're booted down again. [Starts to cry.]

[Int64, male, antisocial behaviour and assault]

For some people, their experiences of victimisation started in childhood. A fifth of the sample disclosed abuse in childhood, and for some the recent experiences of crime brought back painful memories from the past and made recovery difficult.

I ended up in hospital and like it just like freaked me out because I get flashbacks about my abuse when I were younger.

[Int74, male, sexual violence]

3.5 | Participants' perceptions of why they were victimised

The participants identified a range of factors that contributed to them being the targets of crime. Clearly, there is often a range of factors at play (see Figure 18).

[having a mental health problem] it's a license, it makes you so vulnerable. It's awfully awful. It's like this is a sitting duck we can do whatever we want to, however we want. And then they turn it on you and say that you did it to yourself.
[Int7, female, assault, threats and harassment]

Factors associated with having mental health problems

Participants felt that perpetrators saw them as vulnerable due to their mental health problems. Perpetrators either knew about these problems because they knew the person's background, or they picked up on the problems because of that person's body language or behaviour:

When I'm really low I can't look at people. I find that because when I'm vulnerable I attract a lot of negative attention, because unfortunately [...] people they pick up on body language and you're always going to get those not very nice people or abusive people that they can somehow see, and I feel that it's very difficult to protect myself a lot of the time.
[Int61, female, partner violence, antisocial behaviour, threats and harassment]

Often a crime happened when someone was particularly unwell or in crisis. During these periods they

might pay less attention to their safety, be more likely to engage in risky situations, be less able to protect themselves, or show visible signs of distress which could make them easy targets for perpetrators.

[Why do you feel you were assaulted?] Because I was on my own. I appeared to be an easy target. Perhaps also because I could have been appearing in distress [...]
[Int32, female, sexual violence, threats and harassment]

In many cases the perpetrator was aware that the victim had mental health problems and the victim felt that they exploited them when they were particularly unwell.

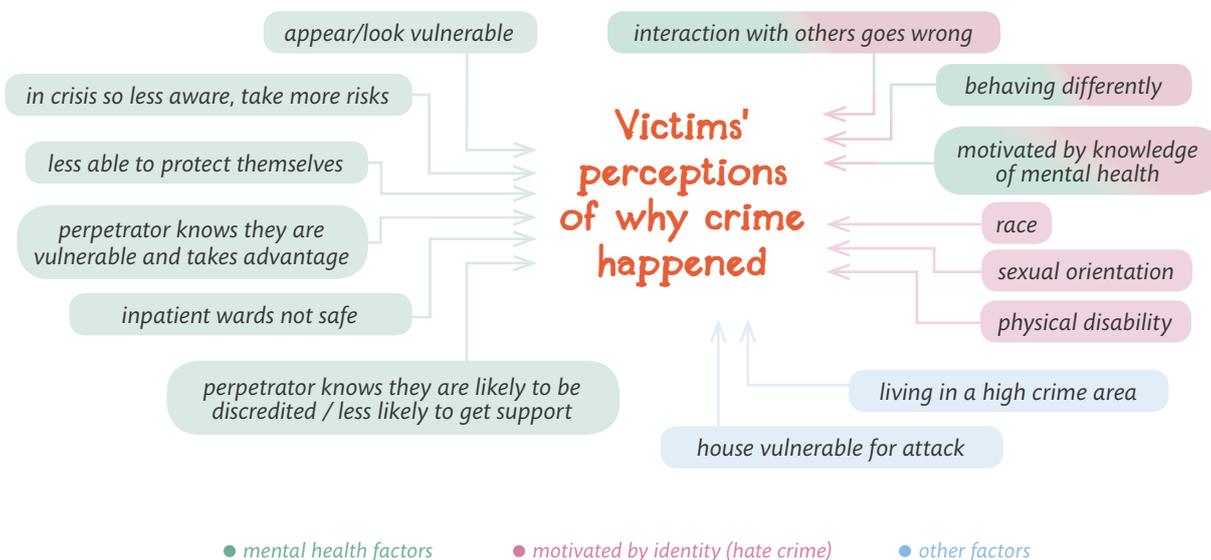
Because once, you talk about your mental health issue and depression and physical health and things, everybody sees you as a soft target, [...] they can easily affect your mental health state.
[Int50, male, assault, threats and harassment]

[flatmate] knew about my depression, he also knew that I was abused as a child cause it was something that I have always been quite open about. [...] It was like he used that like when I was going through sort of an episode of depression and that's when the rape happened.
[Int1, female, sexual violence and theft from person]

Some felt targeted because the perpetrator knew they would not be believed and would be easily discredited if they reported their experiences, and knew that the chances of repercussions were slim:

We may get picked on a lot but we get picked on for a reason because we're never believed and people are allowed to [...]. It's like we have a sign on our head. So

Figure 18: Victims' perceptions of why crime happened.



people do zone in and then realise that actually they can take advantage and that nobody is going to stop them. Nobody does. Let's face it, nobody does. Until it's too late. [Int65, female, sexual violence and antisocial behaviour]

In a few cases participants described perpetrators as using their mental health problem as a basis for abusing them, for example mocking them verbally and displaying prejudice towards their mental health problem:

Because she knew I had mental health issues, she knew I was vulnerable and she kind of knew that I wouldn't fight back [...]. You know, she'd call me a nutter and she'd, I can't remember her exact words now but, you know, really have a go at me for being in [psychiatric hospital]. [Int66, female, antisocial behaviour]

Hate crime

A hate crime is defined as 'any criminal offence which is perceived, by the victim or any other person, to be motivated by a hostility or prejudice based on a personal characteristic.'⁶³ This includes hostility or prejudice against disability, race or ethnicity, religion or belief, sexual orientation or transgender identity. Fourteen participants described being victims of hate crime, although only one participant actually used this term, and for many this reflected multiple discrimination.

[Why do you think that you have been targeted in this way?] Because I'm Asian and because I suffer from mental health problems and because I'm gay. [Int48, male, sexual violence, threats and harassment]

Nine participants said the crime they experienced was motivated by hostility or prejudice towards their mental health problem:

When I was living in [area] there was a guy he used to throw mince meat down in front of my door [and shout]. "Take your medication, take your medication". And I'm thinking you're throwing mincemeat, cooked mincemeat in front of my door, you're more madder than me. [Int18, male, burglary and assault]

Two participants said they were targeted because they had a physical disability:

You know, the first thing I would say is that as a disabled person I experience crime and hatred and discrimination daily. [...] It can be overt in situations where I have been in my wheelchair waiting at traffic lights, might be pushed into oncoming traffic, just to see if I'm really disabled. [Int39, male, assault, threats and harassment]

Four participants suggested that the crimes they experienced were motivated by racism:

It even got to the point of being racially abusive to me. On two occasions he physically assaulted me. These were all reported to the police. [Int30, male, assault and antisocial behaviour]

Two participants experienced incidents of homophobia and one participant was targeted because of their transgender identity:

A service user on another ward threatened to kill me because of my gender identity. [Int32, female, sexual violence, threats and harassment]

Psychiatric wards as unsafe environments

Whilst we were not specifically exploring experiences of victimisation in psychiatric wards, nine participants described this in our qualitative study and 9% of the survey participants said they had experienced victimisation in a mental health facility. Participants from the qualitative study described the ward environment as frightening and felt under threat from patients and staff alike, yet weren't able to protect themselves or access help. They suggested that the imbalance of power between patients and staff made them vulnerable to abuse, and that staff were able to get their version of events believed, could discredit patients and block their access to help. This echoes some of the findings of Mind's 2004 publication *Ward Watch* which identified high rates of victimisation among recent and current psychiatric inpatients and found that there were two extremes of hospital conditions experienced by patients in England: very high quality care in a safe environment and very poor quality care in an unsafe environment.⁶⁴

Some participants also suggested that psychiatric wards were focused on containment rather than care. A few gave examples of being physically restrained and medicated in a very violent manner. These experiences were frightening and distressing. In this case a participant described being restrained by four members of staff, after trying to stop them from hurting another patient, and being forced into taking medicine.

These guys are really hurting me, really, really hurting me. So I'm getting really quite angry [...]. The doctor eventually goes, "Oh, I haven't got time to deal with this" throws the pill at me, gets up, turns to the nurse, "You deal with this." And storms out of the room. So I guess I have no choice, I have to take the pill. And, she goes, "Too late, you had your chance. Turn him over." So the guys who are holding me throw me, lift me up, throw me over, throw me down on the bed. My torso on the bed but my legs hit the floor. [Int54, male, assault]

Concerns about this type of experience have been raised by Mind who recently published a report into the use and impact of physical restraint in crisis care and found huge variation across England. Their report documents the serious impact physical restraint has on people with mental health problems including physical injury and psychological harm which were issues also raised by our participants.⁶⁵

Whilst participants certainly did not indicate that all ward staff were behaving violently towards patients, some did suggest that there was a culture of fear in the wards which prevented staff reporting abuse that they witnessed and which needs to be addressed.

But the thing is they're bullies. And they're bullying other members of staff as well. I've seen it with my own eyes. They get big, they're going bigger, bigger, bigger. And they are untouchable.

[Int17, female, sexual violence, assault, threats and harassment]

Participants who were victimised by other patients attributed this to the patients being unwell, there being a lack of staff supervising the ward, combined with staff rarely taking action when incidents were reported. Female participants described being vulnerable in a mixed sex ward; one had been raped by a male patient.

Other reasons for victimisation

Some identified reasons unrelated to their mental health. For example, over half attributed their victimisation to the characteristics of the perpetrator including that they liked causing harm, or that they had mental health, drug or alcohol problems. Others identified situational factors like 'being in the wrong place at the wrong time'. Several described living in deprived neighbourhoods with high crime rates and problems with gangs and drugs. A few suggested that their victimisation arose from interactions with other individuals that went wrong, for example when a dispute or a misunderstanding escalated, or when they were in a relationship where conflict was a constant feature. Others described being targeted because they were different in the way they looked or behaved, or because of other identify factors that made them more vulnerable such as being a single mother, having another type of disability, being elderly and being socially isolated.

3.6 | Victims' experiences of the police

This element of the research aimed to identify the factors that helped and hindered victims of crime with mental health problems to access justice and support. Participants described their experiences of the police, other criminal justice agencies and other people or services that helped them after they experienced a crime.

Nearly all of our participants had some experience of the police and the majority (80%) of crimes experienced by participants became known to the police. Some of our respondents reported one crime to the police but chose not to report others. Only eight participants said that none of the crimes they experienced became known to the police.

Police came to know about the crime incidents through a variety of paths:

- from the victim themselves
- from a witness to the incident
- through the victim telling someone else about it, who then reported it
- other services referring them (eg accident and emergency services).

As Table 6 shows, victims themselves reported over half of the crimes they experienced to the police, and just over a fifth of crimes were reported to the police by someone other than the victim such as witnesses, services and informal sources.

Many of our participants (67) had previous experiences of the police. Just under a third had been detained under the Mental Health Act 2007 in their lifetime. When people are detained or sectioned, the police may accompany the medical practitioners or take the person to hospital. The police also have the power to remove, from a public place to a place of safety (under section 136 of the Mental Health Act), someone who is experiencing a mental health problem and is in need of immediate care, in order to have them assessed.

How the police became aware of the victim's mental health problem

Participants described that the police became aware of the victim's mental health problems through a number of ways including:

- disclosure from the victim without prompting by police
-

- direct questioning from police causing disclosure from the victim
- disclosure via a trusted supporter with consent from the victim
- police finding out from other routes, without the victim's knowledge or necessarily their consent. For example:
 - the victim's mental health problem is already recorded on a police database
 - the victim is located in a psychiatric facility or social housing allocated for people with mental health problems
 - the victim is highly symptomatic and the police identify their mental health problem from their behaviour
 - police are told by a third person without the victim's consent.

3.6.1 | Factors that helped the person to report the crime

For many participants, the decision to report the crime was taken out of their hands as the police were already alerted by other people. Factors that helped to report the crime were:

- influence of others
- accessibility of the police
- seriousness of the incident and its impact
- a desire to prevent re-occurrence or protect others.

Friends and family played a key role in either reporting the crime themselves or encouraging the victim to report it. This was important to some as it confirmed that the incident was significant enough to report. Professionals such as mental health practitioners also encouraged them, accompanied them or reported it themselves. In a few cases, health and social care professionals observed injuries or changed behaviour in the victim and asked them about it, and then supported them to report.

No, I wasn't going to call the police. My kids say no, poppa, we need to call the police and tell them [...]. Anyway they called the police.
[Int60, male, threats and harassment]

Yeah, [my psychologist] knew all about it. I saw him the next day after the incident, he was the one that advised me to contact the police and tell them. Because I didn't want to. I wanted to just deal with it myself.
[Int23, male, assault and partner violence]

Table 6: How crimes became known to the police

How the crime became known to the police	Female		Male		All	
	No	%	No	%	No	%
Self-reported						
Without support	51		41		92	
With support from others	6		2		8	
Total	57	54	43	54	100	54
Reported by another						
Reported by informal source	4		6		10	
Reported by member of public	2		1		3	
Reported by perpetrator	3		1		4	
Reported by witness	6		5		11	
Reported by formal service	7		4		11	
Reported by private service provider eg café owner	1		1		2	
Total	23	22	18	23	41	22
Police discovered the crime						
Police found stolen goods	0		2		2	
Police were on the scene	0		2		2	
Total	0	0	4	5	4	2
Not reported to the police						
Total	25	24	14	18	39	21
Grand total	105	100	79	100	184	100

I went home. And told my support worker. And like she were like [name], you need to report it. And like it was her that actually phoned the police.

[Int74, male, sexual violence]

A key factor was the police being easily accessible by having a physical presence in a location and having officers that made the effort to reach out and build relationships with the community. Several people were interviewed by police in accident and emergency and one person was clear that they wouldn't have reported the crime otherwise. Another reported an incident to the police at a community event. Several described the benefits of having community police officers they were familiar with and felt happy to talk to.

And I've told P, our community officer, you know, these new PCs. They're wonderful. They listen. [...] Yeah, he's lovely. He always pops in if he's around to make sure everything is fine.

[Int53, female, antisocial behaviour, threats and harassment]

People were more likely to report crimes that they perceived as being more serious, especially if they were being hurt, or were fearful for themselves or others. Often they would report when there was escalation of an ongoing issue, for example domestic violence or harassment.

[Called the police] Immediately, yeah. Because he got me by the throat and my hand, my hand was bleeding, it was quite bad.

[Int41, female, burglary and family violence]

As with other victims of crime, participants often cited protecting others or civic duty as a reason for reporting a crime. For some this was directly about preventing the offender from targeting someone else. For others, it was about the broader issue of raising the profile of the incidents and to help identify a pattern even if this particular incident could not be resolved.

I think going to the police was definitely the right thing to do even though the response I got wasn't what I wanted. I think it's important to stand up to people that commit crime. I think it's good if there's a record of the crime because if they do commit another one the police can look back and see this is a pattern here.

[Int2, female, theft from person and sexual violence]

3.6.2 | Barriers to reporting to the police

Many crimes are not reported to the police, and some participants were reluctant to go to the police. As with the enablers above, some common barriers are shared

with other victims who do not have mental health problems, such as a lack of knowledge, not recognising the incident as a crime, and fearing that the involvement of the police might escalate the problem. The following seemed particularly related to mental health issues:

- previous experience of police
- fearing the response they will receive
- the impact of the crime
- mental health problems
- barriers associated with knowing the perpetrator
- self-identity

Many of our participants had previous experiences of the police and these had implications for how they approached the police for this incident.

A few felt targeted by the police themselves, having been stopped and searched. Many described not being believed or taken seriously when reporting a crime, or of having no outcome, and this made them reluctant to contact the police again.

I thought well, last time they couldn't do anything. [...] I just felt well, nothing come out of it after a serious assault, what's the [point]?

[Int10, male, assault and theft from person]

Having had previous contact with the police while being sectioned, or having been arrested themselves represented a further barrier.

[Partner] rung the police. I don't like the police for obvious reasons, I've been in prison before and I've had some bad experiences with police. I wouldn't have rung them because most burglaries they never get solved and you never get your stuff back.

[Int82, male, burglary, assault and theft from person]

Earlier negative experiences of proceeding through the justice system for example going to court were also barriers to reporting.

I think she said I should talk to the police. But because of an incident of about 10 years ago I kind of lost, I don't know I wasn't as trusting of the police as I was before because it kind of went all wrong that case, nothing happened. So I didn't report it to the police.

[Int20, male, theft from person]

A recurring theme running through many of the interviews was experiencing not being believed by other people – friends, families, other supporters and in previous encounters with the police, which made them reluctant to report again.

Others feared being blamed by the police for causing the incident or being negligent. The fear of being sectioned by the police was also mentioned by some and is a unique concern for victims with mental health problems.

If I'm punched or kicked or knocked down to the floor I just get up and walk away because I don't want trouble in my life, do you know what I'm saying. [Reporting to the police] can backfire on you and you can so easily get labelled as dangerous and, you know, and [a] risk to yourself, to the community and end up getting sectioned.
[Int33, male, assault and antisocial behaviour]

Another barrier was the expectation that the police would think the incident was not serious enough to warrant their involvement.

[Perpetrator] didn't put a knife to my head or beat me up before she stole it, she just slyly took my phone. So I thought the police wouldn't take it seriously.
[Int8, female, theft from person]

The impact of the crime itself was a barrier. Victims described feeling ashamed, foolish or embarrassed. These feelings were particularly acute for those who experienced sexual assault when they had been tricked or felt they might be accused of behaving irresponsibly.

It stopped me, [from reporting] yeah, I was very embarrassed that I was letting some small, tiny woman scare the hell out of me, you know. It never really occurred to me what to do about it. Sometimes I found myself literally sneaking in and sneaking out of the house.
[Int42, female, antisocial behaviour]

Some felt too overwhelmed, confused or distressed by the crime to talk about it or call the police.

I wasn't in a right state to make a phone call direct to the police because I was in shock. And I just couldn't speak for myself. I think I just needed reassurance from someone who I knew, next to me.
[Int41, female, burglary and family violence]

In the following case, the participant attributed his poor recall to his condition, and said that he was unable to explain this to the police officers.

I didn't give an absolutely accurate description [of the perpetrator]. Because I have lapses of memory, short-term memory, I have schizophrenia and I'm not sure it's a symptom [...] I couldn't explain to them.
[Int40, male, assault and burglary]

In some cases, participants were in a relationship with the perpetrator. This barrier is particularly acute for those with mental health problems as they are more likely to know the person who commits the crime. In our sample perpetrators were partners or spouses, co-residents for example a flat sharer, or family members. Participants described fear of reprisals or other repercussions for example loss of custody of their children.

Just supposing that we got to the stage where, you know, we were getting divorced, I had my history of mental health problems and he had a criminal record for abusing me, what might have happened to our daughter?
[Int36, female, partner violence and antisocial behaviour]

Some perpetrators actively intimidated or obstructed participants from reporting. This was also an issue with incidents that happened within psychiatric residential settings where staff prevented them from contacting the police. In this case, the perpetrator inflicted more violence when the victim tried to report the attack.

So I went to the nurses' station. I said I want to call the police right now, you know, so they treat it as an incident. I was knocking and I saw someone trying to open the door [...]. I realised it was [perpetrator]. He push me again, you know, he push me. So I landed on the floor and he went on top of me again trying to restrain me.
[Int17, female, sexual violence, assault, threats and harassment]

For some, their sense of pride and not wanting to be seen as a victim prevented them from reporting a crime. This was particularly the case among some men who felt that they should be able to deal with the situation themselves.

As a man if you can see your pride has been dented, I don't know, you just find your way there. I'm not the kind of person that goes to the police.
[Int15, male, assault, threats and harassment]

3.6.3 | Positive experiences of the police

The survey findings in section 2.5 showed that people with mental health problems were less satisfied with the response of the police and had a worse experience than victims in general. The next two sections explore examples of good practice, and the problems, that the participants in the qualitative interviews encountered. These experiences are particularly important given the likelihood of re-victimisation and the key role that their experiences play in determining whether they will report to the police in the future.

Three quarters of our participants mentioned some positive experiences of the police. Many of these factors would relate to all victims, such as speed of response and taking action, and so we have focused on those which relate specifically to people with mental health problems. Participants found the following helpful:

- positive responses to mental health problems
- caring attitude
- taking the incident seriously and taking action
- communication, information and availability
- working with other services

Positive responses to mental health problems

The response of police officers when they became aware of a mental health problem was key. Participants viewed the actions of the police officers positively when they showed empathy, demonstrated understanding, took appropriate action, linked up with other services, and did not discriminate. These sorts of responses demonstrated to a participant that they were taking their mental health problem seriously.

She probably treated me better because I had mental illness. [...] The way she was kind, considerate and stuff. She was alright.

[Int5, female, assault and partner violence]

And one of the police sergeants had a relative with bipolar and he was very nice and he gave the taxi driver a right talking to. [laughs] On the spot. [...] He said "If you're going to be a public whatever it is, a driver you need to think about your behaviour and your attitude". [...].

[Int76, female, assault, threats and harassment]

The ability to respond sensitively to distress was valued. Participants described the way the police were able to calm them down, during or immediately after the incident, but also later when taking a statement. Police officers also signposted them to other sources of support and reassured the victim.

He was very supportive and he was really calm, he was like going over things really, really slowly. And even when I felt myself kind of gabbling he was able to calm me down and straighten things out. He made you feel really good because, he was being supportive.

[Int45, mother of sexual violence victim]

They just told me to relax, drink water, calm down. That I was safe [...]. And then on the way out obviously they told me that Victim Support is an organisation who would call me if I needed any additional support. They said if I think

I needed any kind of medical involvement then I should call up my GP and get advice from them.

[Int41, female, burglary and family violence]

Caring attitude

Participants praised the positive approach and attitude of some police officers, especially when arriving at a scene of an incident. These actions were described as 'kind', 'considerate', 'supportive', 'helpful', 'friendly', 'empathetic' and 'compassionate', and 'treating people with dignity and respect'.

For many participants, being treated with sympathy and concern and feeling that they were heard was important, especially at the time of reporting when they might be feeling distressed or shocked in response to the crime. Receiving a caring response was also very important after the initial reporting of an incident, for example when taking the statement and with the ongoing follow-up. Spending time with the participant, listening to them, believing and acknowledging their feelings was also valued even if action was not possible.

The police were so nice and so supportive that I actually started crying [he said] "Don't worry, chap, we'll get an ambulance", and he touched me physically, and calmed me, he didn't restrain me, but very gentle contact.

[Int33, male, assault and antisocial behaviour]

They have come and they have listened to me. Although they haven't done anything at least they have listened. [...] It helps because at least in my mind my worries have been noted.

[Int43, female, assault and antisocial behaviour]

The police were very, much more considerate than I expected them to be.

[Int56, male, breaking and entering, threats and harassment]

Continuing to receive a caring response after the incident was also important. The following participant had shown signs of shock and distress immediately after being attacked and was phoned several times to check that he was OK.

I think it's positive on their side. [...] That they do call you to see that things are okay with you. [...] She actually rang me up three times, I think.

[Int47, male, assault]

In the following case the follow-up support from the police was very helpful in validating this participant's experience as she had been blaming herself for not



being able to cope with the harassment she was experiencing from her neighbour.

I felt I was not handling the situation well, I felt I let her intimidate me, I felt I was too emotional, I used to cry, and so I felt weak. And [the police] said actually they didn't blame me, she was quite intimidating. [...] They said they can understand why I felt the way that I did. [...] I felt they listened. I didn't feel they sort of like dismissed it.
[Int42, female, antisocial behaviour]

Taking the incident seriously and taking action

This was important both in terms of treating the incident as serious and worth following up, but also listening to participants as individuals and believing them.

They believed me [...] they took on board what I was saying.
[Int63, female, antisocial behaviour, threats and harassment and family violence]

Clearly the police taking action was a high priority for victims. This included collecting evidence, attempting to find the perpetrator, talking to, arresting or charging the perpetrator, and taking actions to ensure that the victim was safe.

Some participants described receiving support from the police straight after the incident to help them keep safe. For example, one family were removed from their home to a different area, and another victim was escorted back to her home to protect her from harassment from her neighbour.

Several participants received follow-up support such as being provided with safety equipment: CCTV cameras, personal alarms, extra locks, and SmartWater to protect their belongings. Some reported having visits by the police after they had reported the crime to check that they were feeling safe and secure.

[The police] came and talked to me so that made me feel that bit safer.
[Int37, female, threats and harassment]

Nearly three quarters of our participants experienced a crime where the perpetrator was known to them (especially in domestic violence and antisocial behaviour or harassment cases), and in many of these cases the police attempted to contact the perpetrators straight away. Some described the police visiting the perpetrator to get their side of the story, and a range of outcomes were then possible: a warning, arrest and charge, or no action unless further evidence was found.

Communication, information and availability

Good communication from the police was important to participants, being informed about the police action immediately after the incident, and about the progress of the case, even if there was little of substance to report. Participants valued having named officers assigned to them, being able to contact them easily, with a direct number, and being reassured that they could contact them if they wanted to.

He took a lot of time to explain things, [...] he give me his name and his number and he acknowledged that it must

have been very hard for me [...] he let me know when he'd be back in touch next, and what was going to happen, and by when. Which I really appreciated. He made it clear that it would be fine for me to call him any time if I wanted to ask anything or add anything.

[Int79, female, theft from person and partner violence]

They phoned me sort of once a week, once a fortnight, just to say look, this is where we are. This is what's happening. There's not much to tell you but we haven't forgotten about you. Which was nice.

[Int67, female, criminal damage]

In some cases, officers in the community were singled out for praise because of their visibility, approachability and efforts to build relationships with people. Police officers being seen about and who were known made it easier for some participants to raise issues. For example, the following participant felt comfortable disclosing incidents to the police officers she had already built a relationship with, and others described feeling reassured and safe when they saw them around.

Well, if you reported an incident he'd listen to you and he'd try and do something about it. [...] They would make sure that it was attended to. So they put the effort in that was needed. They were good communicators as well and [PCSO] actually became one of the guys that would play football with the kids after school.

[Int69, female, theft from person]

Several participants felt that having a female officer was helpful, especially in cases of sexual assault.

I thought because she was a woman, I thought I can confide in her.

[Int61, female, partner violence, antisocial behaviour, threats and harassment]

[Was it important to you that it was a woman?] Yeah, of course, especially after what had happened and trying to explain. And then, then it was mainly all women I can remember at the suite.

[Int75, female, sexual violence, burglary and antisocial behaviour]

However, some also shared their unhappiness about not receiving the response they expected from a female police officer.

I felt really betrayed in a female way by the way these female officers [...]. They were haranguing me for evidence. You know, straight away they wanted me, they wanted bodily fluids off me, and it was very much like a bit of a

Spanish inquisition thing [...] they were quite aggressive when they were talking about it.

[Int71, female, sexual violence and burglary]

Working with other services

About a quarter of all participants (18) described being referred to other services for support by the police. These were mostly to Victim Support, hospital services (eg accident and emergency), neighbourhood police teams or council antisocial behaviour teams.

Several respondents described the police as liaising and working directly with other services, for example helping people to get re-housed.

The council did not want to re-house me. [...] The police had said about applying to the other housing association, we actually got offered a bungalow. So I think because the police probably had said something as well. They kind of verified our need to be moved.

[Int67, female, criminal damage]

In some cases the police contacted a participant's existing formal network of support (with their consent), such as their community mental health team, which could encourage a joined up approach to support (also see section 3.8.3 on help-seeking).

3.6.4 | Negative experiences of the police

Two thirds of our sample described dissatisfaction with some aspect of the way they were treated by the police. Many of these problems are the mirror of the positive aspects identified in section 3.6.3 above. They include:

- poor responses to disclosure of a mental health problem
- not being believed or seen as credible
- incidents not taken seriously
- being blamed for the incident
- prejudiced attitudes towards mental health
- lack of empathy or respect
- lack of action
- dropping cases
- lack of information and communication

Poor responses to disclosure of a mental health problem

Over a third of participants described a poor response from the police on disclosure of their mental health problem. These included showing a lack of empathy and sensitivity, lack of understanding of the issue and

not providing appropriate support. This participant described the insensitive questioning he received from police officers about his mental health problem.

They were just like, 'you haven't taken nought, have you?' and like 'you haven't self-harmed' and stuff like that.
[Int74, male, sexual violence]

This participant described the reaction of the police officer to her disclosing that she experienced bipolar disorder:

She was writing, and she went, she kind of stopped. "Bipolar?" I went, "yeah, manic depressive, you know, mental health problem" [...]. And she said "Well, his [offender's] barrister will probably tear you apart in court." And she said "Well, if you're prepared to go to court then yeah, we'll do the statement". But it was almost like well, do I bother doing this statement or not. It was that kind of attitude.
[Int31, female, partner violence, threats and harassment]

Several of our participants described police officers' lack of understanding of mental health problems and symptoms. For example, this participant described the response of an officer when she disclosed:

Once I said "Oh, I've got post-traumatic stress disorder, I don't like being on my own", he sort of looked at me like, you know ... that look that you get sometimes like "Oh, my God, a mental person. [laughs] Now what do I do? How do I behave, you know". He looked kind of worried about what to do next.
[Int79, female, theft from person and partner violence]

This participant described having a panic attack in a car and the police officers, although sympathetic, were not aware of how to deal with it, and by banging on the window they made the situation worse:

[Panic attack] means the walls have gone up, I've gone into a cave, everything has blocked off, I'm not doing anything. [...] I'm starting to hear banging and people, "It's the police, it's the police, open the door, we're going to smash the window". And I still wasn't responding. I was completely shut up. And it took this policeman to actually crawl on the bonnet of my car and try and look me in the face and show me his warrant[...] And he said, "what's gone on?" [...] "Just leave me alone, just leave me alone. I will come out of this, just leave me alone."
[Int39, male, assault, threats and harassment]

Not being believed or seen as credible

Many participants felt they were not believed when they reported incidents to the police. Some felt this was directly related to their mental health status and the prejudiced attitudes held by some police officers.

The police just wouldn't believe me. I was just starting to get this really horrible niggling feeling that you know, didn't matter what [police officer] was saying to my face but behind my back she was like "yeah, she's not right, you know, it's a bit dubious about her because she's under the mental health team". And the fact that they weren't doing anything, I thought they're not taking it seriously.
[Int61, female, partner violence, antisocial behaviour, threats and harassment]

In some cases the participant only found out they had not been believed through information they received subsequently, for example in police reports. In several cases, participants reported the police taking the perpetrator's point of view, as they were seen as 'credible' compared to a victim with mental health problems. This was especially the case in domestic violence situations but also with antisocial behaviour, or abuse in institutions.

I know the first time I called the police for my son [perpetrator], he called them back and said "No, my mother is mad, don't come here, that's how she is". And the police didn't come until the next day and by then he had gone.
[Int63, female, antisocial behaviour, threats and harassment, and family violence]

Incidents not taken seriously

Sometimes incidents were not taken seriously by the police, and some described police officers playing it down:

But the police officer said "Oh, well, you know, this is the kind of thing that happens, you know, when you get on buses. It happens all the time".
[Int76, female, assault, threats and harassment]

This participant reported the police not taking his experience of physical assault seriously because he was a physically big man who should be able to look after himself:

I says, "Look, he attacked me in my room." And then the police, it upset me because he started to make a joke of it. [...] He was saying to me, "Well, you're a big lad, you're supposed to be able to defend yourself."
[Int24, male, assault, threats and harassment]

Linked with the down-playing of the incident was a lack of appreciation of the importance of the incident to the individual, particularly in the case of harassment and antisocial behaviour. In some cases, participants reported being accused by the police of being 'time wasters'.

Being blamed for the incident

Several participants described feeling blamed for the incident.

Yeah it was almost as if they were saying like "it's your own fault" [...] without actually saying that. [...] Specifically because this woman said "are you sure this wasn't just a drunk mistake?" and that was said twice and that is something that a person never forgets.

[Int1, female, sexual violence and theft from person]

Participants also felt they were being held responsible for the crime in the follow-up to reporting the crime. For example, several participants were advised to change their behaviour. In some cases this was regarded as helpful safety planning and prevention advice, however some felt this indicated that they were being asked to take the responsibility for the crime.

Some respondents also referred to being 'told off' or 'scolded' by the police.

It was more like I'm dealing with a policeman who's giving me a ticking off for being rude to staff.

[Int4, male, fraud and theft from person]

The sense of being blamed was sometimes linked with being argumentative with the police officers, which for some may have been a symptom of their mental distress.

I think the initial officer I saw thought that I was to blame. But, but because I was arguing with him and it had become quite a feisty argument, he said to me, "We haven't got time to waste with fraudsters.[...] What sort of game are you playing? Do you think we've got time to waste with all this nonsense."

[Int12, male, assault and fraud]

Prejudiced attitudes towards mental health

Several participants felt that some police officers held prejudiced attitudes about people with mental health problems: that they were more prone to violence or more likely to have been responsible for being a victim of crime, and that they were not credible witnesses.

They assume I'm violent. They see their job as protecting the public from schizophrenics, they do not see their job as protecting schizophrenics from the public.

[Int35, male, assault and antisocial behaviour]

As with many victims of crime without mental health problems, some of these victims did themselves have criminal records, and felt that this, combined with their mental health problem, meant that the police

automatically assumed they were perpetrators and did not take their experiences seriously. This participant describes how the police attitude changed when they checked their records and found out that he had a criminal record and mental health problems:

At first when they're talking to you they're talking to you like a human being. And then they said "can we just do a name check, can we have your name please?" [...] And then everything changes, when they find out ... And when they find out you've got a criminal record [...] they started talking to me like I'm a piece of shit. [...] They started being tormentative. Making you feel agitated and aggressive.

[Int18, male, burglary and assault]

In the above situation, they had originally seemed sympathetic and had said the participant's actions were in self-defence, but then after checking his records they arrested him for actual bodily harm (ABH).

Lack of empathy or respect

Police officers were described by some as unwelcoming and not showing any interest in the individual or their case. Others reported feeling humiliated or being treated abruptly, and a few described the police as dismissive.

And so she got really kind of stroppy and she said well, you've been missing appointments, you know, I was waiting for you, so where were you? And you didn't turn up. And I said I was in [different police station].

[Int17, female, sexual violence, assault, threats and harassment]

This participant describes a police officer shouting at her when she was trying to give a statement:

I was called in by this [police officer] at one point she was actually shouting at me. [...] And I felt under pressure and she was saying, she was trying to make out as if I was to blame. [...] It was only when I shouted back at her and she saw me crying that she composed herself.

[Int43, female, assault and antisocial behaviour]

Some described the unwelcoming and unpleasant experience of being at a police station, with long queues and waits. Although these experiences may be the same as other victims', the impact of crime and these circumstances were felt more acutely by people who are already coping with their mental health symptoms. One rape victim described very poor care – being taken to the station in her pyjamas, being left alone for two to three hours and not being informed about what was going on:



Once I got there they just pushed and pulled me about, like from room to room I didn't know where I was, I was still in my pyjamas, I wasn't allowed to have a drink, I hadn't eaten, it was like horrendous.

[Int1, female, sexual violence and theft from person]

Lack of action

Several criticisms were made about the lack of action taken by the police and inadequate or delayed responses. This included delays in attending and not pursuing the perpetrator, not following-up or collecting evidence. Two participants recounted being told to collect their own evidence, including a rape case, and others were asked to take their own photographs as the police equipment wasn't working. Others described police inactivity and letting incidents escalate, and some described the police leaving them in dangerous situations.

[I was saying] "This is not acceptable, why are you not investigating, why are you not arresting this person?" [...] I end up saying, "If I pick up a knife and I go round and I start stabbing people and attacking people isn't that a crime". She told me, "You do whatever you like", started laughing and put the phone down.

[Int49, male, assault, theft from person, threats and harassment and partner violence]

Dropping cases

Ten participants described having their cases dropped. Some, although disappointed, could accept that there wasn't sufficient evidence. The fact that the case has been dropped was made harder for some by the way it was conveyed. A few participants described feeling that the police had dropped their case because they had a mental health problem which was deemed to discredit them, and their account of what had happened.

[The police said] they wouldn't take my case to court because I was a mental health person. I wouldn't be able to explain myself properly, something like that. And you hear that a lot from people with mental health, you know, they just leave you.

[Int6, female, assault, threats and harassment]

And in this case where the case was dropped, the respondent was wondering whether it was down to her mental health status and ability to give evidence:

Well, they said to me that I didn't really have a case, if they put it before the CPS then they would have perhaps, you know, thrown it out of court really because they didn't feel like I had a case. They didn't say this but whether they felt I was an unreliable witness because of my mental illness [...]

[Int83, female, sexual violence and partner violence]

This participant describes finding from notes by police officers in a compensation enquiry, that they were questioning his evidence on the basis of his mental health background:

After speaking to him they believe that [participant] may be psychotic and it is mentioned that when he was admitted he hears voices and was having suicidal thoughts.

[Int48, male, sexual violence, threats and harassment]

Lack of information and communication

About half of the participants who had negative experiences of the police talked about lack of information and poor communication. This included not being kept informed about the progress of their case, problems with contacting the police, not being aware of their rights and receiving incorrect information. These problems have been well documented elsewhere for victims generally, for example Victim Support's report *Left in the Dark*,⁶⁶ and seem to be particularly important for people with mental health problems.

I had to call them almost every day to ask them. [...] "What is the update? Where are we going with this? Is he on bail? Is he going to come round my home? Have you arrested him? Am I going to find him in my home?" Because even after it happened, [...] we caught him coming out of the side entrance and he was in our home.

[Int45, mother of sexual violence victim]

I wanted somebody to call me and talk to me or, if they could give me a phone number so I could have called them and directly ask about things.

[Int22, female, theft from person]

3.6.5 | Future reporting to police

Fifty-five of the participants discussed whether they would report an incident to the police in the future. Just over a third of these said they would report again, a third said they would definitely not report to the police and the remaining third said it would depend on the circumstances.

Those who said they would report again were influenced by wanting to protect others, and to uphold the law. Some referred to how strong they felt mentally.

I think because I am mentally stronger in myself I would go to the police but I know people that wouldn't because they've got mental health issues. Like the person that saw her take my bag but didn't want to take it any further because he is, you know, just too ill.

[Int2, female, theft from person and sexual violence]

Poor experiences of the police and consequent loss of trust was a reason for not reporting again, even for serious incidents. Some referred to the outcome, and others the way they were treated. Some just felt it was unlikely that the crime would be resolved (especially burglary or theft).

If anything really bad happened to me, like say I was mugged again, or heaven forbid raped again, attacked, whatever. There is no way that I would ring up the police, no way, because I wouldn't want to go through all that again.

[Int1, female, sexual violence and theft from person]

If anything ever happened concerning police I would never, ever, ever make that call of 999 again. That is how strongly I feel the police let me down. Because all they did was turn my life upside down

[Int25, female, assault]

For this respondent, it was the trauma of having to go back over her mental health disclosure each time she had a contact with a different police officer that was holding her back:

Because it's not worth the hassle. It's, it's putting yourself through the thing again, you have to be pretty strong to be able to do that. And because of my mental health problems I don't think I am particularly emotionally very strong. And every time you do it you've got to tell your whole story again and you've got to deal with those people's reactions [...], is this person going to be afraid of me? Are they going to be shocked? Are they going to ask me inappropriate questions? [...] Because having a mental health issue, it affects absolutely everything, every bit of your life, you can't kind of deal with something as important as a crime without disclosing it.

[Int79, female, theft from person and partner violence]

3.7 | Experience of court

Ten of our participants' cases went to court and eight were called upon to give evidence, and a further five had previous experience of going to court. This section describes what helped and what hindered the courts process.

3.7.1 | Enablers – good experiences of court

Participants described the factors that helped them in the court experience:

- pre-court visits, preparation and information
- the Witness Service
- special measures
- a judge or magistrate intervening on their behalf.

Participants described feeling anxious and nervous before attending court. Three had an arranged visit to the court which had helped put them at ease. Some described being prepared for, and supported in court. One was accompanied by a mental health nurse and another, denied special measures, described a police officer reassuring and offering advice about giving evidence.

[The police officer] said to me "Look, when you're going to court, don't look at them, no matter what happens, give your evidence looking at the judge [...] but do not look at them because they will try to intimidate you and if they do stare at you long enough you'll lose your nerve and you'll probably crack up" [...]. And that was good advice, [...] I wrote down what he said because when I'm stressed I tend to forget everything.

[Int63, female, antisocial behaviour, threats and harassment and family violence]

Three participants described being helped by the Witness Service on the day they went to court. They appreciated being kept informed, having a separate space to wait before giving evidence and having the courtroom described to them.

Victim Support met me at the train station as well and travelled with me. [...] Because I was scared that his family was going to be at the court and then after I finished [giving evidence] the Victim Support worker was like "You've done really well".

[Int34, female, partner violence]

Two participants were allowed special measures in court (giving evidence from behind a screen or by video link), and a third was allowed to leave by a separate exit to avoid the perpetrator's family.

[Special measures were] immensely [helpful]. She [participant's daughter] found it much better because she don't have the fear of him looking at you. And the fact that she had been self-harming and feeling very low that was one of the reasons she got it, for her mental state.
[Int45, mother of sexual violence victim]

Several of the respondents described the judge or magistrate intervening to support the victim in court, particularly when being cross-examined by the defence barrister.

The judge kept saying "The questions you're asking are very irrelevant"
[Int34, female, partner violence]

One participant described how the Witness Care Unit (WCU) officer realised over the telephone how stressful the court appearance would be for the victim and arranged for her evidence to be read out for her in court.

[The WCU officer] realised how het up I was getting, just by talking to me. She was like "Okay, going to court may not be the best thing in the world for you right now".
[Int67, female, criminal damage]

3.7.2 | Barriers – poor experiences of court

It felt more scarier talking to [defence barrister] than it did going through half of what I went through with the actual person. I didn't know him and it was, I knew he couldn't hit me [...] but it was like the way he was talking to me was like kind of scary. And then I was like actually it felt like I'm the one who should be put behind bars, you know.

[Int34, female, partner violence]

Going to court and giving evidence can be a very stressful time for victims, and our participants outlined a range of problems they faced including:

- seeing the perpetrator and their family/ supporters
- cross-examination in the court
- use of mental health history against them
- not being able to make their point
- long waiting times
- not being given special measures
- lack of information after the trial

Participants were anxious about seeing the perpetrators and their families, and several reported meeting them, either outside the court, or whilst waiting to give evidence. This was very intimidating, and in this case



had a very detrimental impact on one young witness who started to self-harm immediately afterwards:

We left at the same time as the [perpetrator] and he came out of the same entrance as we came. The ushers told us "oh, don't worry him and his family have already left the court about twenty minutes [ago]". [But] my daughter came face-to-face with him, and him and his family wanted to set about her, were hurling abuse at her. And she went to the pub and she broke a glass and she started self-harming in the toilets and we had to call an ambulance. I think it was the trauma of just coming out of the court at the same time.

[Int45, mother of sexual violence victim]

Participants were anxious about giving evidence and several found the cross-examination by the defence very distressing. They described being accused of lying or being racist, or being mocked, and one described this experience as being worse than the original victimisation itself.

In one case, the defence had asked for the victim's medical records and in his view their access to this information meant that he lost the case as they used the fact that he'd attempted suicide in the past to suggest that he had stabbed himself.

Yeah, I did [tell the police about mental health history] but that was my mistake because, the opposition wanted my [medical] files. [...] And they got it and basically it said I attempted to commit suicide before. So they went on that and they basically just won the case, said that I had smoked cannabis on the day, so I must have stabbed myself.

[Int78, male, assault, threats and harassment]

Participants also found it frustrating not being able to make their point, or to give evidence that they thought was relevant. One described finding it hard to express herself quickly and felt that this had not been fully appreciated and she was not provided with an intermediary to assist her.

When I'm talking I'll go all round the houses to get to the (point) [...] I think it would have been helpful if they realised that yes, alright, I can tell you about the situation and what happened but it will take me longer.

[Int28, female, antisocial behaviour and assault]

Participants described waiting for a long time before the case came to court. One had a case repeatedly delayed, and another case was delayed apparently due to evidence not being provided on the day.

Few respondents had heard of special measures or knew that they should have been entitled to them when giving evidence in court. One respondent was denied a screen and another described only finding out that she had been granted a video link 'at the very last minute'.

Several respondents described not being provided with enough information after the trial – not being told about the outcome of the case, or knowing when the perpetrator had been released after their sentence. Others mentioned not being provided with any support after the trial and not knowing where to turn to for this.

Obviously on the day it's a big build-up emotionally but then afterwards there is nothing, if you need to talk to anybody about this, have you got any questions about when he's released, how this affects you, that sort of thing. It's kind of I feel like I've been scrabbling around for bits of information from various sources.

[Int31, female, partner violence, threats and harassment]

3.8 | Getting help from non-criminal justice agencies

The previous sections described how people with mental health problems accessed help and support from criminal justice agencies. Most participants needed help from other sources too, and this section explores who they turned to, and what helped them to, and hindered them from, approaching individuals and services and getting the help they needed. They described going to a range of individuals and services outside of the criminal justice system to seek help after being a victim of crime, from friends, family and neighbours, to housing officers, GPs and mental health professionals.

Help seeking behaviour is complex. How and why people sought, and indeed, got help depended on a range of things, to do with the individual themselves, and the context of the situation they were in. People had a range of different motivations and desired outcomes – some wanted justice, some wanted to have their experience acknowledged, and others needed help to deal with the effects of the crime on their lives. Some wanted help to resolve the issue they were experiencing, especially long-term problems such as domestic violence or antisocial behaviour.

The way in which people sought help also varied due to factors such as their knowledge about what help might be available, how they felt about seeking help and previous experiences, the nature of the crime, and how serious they perceived it.

As the participants described going to many different types of individuals and organisations for help we have divided these into two categories: informal sources and services (see Box B).

The following sections describe what helped and hindered people from seeking and obtaining help, and then goes on to describe their experiences, both good and poor.

3.8.1 | Help seeking enablers

Participants described the following factors as enablers to seeking and/or attaining help. Some of the factors that helped participants are similar to all victims of crime and we have highlighted those issues particularly relevant to people with mental health problems:

- having the presence of a support network
- having a current or prior relationship with services
- the impact of the crime as a trigger to seeking help.

Having the presence of a support network

For two thirds of all the crimes experienced, participants told their friends, family and partners what had happened, in some cases asking for and receiving help. Neighbours and work colleagues were also mentioned. They turned to people who they had close and trusting relationships with, or those who had a good understanding of their mental health problems.

I have my ex-wife and she is a saint to me, you know. She'll keep my spare key and any time I lock myself out day or night I can knock on their door [...] and they'll soothe me down and calm me. She's a really strong friend and ally.

[Int33, male, assault and antisocial behaviour]

I thought I need to tell someone. And A, the guy who lives in Scotland, is my oldest friend and he knew more about my condition than anyone else really.

[Int54, male, assault]

Neighbours and friends were approached when the participant thought they had the knowledge or expertise to help. Close networks were also able to spot when something was wrong, and offer practical support.

My neighbours were very good as well. One managed to get my front door open for me, [...] And then another lady, one of my other neighbours phoned [housing trust] for

Box B: Sources of support

Informal sources of support include family, friends, a partner, neighbours and work colleagues.

Services:

- mental health services for example community mental health teams and inpatient psychiatric teams,
- health services for example GPs and emergency services,
- social care services for example social services and children's services,
- housing services for example local council housing departments and housing associations,
- non-criminal legal professionals for example solicitors,
- probation services,
- local councillors or MPs,
- voluntary and community sector services for example Mind, Victim Support, and Citizen's Advice Bureau.



me and they changed the locks free of charge in the end because it was a crime.

[Int2, female, theft from person and sexual violence]

I got to the point where I was just going on and on and obviously not making much sense, but my neighbour had been here [local mental health charity centre] in the past herself and that, And she [neighbour] felt it might help me, and it has done.

[Int28, female, antisocial behaviour and assault]

Having a current or prior relationship with services

The respondents described how having good existing relationships meant they were more able to gain help. The majority of our participants had existing relationships with services and a third talked about how this link provided them with opportunities to seek or attain help. This re-forces the findings of the survey above which highlighted that the people who had good engagement with their mental health services, were less likely to be victims of crime, and conversely those who did not, were more at risk of being victimised.

Routine appointments provided opportunities to disclose what had happened, and in some cases professionals picked up on visible injuries or behavioural clues that something was wrong.

I think it, I was under the medication review which we have every six months. And [GP] said "are there any problems?" [...] and then I told him what had happened.

[Int53, female, threats and harassment]

I mean soon as I walked into the door, "My God, what's happened to you?" you know, because I looked a mess for a while. Nasty cuts and bruises.

[Int10, male, assault and theft from person]

My care coordinator asked me what happened [...] she was aware that he kept sending me texts and phone calls and I said it felt I was being harassed every time I'm ill and my care coordinator said "something is not right there and if you didn't consent, you can, if you want to, talk to the police".

[Int29, female, burglary, rape, assault]

People sought help from known services they trusted where they had received good support, where they had a positive relationship with a professional, or felt the service understood them.

Because I trusted their judgement. I trusted their support. [...] They've been there, they've listened to problems that I've had. They've provided support.

[Int23, female, sexual assault]

Before that I had met I think someone from [DV support organisation] and so I already had seen her so I called her and told her everything and I was just crying.
[Int22, female, theft from person]

Participants described instances where the encouragement, signposting or referral by a professional in response to their disclosure helped them to attain help, or in some cases, to report to the police.

[housing officer] helped me a lot. [...] he wrote to my doctor [to ask him to visit] and he made sure that I got some kind of help from, the sustenance officer
[Int58, assault and antisocial behaviour]

He [care coordinator] put me in touch with [mental health charity]. [They] came to visit me at home and brought the person – I call her my escort, [laughs] and she suffered from schizophrenia for 20 years and had been in and out of hospital for a great deal of her life. And we talked about it.
[Int54, male, assault in psychiatric care]

Somewhat ironically, some participants framed their help seeking behaviour as arising from having received unsatisfactory responses previously, and seeking an alternative source of support as a consequence. In some cases this related to the response received from the police, but housing associations and mental health services were also mentioned.

Well, they [housing association] should, take the problem seriously. And they're not doing that. That's why in the end I had to go to my MP. [...] He's written to the housing association.
[Int43, female, antisocial behaviour and assault]

I think one of the reasons I went to Victim Support, was I didn't think that there was a sufficient follow-up by the mental health people.
[Int56, male, breaking and entering and threats of violence]

In all of these cases the participant had identified a need for help and had remained motivated to find a source of help despite set backs, showing a level of resilience and determination.

Impact of the crime as a trigger to seeking help

The impact of the crime and the detrimental effects it had on their lives and the lives of those close to them were a trigger to people seeking help. Participants described the emotional, mental and physical health impacts.

Feeling unsafe, frightened or in danger were powerful motivators to seeking help, as well as shock, anxiety, anger, stress and feeling low.

I went to [housing association] because I was so frightened, I was just terrified.
[Int36, female, antisocial behaviour]

When I opened the door and I spotted like a little fan on the window that was broken and straight away my panic level went up and I was becoming breathless and I called up my mum's number and I asked my mum to send one of my brothers across.
[Int41, female, family violence and attempted breaking and entering]

Yeah. I was really fuming, I was trying to keep myself calm at the same time and then [female friend] saw me, she passed and saw me standing there, [...] she says, "Alright, mate?" I says, "Yeah, yeah, do you know this is the guy that assaulted me."
[Int47, male, assault]

The escalation of a victimisation situation was a trigger for help seeking. For example, this participant highlights how she turned to her neighbours after the worsening acts of violence by her partner:

He ended up hitting me, I ended up miscarrying. And then one night when it was happening and I managed to get help I managed to get to my neighbours. I didn't phone the police, I was too scared to phone the police.
[Int34, female, partner violence]

As described in section 3.4, the effects of the crime worsened participant's mental health which could be a trigger to them seeking help. This included increased levels of anxiety and depression, or going into mental health crisis. Several participants described feeling suicidal and eight attempted to commit suicide, which brought them to the attention of services. Victims described seeking help when they had a physical injury themselves or with the assistance of those who were nearby.

So I went to my [previous] GP asked if I could go and see him right away because I wasn't feeling well. And he said you can come in but, we don't have any extra appointments. I said to him, I'll come, I don't mind, I can sit and wait. And I just became so desperate, extremely desperate. I had tablets that I was taking for, the palpitations I just sat there and I popped all of them. And I just drank them down with water and I just lay down.
[Int63, female, antisocial behaviour, threats and harassment and family violence]



3.8.2 | Barriers to seeking help

Participants described the following factors as barriers to seeking and/or attaining help from both informal sources and services:

- fearing the response they will receive
- fear of making the situation worse
- barriers associated with knowing the perpetrator
- barriers of the services
- poor responses by individuals in services
- the impact of crime as a barrier, or emotional and mental health
- mental health problems as a barrier

Fearing the response they will receive

Over a third of participants described fearing the response they would receive from the potential help giver and how this acted as a barrier to seeking help. They feared being blamed or not being believed. Some feared that the help giver's actions or responses could make things worse. These fears were grounded in previous negative experiences of seeking help. For example, a prior unsympathetic and blaming response from a community psychiatric nurse (CPN) made this victim hesitant to ask for help again:

When I was with my ex-partner I went to a CPN and trying to get help because I was trying to get out of the relationship, this male CPN that assessed me said "This lady has had numerous psychoanalytical therapy. She's extremely lucky but it doesn't seem to have done anything at all to help her" [laughs] You think Christ alive, it is worth trusting anybody who puts stuff like that? [Int61, female, partner violence, antisocial behaviour, threats and harassment]

Participants were also concerned they would not be believed and worried that having mental health problems could be used as a basis for disbelieving them. Some had reported several experiences before and didn't want to be seen to be 'crying wolf' or to be viewed as the problem themselves.

I think if I told them a similar story again then they're going to think it's probably me that's the problem. So you know [...] Well, I'll get the disbelief part and then they'll turn around and think maybe it's me and I know that it isn't. [Int30, male, assault and antisocial behaviour]

I feel like I've already got all of these horrible stories. I thought that people wouldn't believe me anyway and maybe it was in my head maybe I was creating. [Int1, female, sexual violence and theft from person]

Similarly to reporting to the police, participants felt that they would be blamed for, or that they had contributed to what had happened. A particular concern was that the incident might be interpreted as an indication of deteriorating mental health. For some, other factors combined with their mental health made them feel they would be blamed, for example having a history of violence, or negative attitudes towards women and sexual violence.

Because as I got bipolar, they probably would have thought it was my fault as I said. [...] In the past I've been violent. But not too violent but I thought I might have been blamed so that's why I didn't say anything. I just thought I'd say nothing. And sort of, just try to get by on my own really.

[Int21, male, assault]

I thought she [care coordinator] might misinterpret what happened and then the psychiatrist might be told and he might think that I was worse than I was, but I don't want them to see me as really ill.

[Int51, female, assault, threats and harassment]

I would just be seen as a hysterical woman, trying to get someone in trouble [...] I didn't think people would believe me. [...] I suppose because there is a belief that women are irrational and I guess I have internalised that.

[Int59, female, sexual violence]

Fear of making the situation worse

Participants feared that seeking help would make the situation worse, for example that friends and family might take action against the perpetrator, or that intervention by services might cause the problem to escalate. Some victims worried that friends or family might provide reactions that would make them feel worse about the situation, or provide opinions that would make them feel more confused, as this participant explains:

And I don't want other people's opinions in my ear saying stuff and, you know, making me feel worse than I already feel about the situation. Usually that's the response, that's the sort of people have around me, they make you feel even more downer than you already are... And it really affects the way I think.

[Int5, female, assault and partner violence]

Others feared that potential help givers might respond in limiting or punitive ways, or just provide additional interference in their lives, for example they might lose their home or have their medication increased.

I'm actually lucky to have a home, I want to hang on to it. You know, if I make too much noise they can take it away from me and that's my greatest fear basically, you know. [...] I've been institutionalised and I was rehabilitated apart from occasionally taking drugs now. I'm a person with a record, you know, there's mud and it sticks, mud sticks, you know.

[Int33, male, assault and antisocial behaviour]

Last year especially I was getting into a lot of arguments with my care coordinator because I was missing medication dates sometimes [...], she wanted to come to my flat and if she had come she would have seen [the exploitation] it wouldn't have been good. She would have probably put me back in section or, you know, got the police involved and so on. I don't want her to have that idea that I'm trying to avoid her coming to my flat administering medication.

[Int78, male, assault, threats and harassment]

Barriers associated with knowing the perpetrator

Unsurprisingly, perpetrators themselves acted as a barrier to participants seeking or attaining help. Perpetrators intimidated participants into staying silent, actively obstructed them from seeking help or punished them when they did. This happened in cases where the perpetrator had some power to disrupt their lives further, for example in domestic violence and anti social behaviour cases, or when professionals were perpetrators.

I tried to tell my sister-in-law. She never done nothing about it [...] Every time I tried to talk to her [perpetrator] beat me.

[Int77, female, partner violence, sexual violence, assault]

Other participants described not seeking help because of their emotional commitment to the perpetrator or because they didn't want to get the perpetrator into trouble.

I didn't really want to tell my mum because I didn't want to get the counsellor into trouble.

[Int73, female, sexual violence and domestic violence]

Barriers of the services

Once participants had decided to seek help, they were confronted with a range of barriers to do with the services themselves. This research took place in a period of enormous upheaval within the health and social care system, with major restructuring and reduction of service budgets, which may explain some of these barriers.

A number of the participants described a lack of services in their local area that could help them, either because they were overstretched or had ceased to exist. This was experienced across the board with mental health, health and social care, legal and community voluntary services. Participants already engaged in services found that they weren't able to access additional support, or that existing support was being withdrawn after funding cuts.

In this Local Authority there's very few places, you've got like a Citizen's Advice Bureau in that normally takes 12 people, you've got 40 people queuing up, so you have to get there for six, seven in the morning. I remember going with someone to report a crime in [location] and we had to queue up at half past five, the doors opened at nine.
[Int12, male, assault and fraud]

[My psychiatrist] wanted more regular appointments but couldn't slot me in, because he sees far too many patients.
[Int66, female, antisocial behaviour]

Others were referred to specialist help such as counselling, with a long waiting list – over a year in some cases. Some participants also described being denied additional help from existing services as they did not meet the service criteria.

The hospital did refer me to an assault and abuse counselling [service]. And I'm on the waiting list still for that even though that happened like a year ago.
[Int71, female, sexual violence and burglary]

[I asked for] counselling at least to deal with, you know, the self-harm that I've started doing again. And they said "Oh well, you don't meet the criteria for therapy". And I'm like what do I need to do? Do I need to take another overdose for people to take me seriously in mental health services?
[Int63, female, antisocial behaviour, threats and harassment and family violence]

Some participants encountered strict limitations on the amount of support they were allowed to access from any one service, which meant that some of their needs were not met. Others were frustrated by services that were unable to support their specific needs, or who could only support some of their needs. This left some participants needing to look for support elsewhere which was difficult to find, or being constantly 'referred' from one agency to the next. For some, having multiple helpers was stressful in itself, as it meant they had to manage relationships with different agencies at a time they felt least able to do so.

I went back to see the [mental health charity] advocate there and I think it was just about the eight weeks time limit, I went back to see her and she said well, we can't see you anymore but I'll follow-up this one thing.
[Int19, female, assault, theft from person, threats and harassment]

I complain to the council, they said "we're not the police". I complain to the legal service commission, why isn't this investigated, "we're no barristers". [...] So it's not me, it's them, it's not them, it's them.
[Int49, male, assault, theft from person, threats and harassment and partner violence]

It becomes quite overwhelming for me to kind of juggle all these different agencies who are trying to get [me] out of this difficult situation.
[Int38, male, burglary]

Some participants had problems getting hold of services. They described not being able to get through on the phone, calls not being returned, or not getting an appointment. There were very practical barriers too, for example, one participant described being raped in a psychiatric ward and could not call for help as the ward phone was out of order.

The resource constraints of the participants themselves were also a barrier which is unsurprising as people with mental health problems are more likely to be living on low incomes.⁶⁷ Participants described not being able to afford phone calls and travelling, let alone paying for private services such as counselling.

Well, I went to them. I told them that my benefit money had been stolen the day before. And they said, "Well, all we can do is offer you a crisis loan" They gave me a number which I tried and I couldn't get through. And actually as a person with a history of mental health issues to be left on hold for half an hour, with this awful music playing I actually started to feel mentally unbalanced and that was actually very traumatic to think what am I going to do for money.
[Int2, female, theft from person and sexual violence]

Poor responses by individuals in services

Poor responses from services acted as a barrier to attaining support. Some participants found it hard to disclose what had happened, and described staff not picking up that something was wrong despite visible injuries or behavioural clues.

My GP asked me, "What brings you here?" I couldn't talk about it. I didn't know where to start. And you know,

should I have said oh, "I want to kill myself I've been having problems and I've been feeling very depressed and as a result I feel like killing myself." [...], I wanted him to say, "sometimes stress can cause this. Have you been maybe stressed at work or in your personal life?". That would have helped me. But he didn't. And gave me a prescription for this stomach problem and then I left.
[Int42, female, antisocial behaviour]

For those who did talk about what happened, some described not being believed, being blamed, not being acknowledged and not being listened to, which led to a lack of help or referring on to other services. Although this applied to all services, a fifth of participants talked specifically about mental health professionals, including all nine participants who experienced crime in a psychiatric facility.

My psychiatrist didn't want to hear about [being raped in the psychiatric ward]. He said, "Well, let's not talk about that." But then something happened to another person on the ward and then they started to think oh, maybe, I don't know maybe he thought he should take it more seriously after that.
[Int2, female, theft from person and sexual violence]

Most of the time they treat me like a child [...] they put a lot of blame on me for not being safe.
[Int44, female, theft from person, sexual violence, threats and harassment]

Others described mental health professionals saying they didn't need more support, and minimising their needs.

He said "I don't think you'll meet the criteria for a refuge." [...] I do because I've been there before. [...] I've asked him more than once to help me with mental health supported housing but he says "well, you don't really want to go on benefits, so you'd probably have to rely on benefits if you were there."
[Int73, female, sexual violence and domestic violence]

The impact of crime as a barrier, or emotional and mental health

Section 3.4 explores the impact of the crime, and it is clear that its negative impact on emotional and mental health is a considerable barrier to seeking help. Participants described feelings of shame, the overwhelming practical and emotional obstacles they faced, not feeling strong enough or not wanting to relive the event, as preventing them from seeking or taking up help.

Several female participants talked about how feelings of shame or embarrassment prevented them from telling friends or family they had been a victim of crime.

I felt so ashamed about it that I felt like I shouldn't have got in that situation in the first place and I was worried that especially my dad would have been angry with me for getting in that situation.
[Int83, female, sexual violence and partner violence]

For some, the impact of the crime had such enormous consequences for their lives that they could not find the time or emotional energy to ask for support and help, or it left them unable to think about what to do.

Victim Support did contact me following the break-in [...]. And they sent me some good information. [...] But the scale of the other problems is so great that dealing with that side of things which is sort of almost under control, the break-in thing, I haven't then followed it up with what Victim Support has said.
[Int38, male, burglary]

Case study 1: spiral of mental health and victimisation

This case shows the negative spiral of low self esteem, depression, risk-taking behaviours and victimisation.

[I was] always going out by myself, getting drunk by myself. [...] Because I felt really alone. [...] I saw my ex, the guy I was with who thought I'd cheated on him, by being raped. [...] And just seeing him, hit me like a ton of bricks [...] And what do I do when I deal with, when I have negative emotions, I go and get drunk, and I went to a fish and chip shop the people working there said something like "Oh, we've got some weed in the back, do you want some?" I really wanted to just obliterate my mind so I said yes. And agreed to go to the back and [...] the next thing I know, I have men having sex with me in turn and I don't remember how I got there, I don't remember saying yes. [...] I don't remember if protection was used. At that time I didn't really care. [...] I felt like people weren't taking me seriously with my depression because it was invisible so I had set out to try and catch AIDS. [...] I figured that if I had this terminal condition that everyone is scared of then, and is really serious, then people will take my suffering seriously.
[Int59, female, sexual violence]

I was going to complain to the health service about it. And I still am. I just don't have the strength to do it.
[Int54, male, assault]

A victim of domestic violence who was extremely distressed while waiting to hear if she was going to be moved to improve her safety, felt unable to take up an offer of counselling because too much else in her life was in flux.

Yeah. I mean it's not something I want to do just yet because at the minute I'm going through this, I want to wait until I'm settled and I know what's going on and then I can deal with everything I've been through altogether rather than dealing with a little bit, then going through more, you know, with the move and all that. I'd rather wait until after [perpetrator's] release, when I'm settled and I've got my whole new routine going.
[Int34, female, partner violence]

A few participants did not seek help as they felt it was too painful to talk about what had happened, and were worried it might be re-traumatising to do so.

For some reason I'm scared that talking about it is going to trigger a relapse. And I really, really don't want to have a relapse because everything is looking up for me.
[Int59, female, sexual violence]

Mental health problems as a barrier

Participants described how their mental health problems were a barrier to seeking help, often at the time when they needed it most. They described symptoms such as low self-worth, having mental health crises, increased depression, paranoia and episodes of disordered thinking which were often triggered or intensified by the victimisation experience.

Some participants described feelings of low self-worth which resulted in them not wanting to trouble other people with their problems, feeling they did not deserve help, or blaming themselves for not being able to resolve the situation themselves or placing themselves at risk of further victimisation.

Perhaps the time when I realise everything is going wrong is when I shut down and I stop going to the places or doing activities or seeing my community team. And [laughs] normally when that happens it's gone past the point of being able to ask for the help then. Because I find that for me other people are worth it more than me.
[Int32, female, sexual violence, threats and harassment]

Some participants explained how the seriousness or worsening of their mental health problem as a consequence of the crime, prevented them from seeking or attaining help. Thus, some participants described turning down offers of help or not being able to engage with support or ask for help at times when they were most in need.

And that's the hardest part because that's when you need to be able to ask for help but you're unable to do so. So how can you make sure you're safe when you're in a crisis?
[Int32, female, sexual violence, threats and harassment]

A few participants also spoke about the cumulative impact of having many experiences of victimisation over their lifetime, combined with deteriorating mental health acting as a barrier to seeking or attaining help.

Feelings of paranoia prevented one participant from being able to utilise the support of a volunteer personal assistant that her mental health team had organised for her.

I refused to come out of my house when I started really deteriorating and I wouldn't go outside [...] I wouldn't even go out to buy food. I had a volunteer that used to come and sit with me every day. And try and force me out to go and do a little bit of shopping, go to a café with her [...] then I started getting paranoid about her. [laughs]
[Int6, female, assault, threats and harassment]

Having disordered thinking can be a symptom of some mental health problems, where people have delusions and hallucinations which can be very distressing, and can relate to previous victimisation incidents. These symptoms are a barrier to seeking help, and were clearly a problem for at least two participants. The professionals interviewed highlighted this as a serious barrier for them in helping people. (See section 3.9)

3.8.3 | Positive experiences of seeking help

Four out of five participants described having a positive experience of seeking help; this related to both the type of help and manner in which it was provided.

The way the support was provided

The nature and quality of participants' interactions with help providers was crucial, and they valued services that listened and responded to what they wanted, and treated them as individuals with unique needs.

They valued:

- empathy
- validation
- responsiveness
- individual and respectful treatment
- professionals with knowledge and expertise.

Empathy

An empathetic response was one of care, concern or sympathy for the participant and what they'd experienced, and one of listening and showing an understanding of the effect it had on them. Some participants received empathetic responses from friends or family, and a number from professionals.

[CPN] listened and talked and tried to look at how I could take things forward. Talking about the [mental health organisation], perhaps how I've coped previously when I've been down.

[Int32, female, sexual violence, threats and harassment]

Validation

Validation is about acknowledging, accepting, believing or confirming another person's experience and their emotional reaction to it. Being validated seemed to be very important to participants which is not surprising given that so many reported not believed or taken seriously.

They were really shocked and disgusted really that he'd done this, you know. Especially because my friend is male, that he'd never do something like that and he can't understand how someone could.

[Int83, female, sexual violence and partner violence]

She said "what you did was perfectly reasonable, [...] and I probably would have done the same." So that helped me a lot. And she wouldn't just say it either, she's very truthful with me. So it's that validation.

[Int76, female, assault, threats and harassment]

Responsiveness

Participants spoke positively about services that took steps to investigate or resolve issues or that offered them support to deal with the aftermath of victimisation.

Well, they [support staff] did do something about it to tell the truth. They had a word with him and they told him to stop asking me for things.

[Int24, male, assault, threats and harassment]

Individual and respectful treatment

Being treated as an individual with unique needs, perspectives and experiences was important to some participants. The ways that services demonstrated this included asking people what help they wanted, respecting their opinions and needs, respecting and supporting the course of action they wanted to take.

Well, they [mental health charity] treat you like a human being for a start. You know, they take what you're saying with consideration.

[Int64, male, antisocial behaviour and assault]

Participants praised services that tailored the support they provided to their needs, and who were responsive to fluctuating needs. Good relationships with professionals were nurtured by regular contact and communication.

I have met up with my caseworker kind of on an average every couple of week, and when, if we have a particularly difficult meeting, she actually rings me up a few days later to check I'm ok, and because I've ended up homeless they have actually helped me with supporting letters for things.

[Int1, female, sexual violence and theft from person]

Participants valued having a dedicated member of staff, and continuity, as it meant they became knowledgeable about the participant's needs and situation and developed trust.

I had a fantastic key worker at [mental health charity] for about a year and a half. She was great, and she eventually handed me over to another key worker, but she kept in contact with me. I could always see her if I had a particular pressing need, to talk to her. [...] She worked with me quite intensively. So when I was particularly unwell she would see me maybe two, three, even four times a week and phone support. I think she understood the nature of the crises, that if you give a person the help at the crisis, the crisis will be shorter and then they'll need less help as time goes on, which is what happened to me.

[Int2, female, theft from person and sexual violence]

Professionals with knowledge and expertise

Some participants appreciated professionals with specific knowledge or expertise about mental health problems and/or the nature and impact of victimisation. This meant they were understanding about the effects of the crime, and were aware of the sorts of things

they could do to help. In some cases this helped the participant to identify that what they had experienced was a crime.

I went to a domestic violence group for advice. And they said to me what he'd done was, he groomed you, that week of the text messages of him being so nice to you, [...] he was a predator, he had it all planned out before he'd even done it.

[Int83, female, sexual violence and partner violence]

The type of support provided and appreciated

Participants welcomed:

- emotional support
- practical help
- advice
- referral or signposting to other sources of help

Emotional support

A quarter of participants valued emotional support from informal sources and services alike. Emotional support was described as having someone to talk to who would listen to their experiences and be attentive to their emotional needs.

It was very supportive. Both staff and the other service members. Very supportive. [...] let me talk about it, get it off me chest, and just supporting me.

[Int10, male, assault and theft from person]

Gaining emotional support could help participants to process what they had been through and provided comfort and reassurance.

Well, I've told quite a few friends about it actually. Because I needed to talk about it. I needed to process it in my mind. And to get it all out.

[Int83, female, sexual violence and partner violence]

Practical help

Over half the sample talked positively about receiving practical help from services and informal sources. The types of practical help participants received included advocacy, help with childcare, accommodation, financial assistance, and support with safety.

Professionals advocated on behalf of participants to obtain help from services. Several participants described professionals writing letters of support which verified their experience and its impact on their lives. This type of help was provided mainly by health or mental health

professionals, or by voluntary and community services that were already supporting the participant.

[domestic violence service] got involved, did their thing, gave me a letter, which I took to [housing association] they put me in a B&B.

[Int46, male, partner violence]

Professionals also helped to write letters of complaint when participants felt they had not been treated correctly by other services.

A few participants described receiving help with childcare and accommodation from family and friends, particularly in cases of domestic violence. Some services also offered help with accommodation when they were unsafe in their own homes, or had been made homeless as a consequence of the crime.

[housing officer] was brilliant. She was good with me [...] you know, because of what happened and everything then she ring me every week. [...] When I got refused, I was like "They've not accepted me in [borough], what do I do? What do I do now?" She said "Hang on, calm down, think of another borough. I will see if I can get you the number for that borough you're going to approach."

[Int25, female, assault]

A few participants were provided with financial help in the aftermath of crime. This was largely from friends and family, although a few were supported with grants from voluntary and community services.

In the end I was getting so desperate because he was being so intrusive and stuff, obviously I knew it was him that put the video there, that I got some money from a grant from the Citizen's Advice Bureau to put up a high fence.

[Int61, female, partner violence, antisocial behaviour, threats and harassment]

A quarter of participants received help with safety. This included: being assisted to secure their homes by having locks or alarms fitted and damage repaired; receiving advice on safety planning; and being supported by measures to prevent the perpetrator from accessing them. This sort of help was provided by housing services, Victim Support and mental health services.

I got on to the housing association straight away, they sent somebody round to change the locks, they done the locks and everything on my door.

[Int57, female, theft from person]

The CPN was quite helpful, he said you see him again, if he's nearby you again just dial 999. He said let the police come and do whatever they need to do. He said don't get yourself involved. Don't do anything silly as well, you know, don't take any chances, just stay away and just dial.

[Int60, male, threats and harassment]

Advice

A number of participants spoke about receiving helpful advice about their rights and the options available to them; how to deal with the perpetrator of the crime(s); how to keep safe; what support they needed and how to access it; and the standards of the service they should be receiving.

It's a charity that helps, like an advocacy service. They helped me a little bit. [...] They helped direct me in the right way to what to do next.

[Int48, male, sexual violence, threats and harassment]

They [local mental health charity] told me, about going to the council, you know, what the council should be doing for me. What the police should be doing for me.

[Int65, female, sexual violence and antisocial behaviour]

Referral or signposting to other sources of help

As discussed already in section 3.6.1 the influence of others was a crucial factor in helping participants to report to the police. Similarly, almost half the sample described being supported by others to access sources of help. Voluntary and community services were most often cited as doing this, but friends, mental health services, housing services and health services were also mentioned. This involved the help provider signposting the participant, or liaising directly with another service on their behalf. Some professionals accompanied participants to meet with the new service.

She [psychologist at specialist clinic], she said that I could report to BACP (British Association for Counselling and Psychotherapy) and she also gave me a number of solicitors.

[Int73, female, sexual violence and domestic violence]

And then [staff member at mental health charity] went over to speak to the manager of Victim Support and she came over to the office and chatted with me.

[Int32, female, sexual violence, threats and harassment]

3.8.4 | Negative experiences of seeking help

Half of the participants described negative experiences of seeking help and they were more likely to be with

services than from friends and family. As with the positive experiences above, they fall into two broad categories: individual responses and problems with services.

Individual responses

This describes the nature and quality of the interaction between the victim and the help provider. Just over a third of participants spoke about receiving a poor individual response from a service or individual they went to. Participants highlighted the following as poor individual responses:

- lack of empathy
- invalidation of the victim's experience
- blaming the victim
- prejudiced attitudes

Lack of empathy

Almost a quarter of participants described receiving a response which lacked empathy. Professionals at services in particular were described as showing a lack of care, compassion, concern or understanding towards participants and their experiences. Some even described professionals as being cruel or unkind.

It was just a nightmare. They wanted me to sleep in the same room that the incident [rape] happened in [...] so I ended up sleeping in the corridor that night, on the floor. And then, the next day I actually ran away from the hospital. [...] I went to the police station, gave two statements. And then I was taken back to [hospital] about two days later. I was kind of voluntary there but then they put me under a section.

[Int2, female, theft from person and sexual violence]

I said to my support worker that the CCTV would stop that. And he said that the police have got better things to do than spend £700 for CCTV for you.

[Int9, male, theft from person]

A few participants also reported receiving responses from friends or partners that lacked empathy and understanding.

They [friends] just told me to keep away from [perpetrator]. [I would have liked them] to be more supportive, to say "is there anything we can do to help you get over this? Do you want us to come shopping with you?" Things like that. [...] It wasn't because they didn't care. I don't think they even thought about it, because they haven't got mental health problems.

[Int53, female, antisocial behaviour, threats and harassment]



Invalidation of the victim's experience

Invalidating responses were those that rejected, ignored, disbelieved, undermined or judged the participant's experience and their emotional reaction to it. This could happen in a direct manner, where victims were simply not believed. A number of participants said they thought they were not believed because they had a mental health problem and could therefore be easily discredited.

[The care coordinator] didn't believe me. [...] He said, "I've worked there 16 years, I go there two or three times a week, and I've never seen anything like that."
[Int54, male, assault]

[The out of hours GP] said "Has that actually happened or is it just psychosis that she's imagined it". My mum, was like "Don't you dare say that", you know.
[Int71, female, sexual violence and burglary]

Participants also described indirect ways that their experiences were invalidated. This included having their experiences trivialised; being discouraged from taking action; not having their emotional response acknowledged, or it being minimised; suggestions that their emotional responses were disproportionate or pathological; and being told to move on. Participants described receiving these sorts of responses from services and, to a lesser extent, from friends, family and partners.

And she [therapist] said "it's a cognitive distortion", thinking that people are always going to hurt me and stuff. That's kind of her response. [...] Just makes you feel like your experience is not valid. [...] I just kept saying "look, you know, you can say that this is me being mental and

I appreciate that I need to be reasonable but these things keep happening, that is a fact." It's very difficult to think, you know, to feel like you're safe when experience keeps proving the opposite.
[Int74, male, sexual violence]

Blaming the victim

Some participants said they were blamed or held responsible for being a victim of crime. Direct blaming included suggesting that it was the victim's fault; that they provoked the perpetrator; that they played a role in escalating the situation; or that the victim put themselves in an unsafe situation. This type of response was experienced both with informal networks and across all types of services except from the voluntary sector.

[Counsellor] had said to me "Well, you must be saying or doing something to set her off." I stopped seeing her after that. It made me feel as though it was me, as though it was something I was doing.
[Int66, female, antisocial behaviour]

More indirect ways of blaming were also reported by a few participants and this commonly involved the victim being told that they should change their behaviour in response to the crime. Participants sometimes received this sort of response from friends, family or partners as well as services.

I was determined not to stop going [because of incident]. Some people were saying, 'No, you shouldn't go out late at night'. Which I think no, I have to have my freedom, you know. [...] It was, it was well meaning, definitely, but it felt very patronising [...]
[Int10, male, assault and theft from person]

Prejudiced attitudes

Some participants explicitly attributed these poor responses to prejudiced attitudes towards people with mental health problems, and this was felt strongly by those victimised in psychiatric facilities.

I learned if you have mental health issues, if you don't call through the people like Mind or social worker or support worker you're not being taken seriously by any kind of organisation, government organisation or any office. You're not being taken seriously at all.
[Int50, male, assault, threats and harassment]

Some participants also said they encountered prejudice from services based on other identity attributes including gender, race, religion and socio-economic status.

Problems with services

Many of the problems encountered in seeking help were to do with problems of the services themselves. The main issues raised by participants were:

- inadequate help provided
- inappropriate help provided
- disempowering or punitive responses
- lack of responsiveness of services
- complex cases and a lack of effective multi-agency working

Inadequate help provided

A quarter of participants described receiving what they perceived as poor quality or inadequate help from services and they often described experiencing multiple forms of support.

Examples of inadequate help included:

- not being provided with or offered the support they considered they needed
- only being provided with help in one area of need when they had multiple needs
- the inadequate expertise of the organisation/staff
- not being provided with follow-up support
- not being referred to other sources of help
- services not taking responsibility for what was happening to the participant, and signposting them rapidly to other services.

[The] mental health services still haven't put anything in place. They've got a social worker who's quite happy to say she'll take me swimming every Wednesday. And I've

told her I don't care about swimming. The issue is my safety and security.

[Int63, female, antisocial behaviour, threats and harassment and family violence]

The housing association just said basically what we know anyway. Make sure the windows are shut, the doors are locked, that sort of thing. We have a housing support worker [laughs] I thought that would be their role to support and make sure we're alright. "I'll inform the team". I'm like "is that it? You're going to inform the team?"
[Int75, female, sexual violence, burglary and antisocial behaviour]

Inappropriate help provided

A number of participants felt they were provided with help that was not appropriate for their specific needs, for example being examined by a male doctor after being raped, or a mother being offered to be relocated with her children away from her support networks, rather than the perpetrator being moved.

Disempowering or punitive responses

Some participants reported that the responses they received from services when they sought help were punitive or disempowering. These responses included being evicted after complaining about other people's antisocial behaviour, being sectioned after running away from being raped on a psychiatric ward, and being threatened to have their children taken into care. These responses had been very distressing for the participants and they described this as worsened by poor communication and a lack of information from services as to why they were taking the actions they were.

Because I was on, a rolling yearly contract. When the contract came up they [housing association] gave me notice to leave, instead of trying to resolve that situation [...]. It was the most awful feeling. They clearly don't want to protect you, and they clearly are dismissive and treat you as a second class citizen.

[Int63, female, antisocial behaviour, threats and harassment and family violence]

Lack of responsiveness of services

A third of participants described services either ignoring them, showing reluctance to get involved, being slow to respond, not providing any support or not taking action. This was particularly from mental health and housing services, although primary care services and voluntary and community services were mentioned too.

Case study 2: complex cases – lack of coordination

Participant 49 was experiencing harassment, death threats and physical violence from his landlord. He had lost his job a few months earlier, had recently had his benefits stopped, and was living in unsuitable emergency accommodation whilst trying to support a partner with alcohol problems, and to deal with his own physical and mental health problems. Consequently his mental health was deteriorating and he attempted suicide.

He had approached different services to try and attain help, but encountered reluctance from them to get involved and was quickly passed on to others. He described his GP as being supportive by maintaining contact with him and referring him to other services, however when other services did not offer support and the participant became increasingly distressed, and the GP did not know what else to do aside from prescribing him with medication.

He had multiple interactions with a range of statutory services including health, mental health, social care, housing, welfare and criminal justice services. He had also been in contact with some local voluntary and community sector services and also tried to contact his MP. He described these services as working in isolation from one another, deflecting responsibility and ultimately leaving him without the support he needed. His attempted suicide illustrates just how distressed and desperate he had become.

So I had to go to my GP and I was in the middle of my prescription, I told her the story. She didn't say anything. I said, "Have you got anything to say about that?" Her reply was, "So I guess I need to fill out your prescription then".

[Int54, male, assault]

I would like the housing association to investigate as to why the problems with the first neighbour were allowed to carry on. And [why] no support was given to me. It's been proven in court that I've been a victim of noise nuisance. And even then they haven't done anything about it. [...] The housing association can [do something] because they have the tenancy agreement with those people. Yet they haven't done anything.

[Int43, female, assault and antisocial behaviour]

Complex cases and a lack of effective multi-agency working

In some cases participants described the victimisation experience and its effects on themselves as very complex, and requiring several different agencies to be involved. For example, with long-term and enduring types of crime, such as antisocial behaviour or domestic violence, the complex dynamics between the victim and offender and the difficulty gaining evidence could make it challenging to resolve. Added to this, some participants were facing other serious difficulties in their lives.

It was evident from participants' descriptions that individuals in single agencies found it difficult to fully understand the situation or what other agencies were

doing to help address it. They described the lack of interaction between professionals in multiple agencies as having direct negative consequences for them (see Case study 2). Such complex cases required a joined-up approach to support from a variety of services, but there were very few examples where this happened effectively and more commonly participants reported going from one service to the next, being unable to gain the help they needed.

Impact of negative experiences of help seeking

The impact of receiving a poor response to help seeking was substantial for many participants and could exacerbate the distress they were experiencing as a consequence of being a victim of crime. Participants described being emotionally affected including feeling frustrated, disappointed, ashamed, stressed and isolated.

I'm feeling like how anyone would feel, let alone someone who's just had to, you know, 10 years of hell or more already, I was completely flummoxed [at lack of response from housing worker] and just went back to bed for the day.

[Int64, male, antisocial behaviour and assault]

So you're just being thrown out to the wolves out there.

[Int49, male, assault, theft from person, threats and harassment and partner violence]

In many cases receiving a poor response meant the participant did not get the help they needed, either because the service denied them the help or because the victim was dissuaded from engaging with that service or seeking help elsewhere.

3.9 | Professionals' perspectives

As part of this research we gained the perspectives of professionals. We conducted focus groups with approximately 30 frontline staff who work with victims of crime who experience mental health problems; police officers, mental health care coordinators, Victim Support and Mind staff. We also gained feedback from 22 police spokespeople who specialised in mental health, through a survey.

These focus groups provided the opportunity to share emerging findings and to hear their experiences of working with victims with mental health problems, including the challenges they face, as well as examples of good practice.

3.9.1 | Understanding of victimisation

Professionals agreed that people with mental health problems are at greater risk of victimisation including in mental health facilities. Isolation, loneliness and social exclusion were identified as factors contributing to their vulnerability, and they are often targeted by people they know.

I think it's very hard as well for service users who are experiencing being victims of crime from known associates because in a way there isn't that separation of other, you know 'I've walked down the street and somebody's nicked my wallet, I don't even know that person, I can hate them, I can feel annoyed, I can feel sorry for myself' [...]. But I guess if it's somebody in their family unit or their extended family or social circle then they can't quite recognise it or see it as the potential crime that it is because its so enmeshed in fulfilling other social aspects and needs.
[Mind professional]

They also highlighted that victimisation can have a very serious impact on an individual with mental health problems and it sometimes triggers crisis or admission into inpatient facilities.

It's a lot of stress on our clients you know and they find stress really difficult to deal with and cope with and that [victimisation] tends to be a trigger for a relapse of illness for many of our clients.
[Care coordinator, community mental health team]

3.9.2 | Challenges faced by victims

Experiencing disbelief

Professionals also felt that victims with mental health problems face disbelief when they report being

victimised to services or the police. This disbelief often derives from prejudice towards, and misunderstanding of, people with mental health problems.

I think this has got to be a training issue here for the police, that they really don't understand it and have stigma about mental health problems and are immediately inclined to look at whether that person really is a victim or is inventing it. One of my clients said with great perception "Just because I'm delusional doesn't mean it didn't happen." And that's what people are up against a lot of the time.
[Mind professional]

Difficulty engaging with police

Professionals said it can be difficult for victims with mental health problems to engage with the police. They talked about victims having low self-esteem or being too embarrassed to report, not understanding the process or knowing their rights, fearing they will be blamed, finding it challenging giving evidence, or not disclosing that they have a mental health problem for fear of discrimination or being disbelieved.

I think sometimes people are very proud and they are ashamed to say that they are being exploited and that's certainly the case with one of my clients where he was quite embarrassed and ashamed that this had happened and couldn't share it with anyone.
[Care coordinator, community mental health team]

The police officers themselves were aware of how difficult it might be for a victim with mental health problems to come to them for help, particularly if they've had a previous negative experience with the police such as being sectioned.

A lot of the people that I've dealt with as victims who have mental health problems have very often said "I've been living with this for 18 months, I didn't know what to do." They didn't know to pick up the phone and dial 999, they didn't know that that person who's walking along in the fluorescent jacket they could just stop and speak to. You're [police officers] seen as these scary individuals sometimes who are part of a world that perhaps they won't be accepted in, or they won't be treated in the way they'd like to be.
[Police officer]

Difficulty engaging with the court process

Professionals agreed that the court process is very intimidating for victims with mental health problems and a number of examples were given where victims



decided to drop the case rather than have to attend court, or where the victim was so severely affected by participating in the court process that they went into crisis.

The court process is difficult enough for anybody, or the vast majority of people, and to go to Crown Court to give evidence when you have never gone there before | in your life is a traumatic experience. But to go there as a victim of crime with a mental health need is exceptionally difficult.

[Mind professional]

Some professionals also suggested that the CPS could be reluctant to take forward cases where the victim had mental health problems because they were perceived to be unreliable witnesses.

What the CPS are looking for is the prospect of conviction. They are looking for reliable witnesses and people with mental health difficulties are sometimes categorised as not being that reliable.

[Police officer]

Difficulties accessing help

Professionals reported that it could be difficult for victims with mental health problems to access the help they needed either because the services were not available or because they were unwilling or unable to provide them with support. This was set in the current economic context of many cuts being made to local services, which means they are under pressure to deliver more with less resource. They reported that victims

could be passed from one service to the next with no one agency willing to take responsibility for supporting them, and how this could worsen the distress the victim was already experiencing.

There's no services out there for a lot of people and we may have people come back and there is nothing that we can offer them and, you know, it's really frustrating and worrying because you see people in such distress.

[Victim Support professional]

Lack of effective multi-agency working

This was raised by most professionals who felt that other services were often reluctant to get involved, make decisions or take responsibility for situations involving vulnerable people, and consequently it could be difficult to find solutions. Different working practices and organisational cultures, as well as a lack of understanding between different services about job roles and responsibilities and poor systems for information sharing, contributed to this. Even when services did come together it was reported that it could be hard to get agreement for concrete actions.

I think if multi-agency teams are involved in somebody's care then as long as somebody is nominated to take the lead and be the chair person to coordinate it all then it can be really effective from my experience. But more often than not in my experience there hasn't been that nominated lead because the more there are of you around the table often I think people can feel "Oh somebody else will do that."

[Mind professional]

3.9.3 | Challenges faced by professionals

Lack of training and information about mental health problems

Both the police officers and Victim Support professionals said they did not feel adequately trained and equipped to support victims of crime with mental health problems. They were concerned about doing the wrong thing and exacerbating any distress the victim was feeling. There was particular concern among Victim Support professionals about how best to support those who were experiencing disordered thinking, delusions or hallucinations. The police officers said that the compulsory online training module on mental health awareness was insufficient and that they needed more comprehensive training.

I just don't think that we're very well educated in mental health and it's just a huge, huge area.

[Police officer]

It's very difficult and the one-day mental health training that the volunteers do, it does not equip them to deal with that. And it is very difficult for us to know [how] to support this person without maybe saying something that is not appropriate because we don't know how it's going to be taken.

[Victim Support professional]

Difficulties engaging people

Some professionals said they experienced engagement and cooperation difficulties when they tried to support victims with mental health problems, for example having clients they could not get hold of for periods of time or who often missed appointments. Other challenges included victims having unrealistic expectations about what a service could provide, being unable to move on from their victimisation experience or not providing the professional with the full information about their case or underplaying their mental health problems.

It can be hard to get them [victim] to where they need to be because they don't always work with you.

[Victim Support professional]

Difficulties supporting complex cases

There was recognition from professionals that some victims with mental health problems were facing multiple difficulties aside from their victimisation experience, which meant their lives were complex and chaotic and which affected their ability to engage with services. The police and Mind professionals said

it could be particularly difficult to support victims in psychiatric wards as staff could prevent access, and care coordinators suggested there was a need to act more quickly when crime or abuse was reported on wards.

The only thing that I find sometimes when we go to the facility is that it's almost as if the staff have made up their mind before we get there that there isn't anything that we can do. So it will be "Well we are reporting this so you can make a record of it" but very often they don't even want us to speak to the person involved. Yet when you do they're more than capable of giving you an account and making a decision about whether or not they want to make a complaint. But sometimes that right is almost taken away from them.

[Police officer]

3.9.4 | Good practice examples

Positive experiences of working with the police

Both the Mind professionals and the care coordinators gave examples of positive experiences of working with the police. This included having a named mental health liaison officer they could work with at the local police station; the police adapting the way they work to meet the needs of the victim, for example visiting them at home to take a statement; the police taking reports of crime seriously and providing safety advice; police officers attending local Mind events to meet with service users and hear their concerns; and Mind staff providing mental health training to police officers.

I've been down to the police station several times with one particular client [...]. She came and told me that she was threatened with a gun [...]. It was believable and the client was a drug user and she said it was a fellow drug user so I had to take her seriously. I went down to the police station with her for her to make a statement and they did take her seriously and they gave her advice as to what to do.

[Care coordinator, mental health team]

Good practice from the police

The police officers described examples where they had provided good support to victims with mental health problems. This included linking up with other services involved in their care to try to encourage a multi-agency approach; spending time building a rapport with the victim in order to build up mutual trust and understanding; putting in place protective measures to try to enable a victim to go to court; and contacting a mental health professional to gain information about

a mental health problem experienced by a victim they were working with so they could tailor the support to their needs.

The spectrum of conditions that comes under mental health is massive and sometimes before I even go and see a victim I'm having to make calls to social care or to a GP saying "Tell me about this person? Tell me about what condition they have? How am I best to talk to them? If I go there in uniform is that gonna be a problem? If I ask them a question in that way is that gonna make a barrier?"

[Police officer]

Two of the police officers attending the focus group were located in the psychiatric unit of the local hospital. This meant they were very accessible to the patients and they described developing initiatives to try and build positive relationships. This included running regular 'cuppa with a copper' surgeries which provided patients with the opportunity to share any concerns.

When they [people with mental health problems] actually see us [police officers] daily they actually drop the barrier a little bit and I run once a month what they call a 'cuppa with a copper' which is a bit like a beat surgery on the ward, and there anybody from off the ward, whether they're on a section, involuntary, voluntary or whatever, outpatients, they can all access part of the police service in the involvement centre where there's a café and they can speak on a one-to-one.

[Police officer]

Police officers also highlighted some new initiatives being developed to try to improve the way they work with people with mental health problems. This included new recruits having a full day's training at the local psychiatric unit in collaboration with mental health professionals, and also piloting a triage service with a police officer and an approved mental health practitioner who work together to support individuals with mental health problems.

Providing good support to victims

Both care coordinators and Mind staff recognised that they could play an active role in supporting victims with mental health problems to engage with the police. They gave examples of occasions when they had accompanied victims to the police station, been present when they provided evidence and followed up on their case for them when they did not feel able to.

Care coordinators felt that their own system of safeguarding was good and enabled them to easily mark up on their computer system when a risk event occurred, enabling them to effectively monitor clients and identify trends in re-victimisation. There was a feeling that the safeguarding system had improved over the past two years. Most care coordinators said they felt confident that a service user would disclose to them if they had been victimised or that they would be able to identify changes in the behaviour.

We are working with them as individuals, so we tend to know our clients so we tend to look out for when things have changed. If I went and saw a client and saw certain differences then I would definitely probe them and ask those questions and you hope that the client is going to open up to you and tell you about. That is the only way we are going to be able to support them.

[Care coordinator, community mental health team]

Mind professionals said their organisations had clear safeguarding procedures which were followed if victimisation was disclosed by a service user. As well as providing help in the immediate aftermath of crime, the members of this focus group talked about things they could do to help the victim in the longer-term that aimed to try to prevent re-victimisation. This included safety planning activities, building self-esteem and helping them connect with social networks and systems so they could become less isolated and vulnerable.

[We do] things that might work on building self-esteem so service users stop thinking of themselves as victims and start learning ways of looking at themselves as being fully integrated and being worth more [...]. A lot of the recovery work I do with my clients is around that.

[Mind professional]

Victim Support staff described their approach to supporting victims with mental health problems as non-judgemental, emphasising the importance of listening to their experiences, acknowledging the distress the experience had caused them, and showing empathy.

We listen, we let them talk, we give helpful suggestions around feeling safer.

[Victim Support professional]



4 | Conclusion

This research paints a stark picture of the risks of victimisation to people with mental health problems in the community, and the barriers they face in getting the support and help they need. It clearly demonstrates that having a mental health problem alone increases the risk of crime by three-fold for any crime, and to ten-fold (for women of assault). Victimisation among this group is extremely high with nearly half in our survey having experienced some type of crime in the past year and experiences of domestic and sexual violence being alarmingly high. Contrary to popular perceptions, people with mental health problems are more likely to be victims of crime than perpetrators and they are most likely to be victimised by someone they know. They are experiencing ongoing victimisation too – are more likely to be repeatedly victimised, and to experience a range of different crimes. This study also worryingly highlighted that they are at risk of victimisation in psychiatric facilities, places which should offer care and safety during times of crisis.

People with mental health problems are at a high risk of victimisation, and the impact is substantial.

This research does not definitively explain why they are so much more at risk than people without mental health problems and we need further research exploring the motivation of perpetrators to gain a greater understanding. The reason for any crime happening to any particular individual is going to be driven by a complex range of factors. Participants' own, and professionals', assessments of why they are more at risk indicate a range of reasons: that they were targeted and deliberately exploited as they were known to be vulnerable especially when they were unwell; that they were often in dangerous environments; that their symptoms reduced their ability to protect themselves; and that their victimisation was motivated by hatred and hostility against people with mental health problems.

This report also identifies that – as with people without mental health problems – drug use and having a history of violence makes people more at risk. What is different for our participants is that, as they are all being supported by mental health services, the better they engage with these services, the less likely they are to be victimised. This relationship needs to be explored further but does suggest there is a key role for professionals to play in helping to protect against victimisation.

Not only are people with mental health problems at a high risk of victimisation, but the impact of crime is substantial and greater than for those without mental health problems. The impacts were wide ranging and devastating for some individuals: an alarming number of people described attempting suicide directly as a result of the incident. They described emotional, physical, mental health impacts as well as impacts on their relationships, on their behaviour and practical problems such as financial and housing problems. Unsurprisingly the impact on their mental health, and their ability to recover, was great.

Victims with mental health problems face considerable barriers to getting help, especially accessing the criminal justice system. Less than half reported to the police, and although this is similar to those without mental health problems, given their enhanced need for support and the fact that they are likely to be a victim of crime multiple times, it is vital to address these barriers. A third of victims did not disclose their experiences to health professionals either. People with mental health problems were fearful of not being believed, of being dismissed or being sectioned by the police, or just not feeling strong enough to approach the police or tell others about their experience.

Where victims did report to the police, they reported a much less satisfactory experience than the general public: some described having been disbelieved, blamed, not being seen as credible, and facing a lack of understanding and sensitivity to their mental health problem. These attitudes often led to a lack of action,

cases being dropped, and poor communication. For those cases that went to court, they described the stress of being cross examined, the impact of seeing the perpetrator again, finding it hard to give evidence coherently and having their mental health history used against them. These negative experiences often prevented them from reporting crime in the future and acted as real barriers to gaining assistance from the criminal justice system.

People with mental health problems have higher support needs after experiencing a crime.

People with mental health problems have higher support needs after experiencing a crime, and their issues are often complex, requiring support from a range of agencies. Getting support from key agencies, such as housing, health, social care and voluntary organisations was also problematic. Barriers included fearing the response they might receive, barriers created by the perpetrator, the impact of the crime on them and their mental health problem, and problems with services, such as services being reduced in a time of financial and structural upheaval. A lack of effective multi-agency working was highlighted as problematic, as was the common experience of services being reluctant to take responsibility for helping an individual, instead referring them on, often resulting in them being left unsupported.

Victims and professionals alike discussed the difficulties they faced in getting help; professionals often expressed a sense of powerlessness to support people adequately, given the complexity of the issues they were facing.

Hearteningly, there were examples of people experiencing good support from all agencies. Participants described police officers showing empathy and understanding and taking appropriate action. Where needs were assessed appropriately, and the views of the individuals taken into account, the support packages that were put in place worked well and were valued. Having a supportive network around them, whether it be friends and family or a good relationship with services, where they could access individuals who listened, believed, validated and empathised with them, was important and encouraged positive outcomes. Collaboration between services or individuals providing support was also crucial. People with mental health problems showed considerable resilience and strength in seeking help and accessing support.

The problems identified in this research are complex, and there isn't one simple solution, or one particular agency that can resolve it. However, many of the actions people valued involved some simple changes and showed a need to enforce already known good practice. We have identified specific and achievable recommendations in the next section. This research is a call to us all to listen, believe, validate and take action to support people with mental health problems.

5 | Key findings and recommendations

Key findings

1. *People with mental health problems are at high risk of being victims of crime*

- Forty-five percent of people with severe mental illness (SMI) were victims of crime in the past year; 18% of an assault.
- Forty to sixty-two percent of women with SMI reported being the victim of domestic or sexual violence since age 16, and 10-16% in the past year.
- People with mental health problems are very vulnerable to repeat victimisation, of different types of crime. Forty-three percent experienced more than one type of crime in the past year.
- People with mental health problems are more likely to be a victim of crime than a perpetrator.

2. *People with mental health problems are more likely to be victims of crime than the general population*

- People with severe mental illness were three times more likely to be a victim of any crime than the general population, after taking into account other factors.
- People with severe mental illness were five times more likely to be a victim of assault than the general population, after taking into account other factors. Women are particularly at risk, and are 10 times more likely to be assaulted.

3. *The impact of crime on people with mental health problems is substantial and is greater than for those without mental health problems*

- People with SMI were more likely to perceive a crime as being more serious, and were more likely to be emotionally and socially affected by crime. Crime may be a trigger to worsening mental health, and potential crisis.
- Victims of domestic violence and sexual assault have a high risk of attempting suicide, with nearly 40% of women and nearly a quarter of men with SMI attempting suicide as a result of experiencing these crimes.

4. *Risk factors: People with mental health problems who do not engage with services, misuse drugs and have a history of violence, are more at risk of being victimised.*

5. *Support needs: People with mental health problems often have higher support needs after experiencing a crime, and often need support from a range of agencies.*

- A third of victims do not disclose their experience to any professional.
 - People face a range of barriers that prevent them from accessing support and help. These include not being believed, previous poor experiences of attempting to get help, not being identified as needing additional help and support, and the impact of their mental health problem and of the crime itself.
 - Less than half report crimes. Friends, family and professionals are key in encouraging them to report incidents and to seek help.
-



Recommendations

1. *Develop a strategic response to support and protect people with mental health problems who are victims of crime*

This research identifies serious and complex problems which require a multi-agency mental health strategy for victims. It calls for a coordinated response from key agencies to:

- develop a national strategy to set the agenda and demonstrate leadership and champion people with mental health problems as victims of crime
- develop a national programme to implement and oversee the following recommendations at a national and local level
- develop new practice and recommendations by supporting pilots and providing funding.

Commissioners for health, social care, police and crime (local authority, National Health Service and police and crime commissioners) should jointly address prevention and provision for people with mental health problems who are victims of crime in their planning and commissioning including:

- in the public health agenda through the Joint Needs Assessments, the Joint Health and Wellbeing Strategy and the work of Health and Wellbeing Boards
- for primary care, social care and mental health services through integrated commissioning between Clinical Commissioning Groups (CCGs), local authorities and the NHS Commissioning Board
- in the criminal justice service through police and crime commissioners (PCCs) commissioning support services for people with disabilities, including people with mental health problems.

Bodies producing evidence and guidance for health, social care, PCCs and professionals should include information on victimisation, prevention and support:

- The Joint Commissioning Panel for Mental Health (JCPMH) should include information on victimisation, prevention and support in its guides for commissioners.
- The National Collaborating Centre for Mental Health (NCCMH) should include information on victimisation, prevention and support in clinical guidance concerned with adults with mental health problems, particularly severe mental illness produced for the National Institute for Health and Care Excellence (NICE).

- The Local Government Association briefings and material for PCCs should include information on victimisation, impact, and support for people with mental health problems as victims.

The College of Policing should:

- update the joint National Policing Improvement Agency (NPIA) and Department of Health ⁶⁸ guidance into Approved Professional Practice (APP) to reflect the needs and experiences of people with mental health problems as victims, and ensure it is disseminated among police forces.

The Association of Chief Police Officers (ACPO) should:

- prioritise victims with mental health problems in their strategy, policies and guidance.

Police forces should:

- recognise and prioritise the high risk of being a victim of crime among people with mental health problems in the Police and Crime Plan, the Annual Community Safety Plan and related processes for action planning, consultation and carrying out Equality Impact Assessments.

Local Community Safety Partnerships should:

- recognize the high risk of being a victim of crime among people with mental health problems and ensure a strategic response in the Annual Community Safety Plan
- consult with individuals with mental health problems and organisations (eg local Minds and Victim Support) in the community who can help them understand their needs and experiences and tailor responses and services accordingly.

Local authorities and housing providers should:

- develop and enforce rigorous schemes to tackle crime against people with mental health problems in local communities.

Voluntary sector organisations should:

- work to raise awareness of the high risk to people with mental health problems as victims of crime among the general public and carers, and supporters of people with mental health problems.
-

2. Train all staff in health, social care and police services, especially frontline staff, on the experiences and needs of people with mental health problems as victims of crime and how to respond appropriately

Police officers should be provided with mental health information, training and awareness-raising:

- to improve identification, disclosure, and good practice on how to respond appropriately
- of the serious impact of crime on people with mental health problems and the importance of referring victims on to other relevant services for further support
- of the fact that when they are in contact with perpetrators of violence, they may have been victims of crime in the past, or are likely to be in the future.

This training should be made mandatory across all police force areas, and be delivered jointly with mental health professionals.

Primary care, social care and mental health professionals should be provided with information, training and awareness-raising:

- of the fact that people with mental health problems are at an extremely high risk of being a victim of crime, that the impact of crime on people with mental health problems is greater and that they are likely to have significant support needs if they have been a victim of crime
- of the increased risk of victimisation for people with mental health problems who engage poorly with services and have drug misuse problems and a history of violence perpetration, and to take this into consideration
- about reporting crime, and services available to individuals so they can better signpost and refer
- of the serious impact of victimisation on people with mental health problems as well as the high rate of repeat victimisation.

Frontline staff in community, public services and social support organisations should:

- receive training to understand the needs of people with mental health problems, and the nature and impact of victimisation on people with mental health problems.

3. Support people with mental health problems to tell someone if they have been a victim of a crime

Police forces should:

- undertake outreach work to develop a community presence, build trust and raise awareness. They should work with voluntary organisations, community mental health teams and health services to reach out to people with mental health problems
- provide information about what constitutes a crime, how to report it and what happens once reported to people with mental health problems, as well as clear information about people's rights, and what to expect from the police and other agencies
- train all police officers to recognise hate incidents (even if the victim has not identified them) and ask open questions to encourage people to tell them what has happened.

Mental health professionals should:

- improve their processes of identification of victimisation, and support people with mental health problems to report incidents to the police.

Inpatient mental health services should:

- raise awareness among staff in inpatient settings of the potential safety issues for inpatients and eliminate mixed-sex accommodation
- ensure service users are informed of their rights to complain, advocacy and access to the police⁶⁹
- ensure patients are supported to report any incidents and that they are handled through the appropriate channels.

Victim Support, and voluntary sector organisations should:

- provide information about what constitutes a crime, how to report it and what happens once reported to people with mental health problems, as well as clear information about people's rights, and what to expect from the police and other agencies.

4. Measure and improve police and CPS responses to crimes reported by people with mental health problems

Police and the Crown Prosecution Service (CPS) need to take positive action to address the barriers that people with mental health problems face in the investigation and prosecution process. They should:

- prioritise responses for people with mental health problems especially around repeat victimisation and targeted crime.
- ensure reasonable adjustments are made to allow people with mental health problems to report crimes, make statements and pursue the case, following *Achieving Best Evidence Guidance in Criminal Proceedings*⁷⁰. For example the police and CPS should:
 - in deciding whether to investigate cases reported by people with mental health problems, and in deciding whether to charge individuals in cases, base decisions on the seriousness of the offence rather than the perceived credibility of the victim
 - draw on expert advice and support to get best evidence, using Registered Intermediaries who are communication experts to facilitate communication with the police and the courts, and trusted friends / relatives for support
 - explain to people why a case has not been taken forward as per the Victims' Code⁷¹
 - consider having dedicated specialist police officers who support high risk victims and coordinate responses
 - CPS, judiciary, police and Witness Care Units should work together to identify victims with mental health problems, assess their support needs and provide enhanced services, including access to special measures, and additional support, at the earliest opportunity and make sure that this is made known during court proceedings.

5. Develop effective services that address the substantial impact that being a victim of crime has on people with mental health problems

Agencies that provide services for people with mental health problems including housing associations, community mental health teams, criminal justice agencies, health and social care, and voluntary organisations should consider the breadth of the impact of criminal incidents on people with mental health problems and:

- provide emotional, financial, practical, and social support for victims after an incident
- provide advocacy services where necessary
- explore innovative models of providing services for people with mental health problems, with allocated funding and evaluation
- draw on good practice models for working with people experiencing domestic violence and hate crime
- develop services that support and build on victims' support networks, and focus on people who have fewer networks.
- consider whether these additional risks should trigger responses from relevant multi-agency support, for example safeguarding, multi-agency risk assessment conferences (MARACs), or child protection.

6. Remove the barriers and improve the experience of people with mental health problems in courts

- Recommendations from the research published by the Ministry of Justice (2010) on support pathways, identification of mental health problems, disclosure, access to specialist support and provision of special measures should be implemented.⁷²
- The CPS needs to take proactive measures in the adversarial system to make sure that mental health is never used against people to cast doubt on their reliability as a witness, including:
 - ensuring the implementation of CPS guidance on disclosure of medical records, using expert evidence, assessing credibility and access to special measures⁷³
 - providing information for health professionals about responding to requests from defence about a victim's mental health history.
- Training should be offered to ensure that CPS, courts and judiciary are aware of the impact of the crime on the individual and their mental health when charging and making sentencing decisions.
- Judges should make appropriate interventions to protect individuals with mental health problems when giving evidence.
- Judges should be aware of how stressful court can be for a victim or witness with mental health problems and support initiatives to improve their experiences such as allowing special measures.
- The CPS should work closely with the police to ensure early identification of vulnerability and special measures applications are completed on time, and the use of Registered Intermediaries is considered at the outset.
- Training should be provided for all trial advocates on dealing with vulnerable witnesses, especially those with mental health problems.⁷⁴

7. Improve communication with people with mental health problems

- All criminal justice agencies, health, social care, mental health and voluntary services should take steps to improve communication with people with mental health problems:
 - acknowledge how the person is feeling
 - listen sensitively and actively
 - ask open questions
 - use a calm and reassuring tone
 - use responsive body language
 - reflect back information and summarise issues to show you have been listening
 - provide a named person they can contact
 - provide regular updates on the case and inform sensitively when a case is closed and explain why.
- All organisations should monitor this and systematically collect and act on feedback from service users.

8. Empower and support people with mental health problems to help individuals take proactive steps to prevent repeat victimisation themselves where possible

Police forces should:

- prioritise responses for people with mental health problems especially around repeat victimisation and targeted crime (hate crime), and continue to address hate crime prevention
- ensure any incident reported by a victim with mental health problems is followed up with community safety support.

Mental health professionals, support workers and Victim Support should:

- provide safety planning and crime prevention advice
- work jointly with individuals to develop safety plans.

The Ministry of Justice should:

- work with Victim Support and CJS agencies to provide information on victims' rights, what to expect from criminal justice agencies and how to challenge poor practice (for example when disseminating the new Victims' Code)
- draw on good practice elsewhere to help individuals develop their resilience and confidence (for example with women who experience domestic violence).

9. Work collaboratively in partnership to provide joined up services for people with mental health problems

People with mental health problems often have higher and multiple support needs after experiencing a crime. Inter-agency working should be promoted by staff at all levels. This includes:

- establishing known contact points, referral routes and mechanisms for information sharing between agencies. In particular, systems for information sharing should be established between mental health services and the police to establish appropriate levels of support for victims.
- utilising the principles of 'case management' in order to improve a supportive, coordinated response to the victim with mental health problems. For example, assigning a 'named key worker' to help coordination and navigation in support of the person with mental health problems.

PCCs should:

- establish clear referral routes and information sharing across different agencies.

Mental health services should:

- with permission from the victim, liaise with the police and services involved and provide relevant information to help them give evidence and gain a conviction.

Victim Support should:

- work with other agencies, especially the police, to improve the identification of people with mental health problems and referral to adequate support.
-

10. Increase and develop understanding of why people with mental health problems are at such greater risk of crime

Further research is needed to:

- explore the motivation of perpetrators, to identify approaches to prevention
 - explore the relationship between engagement in services and victimisation
 - explore the role that informal networks may play in protecting against the victimisation of people with mental health problems
 - develop evidence-based good practice in supporting people with mental health problems who are victims of crime.
-

Appendix 1 | methodology

The Office for National Statistics' Crime Survey for England and Wales (the ONS-CSEW) (the source of our comparison group)

The Crime Survey for England and Wales (CSEW) measures the experiences of recent crime victimisation among people living in private residential households in England and Wales.⁷⁵ The survey, run by the Office for National Statistics (ONS), recruits a nationally representative random sample of around 40,000 people aged 16 or over each year. The sample usually includes 3,000-4,000 London residents. It addresses people's experiences of personal or household crime in the past year, their feelings of safety in their local area, and their experiences with and attitudes towards the police. In addition, people aged 16-59 are invited to take part in a 'self-completion module' on their experiences of domestic and sexual violence (in the past year and since the age of 16), and their drug and alcohol use habits. For this study, we gained approval from the UKDA and the ONS to use the 2011/2012 ONS-CSEW data in our research. For our comparison sample, we included all ONS-CSEW participants aged 18-65 living in London. We excluded people who reported a limiting disability due to mental illness.

Our survey of people with severe mental illness

We gained approval from the Kent Research Ethics Committee to conduct this study (REC reference 11/LO/0672). We recruited a random sample of people with severe mental illness under the care of community mental health teams (CMHTs) in South London and Maudsley NHS Foundation Trust and Camden and Islington NHS Foundation Trust. These Trusts serve the London boroughs of Lewisham, Lambeth, Southwark, Croydon, Camden and Islington, covering a population of 1.5 million people. We included people aged 18-65 with any diagnosis, people who have been under the care of community mental health teams for one year or longer, and those whose care was planned and coordinated under the Care Programme Approach or CPA (this type of care is normally given to people with severe and enduring mental illness who have complex psycho-social needs). We excluded people who were too

ill to consent to taking part, or whose English language was too poor to participate.

Participants were interviewed in a private setting by one of six trained interviewers at NHS premises or at their home, according to a participant's preference. Interviewers used computer-based questionnaires (or a paper-based version where this was not feasible). Those who agreed to participate in the self-completion module were encouraged to complete this themselves (using a computer or paper-based version), but were offered a face-to-face interview if they preferred (in order to maximise participation).

Qualitative study

The study design drew on interpretive social science approaches which emphasise the multiple experience and interpretations of individuals in social interactions.⁷⁶ Qualitative data collection was undertaken in two phases: semi-structured interviews with people with mental health problems and focus group interviews with those employed in health care, support and criminal justice services.⁷⁷

For the semi-structured interviews, participants were recruited via invitations to participate circulated in local Mind and Victim Support services as well as community mental health teams. Interviews were conducted in those premises. Information about the study was given beforehand and written consent obtained. A topic guide was used to ensure the issues of interest were addressed. With permission, the interviews were digitally recorded then transcribed replacing the person's name with a unique identifier. All other potential identifiers of individuals or individual services were removed. The recording was then deleted. All research materials were kept on password protected files and computers. The transcriptions were then coded, using the NVIVO software package, and analysed both thematically and using techniques of constant comparison⁷⁸ by three researchers, resolving differing opinions in discussion. Participants were given £20 to thank them for their time and travel expenses were reimbursed.

Particular ethical issues that were considered in planning the study were the potential for causing and then managing distress in participants, and actions to be taken should anyone disclose information suggesting a vulnerable adult was subject to abuse or neglect.

The focus group participants were initially invited to participate via partner networks and Advisory Group members. Information was provided to participants beforehand and consent obtained. The homogenous focus group interview method was chosen to a) maximise the sharing of information from those with homogenous characteristics by virtue of their work or volunteering role, b) obtain as broad a range of viewpoints as possible, most efficiently, within the resources of the study and c) be able to compare and contrast viewpoints between those in different work and volunteer roles.⁷⁹

The groups had five to six participants and were led by two researchers using anonymised emerging findings from phase one and a topic guide. Field notes were taken and the group interview digitally recorded with the permission of the participants. The field notes were typed up, made anonymous and verified with the digital recordings, which were then deleted. The notes were thematically analysed.⁸⁰ Where deemed appropriate, participants were thanked for their time with a £20 shopping voucher. The research was given a favourable review by a University Research Ethics Committee. All participants were made aware that any disclosure that suggested a vulnerable adult was subject to abuse or neglect or a criminal act would require the researchers to act within local safeguarding of vulnerable adults procedures.

The analysis from the two phases of the study was then compared and contrasted and synthesised as appropriate, ensuring the experiences of the people with mental health problems were privileged in the reporting.

Appendix 2: Glossary

Mental health terms

Anxiety

Everyone experiences anxiety at some point in their lives when faced with difficult or threatening situations. It is a feeling of uneasiness, such as worry, fear or panic, and can be severe or mild. Some people find it difficult to control their worries. Their feelings of anxiety can be strong, constant and enduring when there is no real threat, often interfering with their day-to-day lives. They may also have panic attacks. People with such symptoms of anxiety may be diagnosed with an anxiety disorder.

Bipolar affective disorder

A mood disorder once known as manic depression, it involves severe mood swings (high/manic episodes and low/depressive episodes) that are far beyond what most of us experience in everyday life.

Care coordinator

A designated professional (usually from the community mental health team – see below for definition) who acts as the main point of contact and support for a person with mental health problems requiring ongoing care.

Community mental health team (CMHT)

Provides support to people with mental health problems in the community. A CMHT is comprised of a range of different professionals including community psychiatric nurses (CPNs), social workers, psychologists, psychiatrists and occupational therapists.

Community psychiatric nurse

A nurse who specialises in mental health and can assess and treat people with mental health problems.

Depression

A term used to describe a range of symptoms, characterised by very low mood, which don't go away quickly and interfere with everyday life. Depression will often include feelings of hopelessness, low self-esteem, lethargy, sleep problems and suicidal thoughts.

Independent Mental Health Advocates (IMHA)

The role of an IMHA is to provide information or help obtain advice on any rights that a person has under the Mental Health Act. Information on IMHAs and how to contact them should be given to a person if they are admitted to hospital or accepted into guardianship.

Mental Health Act (1983)

Legislation governing the compulsory admission and treatment of people with mental health problems in England and Wales. Most patients will be admitted to hospital as informal patients, which means that they have voluntarily agreed to go. Compulsory admission may be necessary when, for example, someone has such severe problems that they are a risk to their own health or the health or safety of others.

Mental health crisis

An acute or very severe episode of mental distress requiring urgent support. This includes suicidal behaviour or intention, panic attacks and extreme anxiety, psychotic episodes (loss of sense of reality, hallucinations, hearing voices) or other behaviour that seems out of control and that is likely to endanger themselves or others.

Mental health professional

Healthcare professionals with specialised expertise in caring for and supporting people with mental health problems.

Mood disorders

Also called affective disorders or depressive disorders, people experience mood changes or disturbances, generally involving either mania (elevation) or depression.

Obsessive compulsive disorder

A condition characterised by obsessions and compulsions. Obsessions are persistent intrusive thoughts or images which cause anxiety and distress. Compulsions are acts (either physical or mental) which are repeated over and over again aimed at reducing the anxiety caused by obsessions eg someone who has a fear of contamination from dirt or germs may repetitively wash.

Panic attacks

Sudden unpredictable and intense attacks of anxiety and terror which are often accompanied by unpleasant physical symptoms such as trembling, shortness of breath and dizziness, often resembling a heart attack.

Personality disorders

Personality disorders are the most often misunderstood and stigmatised diagnoses in mental health. They can mean that patterns of thinking, feeling and behaving are more difficult to change and people can experience a more limited range of emotions, attitudes and behaviours with which to cope with everyday life.

Post traumatic stress disorder

An anxiety disorder caused by a traumatic experience. Symptoms can include re-experiencing the event (eg via flashbacks),

difficulties sleeping, avoiding places, people or events that remind the person of their trauma, severe anxiety, feelings of isolation, guilt, anger or depression.

Psychiatric wards (acute wards)

Inpatient facilities reserved for those who are most unwell, many of whom are detained under the Mental Health Act. Admission is determined by crisis resolution and home treatment teams (CRHTs) and is influenced by safety considerations, bed availability and the social support the person has. Wards may be locked, even though some patients might not be detained. People who are deemed to need closer supervision for their own or other people's safety may be admitted to a psychiatric intensive care unit (PICU).

Psychiatrist

A medically trained doctor who specialises in mental health problems and is trained to deal with the prevention, diagnosis and treatment of mental and emotional disorders and who can prescribe medication.

Psychologist

A professional who is interested in how people think, act, react, interact and behave.

Psychotic disorders

These involve distorted awareness and thinking. Symptoms can vary from person to person and may change over time. They can include agitation, over-activity, lowering of inhibitions, over-familiarity, sleeplessness and irritability. Hallucinations (when you hear, smell, feel or see something that others cannot) and delusions (unlikely beliefs that are held despite evidence to the contrary) are common symptoms of psychotic disorders.

Schizoaffective disorder

A psychotic disorder which has symptoms of both schizophrenia and mood disorders.

Schizophrenia

A psychotic disorder which affects how people think, feel, behave and how they perceive their own intense thoughts, ideas and perceptions. It can develop slowly and people may become withdrawn, lose interest in things and possibly have angry outbursts. They will often have symptoms of psychosis.

Sectioned

The term used when someone is admitted, detained and treated in hospital against their wishes. The legal authority for admission to hospital comes from the Mental Health Act, usually because of an inability or unwillingness to consent. It refers to the use of a 'section' or paragraph from the Mental

Health Act as the authority for detention. A better word is 'detained' as people are detained under the Mental Health Act. The paragraph or 'section' number is often used so a patient may be told they are on a section 2 or section 3.

Severe Mental Illness (SMI)

A term used in this report to refer to people with any mental health diagnosis who have been under the care of community mental health teams for one year or longer, and whose care is planned and coordinated under the Care Programme Approach (CPA).

Criminal justice terms

Code of Practice for Victims of Crime

The statutory code which sets out the minimum level of service victims should get from criminal justice agencies. It was established by the Domestic Violence, Crime and Victims Act (2004) and gave victims of crime statutory rights for the first time. At the time of writing, the code was being reviewed and revised by the government.

Crown Prosecution Service (CPS)

The government department responsible for prosecuting criminal cases investigated by the police in England and Wales. They decide whether there is enough evidence to bring a prosecution, who should be charged and what the charge should be.

The criminal justice system

A term used to describe all the different agencies and organisations that are involved in law, order, crime and punishment in England and Wales and how they work together.

The Crime Survey for England and Wales (CSEW)

The Crime Survey for England and Wales (formerly the British Crime Survey) asks people aged 16 and over living in households in England and Wales about their experiences of crime in the last 12 months. Respondents are also asked about their attitudes to crime-related issues such as the police and the criminal justice system.

Police Community Support Officers (PCSO)

Trained civilian members of police staff who work alongside police officers to provide a visible, accessible and familiar presence in local communities. They don't have the same powers as police officers

Prosecutors' Pledge

Sets out the level of service that victims can expect to receive from prosecutors. Its purpose is to ensure that: the victim's voice is heard and taken into account; the victim is informed and communicated with about the process and progress of a case; the victim is

protected from an attack in court related to their character.

Registered Intermediary

A professional who has been recruited, selected and accredited by the Ministry of Justice, and whose details are recorded on the Intermediary Register. They assist vulnerable victims and witnesses with communication and understanding so they can give their best evidence.

Special measures

Provisions introduced by the Youth Justice and Criminal Evidence Act 1999 to help vulnerable and intimidated witnesses give their best evidence in court. These can include things like video links, video recorded statements, screens around the witness stand and assistance with communication.

Victim personal statements

These give victims an opportunity to describe the wider effects of the crime on them, express their concerns and indicate whether or not they require any support.

Witness Care Unit

Provides a single point of contact for victims and witnesses for information and support from the point at which a defendant is charged to the conclusion of the case.

Witness Charter

Outlines the standards of service that all witnesses can expect to receive from criminal justice agencies and legal practitioners. It is currently being reviewed and revised by the government.

Witness Service

A service run by Victim Support and based in every Crown and magistrates' court in England and Wales which provides information and support to witnesses, victims and their friends and family when they go to court. This includes organising and conducting pre-trial visits which enable witnesses to see the court beforehand and providing a private space for witnesses to wait before they give evidence. Much of the service is delivered by trained volunteers.

Types of crime

Antisocial behaviour (ASB)

Defined in the Crime and Disorder Act (1998) as 'acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as the perpetrator'.⁸¹ The distinction between an ASB incident and an incident of crime is not always clear.

Assault

An act or physical contact (with or without a weapon) which causes harm to another and can result in injury eg being kicked, punched, slapped, being hit with a bat etc.

Burglary

Entering a building without the consent of the owner and stealing or attempting to steal property, or, entering a building with consent then stealing property and breaking out.

Family violence

Physical, sexual, psychological or financial violence perpetrated by a family member. It is characterised by controlling behaviour, commonly long-term and repetitive in nature and often takes place in private spaces where it can be effectively hidden from others.

Fraud

Broadly defined as 'when trickery is used to gain a dishonest advantage, which is often financial, over another person.'⁸²

Harassment

Any form of unwanted and unwarranted behaviour which has the purpose or effect of violating another person's dignity or which creates an intimidating, hostile, degrading, humiliating or offensive environment for that person.

Hate crime

'Any criminal offence which is perceived, by the victim or any other person, to be motivated by a hostility or prejudice based on a personal characteristic.'⁸³ This includes hostility or prejudice against disability, race or ethnicity, religion or belief, sexual orientation or transgender identity.

Partner violence

Physical, sexual, psychological or financial violence perpetrated by an intimate partner. It is characterised by controlling behaviour, commonly long-term and repetitive in nature and often takes place in private spaces where it can be effectively hidden from others.

Sexual violence

Any unwanted sexual act or activity. There are many different types of sexual violence including rape, sexual assault and sexual harassment.

Theft from person

Taking property belonging to another person with the intention of depriving them of that property permanently.

Threats

Words or behaviour that communicates intent to inflict harm on another person eg threats of violence, threats to kill etc.

Appendix 3 | Tables and data

Table A1: Sample socio-demographics for people with SMI and general population (relates to section 2.1 and Figure 1)

	People with SMI (n=361) %	Control ² (n=3,138) %
Age: mean (standard deviation)	41.8 (0.57)	40.9 (0.22)
Sex		
Male	56.2	46.0
Female	43.8	54.0
Ethnicity		
White	41.6	63.4
Asian/Chinese/other	35.2	23.0
Black/Black British	23.0	13.4
Marital status		
Single	72.6	43.1
Married/cohabiting	7.8	42.6
Divorced/separated/widowed	18.3	14.2
Employment status		
Employed	10.2	71.3
Student/economically inactive	10.5	19.1
Sick/unemployed	79.2	9.3

Table A2: Survey participant's clinical characteristics (relates to section 2.1, Figure 2)

Diagnosis	% (N)
Schizophrenia and related disorders	58.4 (206/353)
Bipolar affective disorder	12.2 (43/353)
Depression and other mood disorders	9.9 (35/353)
Personality disorders	8.2 (29/353)
Other	11.3 (40/353)
Illness duration	
< 5 years	19.6 (62/316)
>5 &<10 years	26.3 (83/316)
> 10 years	54.1 (171/316)
Age at illness onset	
<20	21.8 (67/307)
>20 &<35	53.7 (165/307)
>35	24.4 (75/307)
History of admission under MHA	57.8 (185/320)
History of violence perpetration	
Lifetime (any)	32.1 (108/336)
Lifetime (serious)	22.0 (74/336)
Past year (any)	17.3 (58/336)
History of drug misuse in last year	35.0 (105/300)

Table A3: Prevalence of past-year victimisation in people with SMI and controls: interview-based measures – (relates to section 2.2 Figure 3)

Victimisation experience	All		Men		Women	
	People with SMI ¹ (n=61)	Control (n=3138)	Men with SMI (n=203)	Control (n=1445)	Women with SMI (n=158)	Control (n=1693)
Any crime	44.3 (160)	15.6 (489)	47.8 (97)	15.2 (220)	39.9 (63)	15.9 (269)
Personal crime ¹	31.9 (115)	8.2 (257)	33.0 (67)	8.2 (119)	30.4 (48)	8.2 (138)
Assault ¹	18.0 (65)	2.6 (83)	17.7 (36)	3.5 (50)	18.4 (29)	1.9 (33)
Mugging or theft from person ¹	9.1 (33)	4.0 (127)	8.9 (18)	3.2 (46)	9.5 (15)	4.8 (81)
Threats of violence ¹	8.3 (30)	2.1 (66)	10.3 (21)	2.4 (35)	5.7 (9)	1.8 (31)
Household crime	23.3 (84)	8.5 (268)	24.1 (49)	8.2 (119)	22.2 (35)	8.8 (149)
Acquisitive crime	19.7 (71)	7.3 (228)	21.7 (44)	7.0 (101)	17.1 (27)	7.5 (127)
Burglaries ¹	10.2 (37)	7.2 (225)	11.8 (49)	6.9 (100)	8.2 (13)	7.4 (125)
Theft from household ²	10.5 (38)	<1.5(**) ³	10.8 (22)	** ³	10.1 (16)	** ³
Criminal damage ¹	5.5 (20)	1.8 (55)	3.9 (8)	1.9 (27)	7.6 (12)	1.7 (28)

¹ Prevalence figures differ between people with SMI and controls at 1% significance level for all experiences except burglary (see 2)

² For burglaries p=0.03 for all, 0.01 for men and 0.7 for women

³ (***) Numbers too small to report

Table A4: Adjusted relative odds of past-year victimisation in people with SMI compared with controls: interview-based measures (relates to Section 2.2, Figure 4)

	Adjusted odds ratio (95% confidence interval)		
	All	Men	Women
Any crime ¹	3.0 (2.2-4.1)	3.1 (2.0-4.8)	3.0 (1.9-4.6)
Personal crime ^{1*}	3.4 (2.4-4.8)	3.5 (2.1-5.8)	3.4 (2.0-5.6)
Assault	4.9 (2.9-8.2)	3.1 (1.5-6.2)	9.7 (4.3-21.7)
Mugging or theft ³	1.4 (0.9-2.4)	1.7 (0.8-3.8)	1.2 (0.6-2.5)
Threats of violence	3.8 (1.9-7.3)	6.5 (2.4-17.6)	2.6 (1.0-7.0)
Household crime (non-vehicle) ²	2.9 (2.1-4.1)		
Acquisitive crime	2.8 (1.9-3.9)		
Burglaries ³	1.5 (1.0-2.2)		
Theft from household	At least 15-fold		
Criminal damage	2.8 (1.4-5.6)		

¹ OR adjusted for personal, household and area factors: age, sex, ethnicity, marital status, educational attainment, employment status, housing tenure, social class of household reference person, lone adult households, children in households, area deprivation, Output Area Classification.

² OR adjusted for household and area factors: housing tenure, social class of household reference person, lone adults households, children in households, area deprivation, Output Area Classification.

³ All odds ratios are significant at 1% level, except for mugging/theft and burglaries (p>0.05)

Table A5: Past-year victimisation: recurrence, motive, victim-offender relationship (section 2,2 – relates to Figures 5 and 6)

	People with SMI (n=160) % (n)	Control (n=489) % (n)	P value ¹	Adjusted OR ² (95% CI)
Experienced multiple crime types ³			<0.001	
1	56.9 (91/160)	78.4 (381/486)		1
2	29.4 (47/160)	14.8 (72/486)		4.7 (3.4-6.0)
3 or more	13.8 (22/160)	6.8 (33/486)		6.7 (5.3-8.1)
Experienced series of incidents for a given crime type	30.4 (48/158)	18.4 (90/489)	<0.001	NS
Hate crime	42.6 (52/122)	5.1 (25/489)	<0.001	8.4 (4.3-16.5)
Hate crime (specific to mental illness)	25.4 (31/122)	Not applicable		
Perpetrator-Victim relationship				
Unidentified	42.5 (68/160)	67.0 (325/485)	<0.001	0.35 (0.21-0.58)
Stranger	33.8 (54/160)	42.9 (208/485)	0.04	0.44 (0.26-0.73)
Acquaintance	45.0 (72/160)	10.9 (53/485)	<0.001	3.0 (1.8-5.1)
Partner, family of household member	13.1 (21/160)	3.1 (15/485)	<0.001	3.4 (1.4-8.2)

¹ Crude association

² OR adjusted for personal, household, area and crime characteristics: age, sex, ethnicity, tenancy, living alone, area deprivation, crime type, number of victimisation experiences

³ Ordered logistic regression used for this outcome

Table A6: Prevalence of domestic and sexual violence victimisation since the age of 16 among people with SMI and controls: self-completion measures (relates to section 2.3 and Figure 7)

	Men		Women	
	People with SMI n=181	General population n=5129	People with SMI n=134	General population n=5991
Partner abuse				
Emotional/physical	35.2	12.7	57.9	24.3
Emotional	32.1	8.4	53.2	16.6
Physical	21.4	7.3	51.6	17.1
Family abuse				
Emotional/physical	31.2	7.0	40.2	9.2
Emotional	24.9	4.0	37.9	5.9
Physical	21.4	3.8	22.7	5.3
Sexual abuse				
Any (indecent exposure, touching, rape, attempted rape)	22.0	2.7	61.7	19.6

Table A7: Sample Socio-demographics for people with SMI and general population: tenancy and deprivation indices (relates to section 2.1, figure 1)

	People with SMI (N=361) % (n)	Controls (N=3138) % (n)
Tenancy		
Owners	6.1 (22)	48.9 (1534)
Private renters	30.7 (111)	30.2 (948)
Council renters	62.9 (227)	20.7 (648)
Area Multiple Deprivation Index quintiles		
Q1: 20% least deprived	0.3 (1)	8.7 (273)
Q2	1.1 (4)	13.6 (428)
Q3	8.9 (32)	20.5 (643)
Q4	36.3 (131)	30.2 (948)
Q5: 20% most deprived	52.4 (189)	27.0 (846)

Table A8: Impact of victimisation (relates to section 2.4, Figure 9 and 10)

	People with SMI (n=160) % (n)	Control (n=489) % (n)	P value ¹	Adjusted OR ² (95% CI)
Perceived seriousness⁵: 1 (least serious)-20 (most serious)³				
1 to 5	35.8 (44/123)	47.6 (233/489)		1
6 to 10	32.5 (40/123)	31.5 (154/489)		1.9 (0.93-2.8)
11 to 15	14.6 (18/123)	14.3 (70/489)		3.4 (2.4-4.4)
16 to 20	17.1 (21/123)	6.5 (32/489)		4.7 (3.7-5.7)
Perceived effect of victimization				
Any physical health problems	28.1 (34/121)	18.4 (90/488)	0.02	NS
Any emotional or mental health problems	97.6 (123/126)	89.3 (436/488)	<0.01	NS
Any social problems	65.8 (79/120)	45.9 (224/488)	<0.001	2.2 (1.3-3.7)
To what extent affected emotionally³				
Only a little	31.9 (43/135)	50.2 (245/488)	<0.01	1
Quite a lot	36.3 (49/135)	28.3 (138/488)		2.2 (1.3-3.2)
Very Much	31.9 (43/135)	21.5 (105/488)		3.7 (2.7-4.7)
Made changes to prevent future victimisation	55.1 (59/107)	67.6 (330/488)	0.01	0.48 (0.28-0.82)
For assault victims				
	People with SMI (n=65) % (n)	Control (n=83)% (n)		
Reciprocal violence	37.3 (22/59)	29.5 (33/112)	0.3	NS
Injury	74.2 (49/66)	40.7 (50/123)	<0.001	3.5 (1.6-7.7)
Medical attention ⁴	20.5 (16/78)	12.0 (23/191)	0.07	0.31 (0.10-0.90)

¹ Crude association

² OR adjusted for personal, household, area and crime characteristics: age, sex, ethnicity, tenancy, living alone, area deprivation, crime type, number of victimisation experiences

³ Ordered logistic regression used for this outcome

⁴ OR also adjusted for injury

⁵ Victims were asked to rate the seriousness of their experience on a scale of 1 (e.g. theft of a milk bottle) to 20 (e.g. murder).

Table A9: Reporting to professionals and contact with Victim Support (relates to section 2.5 and 2.6, Figures 11 and 12)

	People with SMI (n=160) % (n)	Control (n=489) % (n)	P value ¹	Adjusted OR ² (95% CI)
POLICE and CJS				
Disclosure to police				
Police know about incident (from victim or someone else)	55.2 (79/143)	46.2 (226/489)	0.06	NS
Police told by victim about incident	44.8 (64/143)	35.4 (173/489)	0.11	NS
Where police aware:				
Progress through CJS				
Police found offender	47.6 (30/63)	28.4 (58/204)	<0.001	NS
Police took action against offender	44.0 (11/25)	62.7 (32/51)	0.12	NS
Offender went to court	36.4 (4/11)	34.4 (11/32)	0.91	NS
Victim attended court	50.0 (2/4)	36.4 (4/11)	0.63	
Satisfaction with police				
	n=64	n=226		
Police fair	56.3 (36/64)	83.1 (182/219)	<0.001	0.39 (0.19-0.81)
Police respectful	67.2 (43/64)	89.4 (195/218)	<0.001	0.24 (0.10-0.59)
Satisfied overall with police	46.9 (30/64)	78.7 (170/216)	<0.001	0.30 (0.14-0.61)
Contact with CJS (other than police)	3.0 (2/66)	8.5 (19/223)	0.13	NS
MENTAL HEALTH PROFESSIONALS (MHPs)				
MHPs know	59.4 (82/138)	Not applicable		
MHPs told by participant	55.8 (77/138)			
Participant told MHP or police	72.0 (103/143)			
VICTIM SUPPORT				
Contact with Victim Support			0.03	
Letter/phone	7.3 (8/109)	10.9 (53/486)		
Face to face	2.8 (3/109)	0.4 (2/486)		
Satisfaction with Victim Support	70.0 (7/10)	86.5 (45/52)	0.19	

¹ Crude association² OR adjusted for personal, household, area and crime characteristics: age, sex, ethnicity, tenancy, living alone, area deprivation, crime type, number of victimisation experiences³ Please note denominators.

Table A10: Help received and wanted (relates to section 2.6 Figures 13, 14 and 15)

	People with SMI (n=160) % (n)	Control (n=489) % (n)	P value ¹	Adjusted OR ²
HELP RECEIVED²				
Received help-any	64.1 (91/142)	14.6 (69/472)	<0.001	12.8 (7.2-22.8)
Received-talking help	79.2 (61/77)	49.3 (34/69)	<0.001	
Received-help to access police/CJS	33.8 (26/77)	36.2 (25/69)	0.75	
Received-practical/financial help	40.3 (31/77)	14.5 (10/69)	<0.001	
Received-help to access other services	15.6 (12/77)	4.3 (3/69)	0.03	
Received-crime prevention advice	0.0 (0/77)	34.8 (24/69)	<0.001	
Received from:				
Mental health services	57.4 (35/61)	Not applicable		
Police/CSJ	31.1 (19/61)	64.2 (34/53)	<0.001	
Victim Support/other formal source	13.1 (8/61)	43.4 (23/53)	<0.001	
Family/friends	67.2 (41/61)	20.8 (11/53)	<0.001	
Overall satisfaction with help	72.6 (45/62)	80.0 (28/35)	0.42	
HELP WANTED²				
Wanted help-any	45.0 (50/111)	28.4 (133/469)	<0.001	NS
Wanted-talking help	39.6 (19/48)	32.8 (43/131)	0.4	
Wanted-help to access police/CJS	39.6 (19/48)	49.6 (65/131)	0.44	
Wanted-practical/financial help	58.3 (28/48)	19.8 (26/131)	<0.001	
Wanted-help to access other services	10.4 (5/48)	4.6 (6/131)	0.11	
Wanted-crime prevention advice	22.9 (11/48)	32.1 (42/131)	0.34	

¹ Crude association

² OR adjusted for personal, household, area and crime characteristics: age, sex, ethnicity, tenancy, living alone, area deprivation, crime type, number of victimisation experiences

³ Please note denominators (details on help received and wanted only available for a subset of victims).

Table A11: Factors independently correlated with past-year victimisation in people with SMI: any crime, assaults and household victimisation (relates to section 2.7 Figure 16)

	N	Any victimisation %	Adjusted OR ¹	%	Assault Adjusted OR ¹	Household crime %	Adjusted OR ¹
Violence perpetration ever							
No	228	35.1		11.8	1	18.4	1
Yes	108	60.2	2.7 (1.6-4.6)	28.7	3.2 (1.7-6.0)	33.3	1.8 (1-3.3)
All	336	43.2		17.3		23.2	
Drug misuse last year							
No	195	33.8	1	13.8	1	16.9	1
Yes	105	61.0	2.8 (1.6-4.8)	27.6	1.9 (1-3.8)	33.3	2.0 (1.1-3.6)
All	300	43.3		18.7		22.7	
Service engagement							
Good	41	22.0	1	7.3	1	9.8	1
Intermediate	97	51.5	4.7 (1.7-12.6)	24.7	6.2 (1.3-29.5)	27.8	3.4 (1.1-11.1)
Poor	41	61.0	6.6 (2.1-20.3)	31.7	7.5 (1.4-39.5)	34.1	5.2 (1.4-18.7)
All	179	46.9					

¹ OR adjusted for age, sex, and other factors in this table.

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For more information please contact:

Victim Support

Hallam House
50-60 Hallam Street
London W1W 6JL
020 7268 0200

www.victimsupport.org.uk

Registered charity number: 298028

Mind

15-19 Broadway
London E15 4BQ
0202 8519 2122

www.mind.org.uk

Registered charity number: 219830