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"Keeping Control": A user-led exploratory study of mental health service user experiences of targeted violence and abuse in the context of adult safeguarding in England

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Abstract

The situation for people with mental health problems as a group of disabled people who experience targeted violence and abuse is a complex one. Disabled people, particularly those with mental health problems, are at higher risk of targeted violence and hostility with few effective evidence-based prevention and protection strategies. Achieving effective safeguarding for adults with mental health problems is characterised by differential attitudes to and understandings of abuse by safeguarding practitioners, as well as systemic issues arising from multi-agency working. "Keeping Control" was a 16-month user-led, co-produced exploratory qualitative study into service user experiences of targeted violence and abuse that was examined in the context of Care Act 2014 adult safeguarding reforms in England. User-controlled interviews of mental health service users (N = 23) explored their experiences and concepts of targeted violence and abuse, prevention and protection. Preliminary findings from these interviews were discussed in adult safeguarding and mental health stakeholder and practitioner focus groups (N = 46). The data were also discussed via two facilitated Twitter chats (responses N = 585 and N = 139). Mental health service users' experiences and concepts of risk from others, vulnerability and neglect can be different to those of practitioners but should be central to adult safeguarding. Histories of trauma, multi-factorial abuse; living with fear and stigma as well as mental distress; the effects of "psychiatric disqualification" and individual blaming should be addressed in adult safeguarding in mental health. Fragmented responses from services can mean a person becomes "lost in the process". Staff can feel disempowered, afraid or lacking in confidence to "speak up" for individuals in complex service systems with poor communication and lines of accountability. Adult safeguarding practitioners and stakeholders need to be confident, accessible and respond quickly to service users reporting incidents of targeted violence and abuse particularly in closed environments such as wards or supported housing.

KEYWORDS
adult mental healthcare, adult protection, Interprofessional Mental Health Work, social work and healthcare, user-led research, user's views

1 | INTRODUCTION

"Keeping Control" was a 16-month user-led exploratory qualitative study into service user experiences of targeted violence and abuse (disability hate crime) conducted in 2016, in the context of adult safeguarding reforms in England (DH, 2014). It built on the literature on risk and adult social care that revealed significant gaps in the UK primary research evidence on mental health service users' views and experiences.

The research is intended to support relevant mental health and adult safeguarding practitioners and agencies to understand the role that targeted violence and abuse plays in mental health service users' lives and their help-seeking and prevention behaviour, from the perspective of service users themselves. The research design allowed practice and policy stakeholders to explore what the implications may be for adult safeguarding and mental health in relation to implementation of "The Care Act 2014: Care and support statutory guidance" for England (DHSC, 2018) in relation to targeted violence and abuse.

What is known about this topic

- The situation for people with mental health problems as a group of disabled people who experience targeted violence and abuse and adult safeguarding is a complex one.
- Existing research on adult safeguarding in mental health has focused on practitioner and service perspectives.
- Achieving effective safeguarding for adults with mental health problems is characterised by differential attitudes to abuse as well as systemic issues from multi-agency working.

What this paper adds

- Service user concepts and understandings of targeted violence and abuse within the context of adult safeguarding.
- Adult safeguarding practitioner responses to the service user experiences and concepts of targeted violence and abuse.
- Service user and practitioner defined lessons for implementing adult safeguarding policy in mental health.

2 | BACKGROUND

In England and Wales, discourses on adult safeguarding in mental health and "targeted violence and hostility" (Sin, Hedges, Cook, Mguni, & Comber, 2011) also termed "disability hate crime" against disabled people, appear to be largely separate in research and practice. "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" (HM Government, 2012a p.11) and is covered under s146 of the Criminal Justice Act 2003 (CPS, 2018). Government policy has emphasised the need for multi-agency working to support victims of hate crime to report it (HM Government, 2012b). It is well documented that disabled people, particularly people with mental health problems or "psychosocial disabilities", are at higher risk of targeted violence, hostility or abuse but with few effective evidence-based prevention and protection strategies (Emerson & Roulstone, 2014; Mikton, Maguire, & Shakespeare, 2014; Sin, Hedges, Cook, Mguni, & Comber, 2009).

The situation for people with mental health problems as a group of disabled people who experience targeted violence and abuse is a complex one and underexplored in the context of adult safeguarding. Existing mental health adult safeguarding research has focused on financial and sexual abuse and on capacity to consent (Brown & Keating, 1998). Achieving effective safeguarding for adults with mental health problems has been characterised by differential attitudes to and understandings of abuse by health and social care agencies, as well as systemic issues arising from multi-agency working (Brown & Keating, 1998; Fannernan, Kingston, & Bradley, 2013). People with mental health problems may not feel that adult safeguarding or the protections against disability hate crime apply to them (Clement, Brohan, Sayce, Pool, & Thornicroft, 2011). Some findings suggest professional advice on prevention and protection amounts to ignoring abuse or avoiding situations where violence or hostility may occur, thus potentially increasing social isolation (Clement et al., 2011; Sin et al., 2011). In the general absence of service user perspectives in studies on risk and safeguarding, these remain largely defined by practitioners and articulated using managerial language (Mitchell, Baxter, & Glendinning, 2012; Wallcraft, 2012). Research into service user perspectives on risk and safeguarding shows that fear is a significant concern, particularly for those with mental health problems (Faulkner, 2012), but this is not necessarily something considered by social care practitioners thus impeding outcome-focused and person-centred practice (Carr, 2011,).

The Care Act 2014 for England and Wales sets out legislation regarding the safeguarding of adults at risk of abuse or neglect (HM Government, 2014). The Act determines that safeguarding is everybody's business and should be outcome-focused and person-centred (DH, 2014; LGA, 2014). Local authorities have statutory

obligations to provide multi-agency Safeguarding Adults Boards in their area, to include the police, the NHS and other local stakeholders such as housing (DH, 2014). The guidance states that using an asset-based approach to identify a person's strengths and networks can help them to make difficult decisions and manage complex situations, and that empowerment and control are important aspects to adult safeguarding (LGA, 2013). Professional and regulatory standards for health and social care staff, Local Authorities and the NHS enforce personalisation and service user empowerment in adult safeguarding (LGA, 2015; NHS England, 2017; Skills for Care, 2018). However, much of the available research on adult safeguarding explores systemic issues, service configuration and models, decision-making and practitioner concepts of safeguarding (Graham et al., 2014; Johnson, 2011; Norrie et al., 2014; Trainor, 2015) and suggests that reactive or technical approaches to risk management and safeguarding are inadequate for person-centred practice (Manthorpe et al., 2008). Risk averse cultures can be disempowering for service users who are unable to be meaningfully involved in the processes of risk management, assessment and decision-making that affect them (Faulkner, 2012; Wallcraft, 2012; Whitelock, 2009). Little is known about how person-centred adult safeguarding should work for people with mental health problems experiencing targeted violence and abuse.

The study literature scoping review (1990–2016) of mental health service user experiences of targeted violence and hostility and help-seeking in the UK (Carr et al., 2017) included 13 studies and revealed 'specific issues regarding mental health and disability hate crime, particularly relating to victim fear responses, social isolation, "psychiatric disqualification", acceptance of abuse as part of everyday life, stigma and its relationship to help-seeking, and the expectation of "not being believed" or "being in the wrong" (Carr et al., 2017, p.19). "Psychiatric disqualification" has been defined as being discredited or invalidated because of mental health problems. The review also indicated that although mental health practitioners were most commonly approached for help, "adult safeguarding did not feature strongly in the findings about help-seeking behaviour and reporting" (Carr et al., 2017, p.18). Further research is needed to understand the implications of the Care Act 2014 reforms for person-centred safeguarding in mental health and the relationship of adult safeguarding to disability hate crime where the victims have mental health problems. This study aimed to explore mental health service user concepts and experiences of targeted violence and abuse; where mental health service users go to get support if they are afraid, threatened or have been victims of targeted violence and abuse; and the responses of adult safeguarding, mental health and other relevant practitioners.

3 | METHODS

This exploratory, qualitative study (Gray, 2014) drew on theories of experiential knowledge and user research (Beresford, 2003; Beresford & Croft, 2012), which have been recognised in the typology of social care and mental health knowledge and as contributing to the social care evidence base (SCIE, 2003). Mental health service user involvement in research is important for enhancing subject knowledge and increasing understanding of mental distress, self-management and social inclusion (Tait & Lester, 2005). The study examined first-hand experiences of sensitive and distressing experiences in order to address an important gap in the mental health and social care practice evidence base (Newman, 2006, p.42). The study design (see Figure 1) was informed by emancipatory research theory and principles (Stone & Priestley, 1996) as well as service user and survivor research values, ethics and practice (Faulkner, 2004; Rose, 2017). Accordingly, this study was an attempt to "share, validate, collectivise and thereby reframe and render more general the experiences that individuals bring" (Rose, 2017 p.782). The research design aimed to support user-led structured conversations through interconnected work streams utilising different data collection methods to facilitate wider discussion with stakeholders. The research conduct aimed to equalise the relations in research production, employ a plurality of methods and maximise the impact of service user reported experiential knowledge during the research process (Stone & Priestley, 1996).

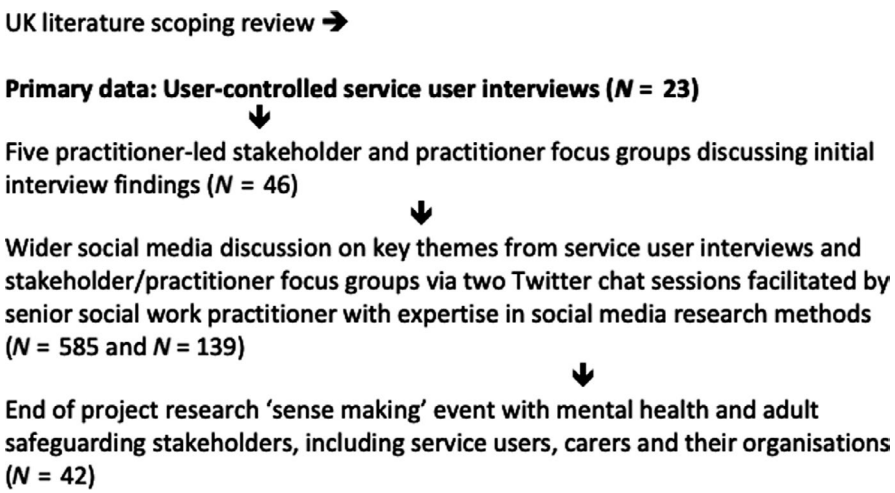

FIGURE 1 Study design structure

3.1 | Data collection and analysis

Thirty-one adults living in England over 18 years with self-defined mental health problems and mental capacity to self-select were recruited to the study via open recruitment. This was through mental health service user and survivor networks and organisations and through social media. A snowball sampling technique was used as this approach is suitable for accessing hidden or "seldom heard" populations where a degree of trust is needed for engagement, although there are problems with selection bias (Atkinson & Flint, 2001). To achieve diverse sample, the team used purposive subsample targeting for people with the protected characteristics of race, gender identity, sexual orientation and additional disability, as well as those living in rural and urban areas. Two carer proxies were included to improve the inclusion of perspectives from male service users and those in rural villages, with recognition of the limitations of this mediated approach. When followed up for interview, two people did not meet with the study inclusion criteria and four people did not respond to three further attempts to follow up and arrange an interview. A total of twenty-three service users were interviewed. An overview of participant characteristics is given in Table 1.

Interviews were conducted across England by a team of trained, experienced service user researchers and according to participant preference (face-to-face, by telephone, Skype or as a written response) over a course of three months, using a combination of a topic guide and narrative inquiry techniques (Bell, 2005). The topic guide was informed by themes from the literature scoping review (Carr et al., 2017) with input from the research advisory group. Interviews aimed to gather data on service users' own concepts and experiences of mental health–related violence and abuse and hostility, how and where they access support if the support is helpful (including experiences of adult safeguarding) and their advice on improving mental health adult safeguarding practice. Verbal interviews were digitally recorded and transcribed with written participant informed consent. Honouring full narratives was an integral part of interview conduct and allowed participants maximum control during the process (Faulkner, 2004). Interview duration times ranged from 43 min to almost 3 hr. During the interviews, participants were encouraged to explore their own understanding and interpretation of experiences of abuse in relation to mental health problems, allowing them to explore complex factors.

The second work stream used focus groups with mental health and adult safeguarding stakeholder and practitioners, including proxy representatives from organisations and networks indicated in service user interviews as being sources of support. Recruitment was via targeted invitations through research team and advisory group networks to support optimum stakeholder representation, including social work, police, housing and voluntary sector providers. Using a broad topic guide, participants were invited to reflect on the initial themes that emerged from preliminary analysis of the service user interviews and to facilitate discussion on implications for adult safeguarding practice. These lasted approximately 90 min and were co-led by a practitioner researcher (THL) and a service user researcher (AF). Two focus groups were each held in London and Birmingham with two additional, opportunistic focus groups of postgraduate social workers with statutory adult safeguarding responsibility and best interest assessors were held at Middlesex University London. Service user interview findings were discussed at a National Safeguarding Leads Board Meeting. The research team used an individual interview and a smaller group discussion to ensure the engagement of police participants. A total of forty-six participants took part, and an overview of participant characteristics is given in Table 2. Discussions were recorded and transcribed with written participant informed consent.

Social media was utilised as a novel triangulation data collection platform for the wider views of stakeholders in relation to the broad topic areas and empirical findings of the research (Megele, 2015). Using social media for research allowed access to a large and diverse dataset from individuals and organisations (Megele, 2015). Two Twitter chat sessions on a specialist mental health account with 78,000 followers were designed with an informed consent process to discuss the findings from the service user interviews and then from the stakeholder focus groups and were each conducted over a period of ten days. The first session yielded 585 responses, and the second, 139 responses. Participants were advised that they could publicly Tweet, Direct Message the account or privately email the work stream lead (CM).

The service user interview narratives were analysed through an initial thematic analysis (Braun & Clarke, 2006), followed by a moderated team analysis to reduce bias and to cross-refer interpretations of the data. This analysis utilised a coding frame (Ritchie & Spencer, 1994) derived from the preliminary thematic analysis that used the principles of grounded theory (Glaser & Strauss, 1967) and developed core categories and themes through comparative analysis. Transcripts from the stakeholder focus groups and interviews were analysed using the same method as the service user interviews. Following screening to only include responses from England, the transcripts from the Twitter discussion sessions were created and analysed using open coding, supported by NVivo software. This was cross-referred to the findings from the interviews and focus groups to triangulate cross-cutting themes and to highlight any additional themes.

3.2 | Ethical considerations

Ethical approval from Middlesex University London Research Ethics Committee was obtained. Whilst research with vulnerable adults has a number of ethical implications, affording mental health service users their right to a voice and to meaningful participation in research and practice is recognised as an ethical issue in itself (Faulkner, 2004). This required considered approaches to conceptualising "harm" and "benefit" and the recognition that distress when recalling traumatic or upsetting events, is not necessarily equivalent

TABLE 1 Service user interview sample characteristics (*N* = 23)

Age	18–25	2
	25–36	0
	36–45	5
	45–56	7
	56–65	6
	66–75	1
	None recorded	2
Ethnicity	White British	15
	Black British	1
	Asian British	2
	Black African	2
	White African	1
	European	2
Gender assigned at birth	Female	21
	Male	2
Gender identity	Female	21 (1 transwoman) (1 proxy female carer of a male service user, 1 proxy female carer of a female service user)
	Male	1
	Non-binary	1
Sexual orientation	Heterosexual	18
	Bisexual	1
	Lesbian/gay	2
	Other	1
	Prefer not to say	1
Disability (additional)	Yes	9
	None recorded	1
Geographical location	Urban city SE	9
	Urban city Mid	1
	Urban SW	1
	Rural town NW	1
	Rural town SW	1
	Rural town Mid	2
	Rural town (unknown region)	1
	Rural village E	1
	Rural village SW	1
	Rural village (unknown region)	1
	None recorded	4
Other notes	Service user participants	21
	Proxy carer participants	2

to harm if the necessary supports and protocols are in place and the interviewer has the requisite skills and experience (Faulkner, 2004). Interview and focus group participants provided fully informed written consent. Interviewees were offered the opportunity to see and censor the transcripts of their interviews and to withdraw from the research at any stage. All were provided with a customised safeguarding and abuse support resources and helpline sheet. The Twitter data gathering was conducted in accordance with ethical guidance from the Association of Internet Researchers (www.aoir.org) and a consent by design approach was adopted where informed consent was embedded in the engagement process. A participant information blog was circulated through the Twitter account prior to data collection. Privacy settings for accounts were determined by individual participants and the public nature of the Tweets was emphasised in the participant information. Final data could not be retraced to any specific participant.

TABLE 2 Focus group participant characteristics (*N* = 46)

Professional background	Social work	21 (5 mental health social workers)
	Police	4
	Mental Health Nursing (CPN/RMN/Critical Care)	3
	Youth Justice	1
	Safeguarding Lead	3
	Voluntary sector (Community Development/Advocacy/Employment)	5
	Peer Support/User-led Organisation	2
	Housing (Health Liaison/Neighbourhood)	2
	Civil service	1
	Fire service	1
	Senior managers (Patient experience/Forensic Mental Health/CEO)	3
Length of experience	Range = 6 months – 35 years	No response = 7
	Mean = 14.5 years	
Working directly with mental health services or service users	Yes	21
	No	20
	Not sure/no response	5

3.3 | Findings

The overall findings showed that the service users and practitioner participants agreed that mental health service users may not think adult safeguarding or disability hate crime definitions apply to them and that reduced services may increase the risk of individuals in crisis to being exposed to targeted violence and abuse in their neighbourhoods. Instances of targeted violence and abuse in closed environments such as inpatient settings and the increased vulnerability associated with poor housing and socially deprived neighbourhoods were reported and recognised by both groups as concerns for mental health adult safeguarding. Practitioner discussions about "buck passing", "blame cultures" and "fear of speaking up" in adult mental health services and safeguarding provided insight into service user reported experiences of feeling "lost in the process" and of "fragmented", absent or inadequate service responses. Staff discussion of desensitisation to targeted violence and abuse provided one possible explanation for the reported service user experiences and perceptions of individual blaming and not being believed. Points of commonality between service users and practitioner responses indicated a structure of interrelating socio-political, service and individual-level risk and vulnerability factors. On the macro level, these were societal, political and systemic; mental health services, staff and organisational cultures were located on the meso-level and individual situations, diagnosis, self-work and histories of trauma and distress on the micro level.

The main themes and findings from the individual work streams are discussed below.

3.4 | Service user interview findings (*N* = 23)

3.4.1 | Experiences of mental health and adult safeguarding responses

Generally, participants were unclear about the role and remit of adult safeguarding in mental health. Just under half the interview participants had direct experience of adult safeguarding and very few had found it satisfactory or helpful. Others had not heard of adult safeguarding, or thought it did not apply to them, either because of their perception of the abuse or because they believed safeguarding was for other service user groups (e.g. children or people with learning disabilities).

The police were commonly reported as first point of access in help-seeking, with several participants reporting satisfaction with police responses as they felt "taken seriously", with immediate responses focusing on their safety. Social workers did not help if they were inconsistent or inflexible, focused on eligibility and were uninformed about adult safeguarding or had inappropriate responses to requests for help.

> …when people do come to seek help, it would be nice if people could not say it's not in their remit… just help them (Black British Woman, London).

Interviewees who reported incidents of targeted violence or abuse found responsible services to be "fragmented", with health and social work professionals sometimes "passing the buck" resulting in long response delays and lack of support. This could then lead to a loss of trust and faith in services, reducing likelihood of reporting

and help-seeking and increasing likelihood of disengaging and risking exposure to harm.

> But yeah it's the response afterwards which was dreadful - that was the worst thing…if bad things happen and then you are not helped or protected that makes it much worse (African Woman, Urban).

3.4.2 | Understandings and experiences of risk and vulnerability

Risk and vulnerability were understood and conceptualised by the mental health service users in ways that were different to those of the adult safeguarding practitioners. Levels of vulnerability, risk from others and feelings of powerlessness were reported as being determined by a person's situation, environment, diagnosis or relationships. Risk of vulnerability was felt to be compounded by the broader context of the socioeconomic effects of austerity. Participants referred to reductions in support packages, absence of preventative support and difficulties with accessing services as factors potentially increasing the risk of crisis and then exposure to neighbours or housing officers.

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

> On the ward it seemed it was a free for all in there and that we were locked up out of sight and we had no rights and that this was a land that time forgot (White British Woman, Small Town).

> So I know that my diagnosis means that people will inherently red flag anything I say…I know that I'm in a position of extreme vulnerability, where is my power in this? (White British Woman, Urban).

Neglect by mental health services and staff was experienced as abusive and as a factor for increasing the risk of violence and abuse by those who had used inpatient and community mental health services. They reported risk of abuse, assault (including sexual) or theft from staff as well as fellow service users in closed environments such as wards and supported housing. Living in fear and feeling unsafe were common themes across the interviews. Abusers, including mental health staff, were thought to target victims in situations where individuals are vulnerable or where there were significant power imbalances. Interviews indicated that mental health service users may not know about adult safeguarding, their rights and protections or how to use safeguarding language to raise alerts. The majority of participants did not identify incidents of targeted violence and abuse as disability hate crime.

3.4.3 | Life histories, trauma and abuse

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

> I think that experience of all those incidents happening has made me feel as though I'm outside of society I suppose in a way (White British Woman, Small Town).

> …our baseline understanding of the world is badly damaged (White British Woman, Urban).

Many participants reported multi-factorial abuse and discrimination impacting on mental health, such as racism, sexism, homophobia and discrimination or abuse based on disability and gender identity from neighbours, family, colleagues, mental health practitioners and in society.

3.4.4 | Reporting, self-worth and "psychiatric disqualification"

Interviews showed that recognition and reporting of targeted violence and abuse can be compromised by service users feeling it is an inevitable part of their life; not feeling or being believed because of their mental health status (the "unreliable witness"); self-blame; not feeling they are "worth it"; and believing services will not respond appropriately or in ways that are additionally harmful.

> Part of me probably still thinks that I shouldn't have put myself in that situation. So there is blame as well I think (White British Woman, Rural Village).

> I feel really pushed aside because of my mental health difficulties (White British Man, Rural Town).

> …my capacity to be a witness and give any kind of testimony in any way is contaminated (White British Woman, Urban).

> …like many survivors, we never think that it's bad enough (White British Woman, Urban).

Some participants felt that the "burden of proof" was on them and were characterised as the problem, rather than the perpetrator. Several had been forced to leave their homes, or to move house several times as a result of victimisation.

3.4.5 | Positive survival strategies, resourcefulness and perseverance

Several participants reported employing positive strategies to cope and seek help, they discussed resourcefulness and perseverance with mental health, adult safeguarding and criminal justice services after reporting an incident of targeted violence and abuse or in the absence of adequate service responses. Many of the interviewees used, or intended to use their experiences to help others or to inform change, such as involvement with training social workers and police and in local service user organisations, with several citing this as a reason for volunteering to be interviewed for the study.

> My decision to put my experiences to good use… that's been a real survival thing for me, because if I can see that it's actually worth something to the system or to the people working in it, that's why I do the work that I do (White British Woman, London).

3.5 | Mental health and adult safeguarding practitioner and stakeholder focus group findings (*N* = 46)

3.5.1 | Experiences of adult safeguarding and mental health

A number of systemic, structural, resourcing and cultural issues in mental health and adult safeguarding were identified. Respondents concurred that austerity and cuts to all services and support used by people with mental health problems were affecting service user and carer safety. Consistent with the interview findings, several mentioned very marginalised or traumatised service users not thinking that adult safeguarding applied to them.

> The idea that one of our clients would say I want to raise a safeguarding or I want to complain or I want, it wouldn't even come into their heads, it just wouldn't… (Participant, Focus Group 1).

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

> You see with partnership working, no one takes ownership… (Participant, Focus Group 2).

Inequalities in mental health adult safeguarding were identified, with respondents perceiving safeguarding was better for older people and people with learning disabilities. Inequalities were also highlighted with the way child protection currently functions.

One police respondent said that a specialist mental health equivalent of the domestic violence multi-agency risk assessment conference (MARAC) was needed, a model which they had experienced as beneficial for facilitating multi-agency working and action planning with assigned responsibilities. A number of social workers reported that they had no mental health representatives on their local multi-agency safeguarding hub (MASH).

3.5.2 | Views on vulnerability and risk

Practitioner participants generally perceived risk from others as being about coercive control by family or friends, abuse by neighbours and financial exploitation. "Mate crime" was seen by most social workers as difficult to address because of the belief that individuals rely on the people who are exploiting or abusing them, and therefore reluctant to report the abuse or pursue a criminal case. Safeguarding leads and police respondents said that under-reporting led to lack of data on violence and abuse against people with mental health problems.

Responses to the interview findings ranged from despairing to desensitised, with some noting that violence or abuse on wards was often seen as a "hazard" rather than a crime. Many participants agreed that closed environments such as wards, poor supported accommodation or housing, deprived neighbourhoods, social isolation and disconnected communities were circumstances that increased vulnerability to targeted violence and abuse. Sexual safety for women on mixed-sex wards was mentioned, along with the risks posed by high staff turnover and the use of agency staff on wards to ensuring patient and staff safety.

> …where you'll find not so good outcomes is closed environments which have little outside influence coming in… (Participant, Best Interest Assessor Focus Group).

> Not having staff you can rely on makes it much more difficult…when we talk to staff, particularly unqualified staff, about what makes them feel unsafe, they say agency staff… (Participant, Social Worker Focus Group).

The reduction in or lack of access to mental healthcare and support was recognised as potentially increasing vulnerability to targeted violence and abuse from neighbours and others. The institutionalisation and desensitisation of mental health ward staff was seen by some as risking the safety of patients, with police respondents citing difficulties in accessing wards and gathering evidence from victims in response to patient reports of crime.

3.5.3 | Views on professional roles and responsibilities

Data from focus groups confirmed findings from service user interviews about systematic "buck passing" between professionals and

agencies and lack of follow-up after incident reporting or a complaint. There was a specific example restrictive professional boundary setting by a children and families social worker:

> …I was expected to be the master of it all then, dealing with these children and talking her [mother] down from the issue [targeted abuse]…and I was saying to her, it's not my area (Participant, Social Worker Focus Group).

Practitioners reported difficulties in being able to take individual responsibility for responding to reports of targeted violence and abuse in fragmented systems and structures with imprecise lines of reporting. Unclear communication and management, as well as a lack of shared language were also emphasised as problems. "Blame cultures" in mental health and social work could mean that practitioners are afraid to take responsibility or whistle blow for fear of reprisal. Defensive practice was highlighted as a difficulty by social workers and some mental health practitioners.

> …to provide a holistic service around a vulnerable person…criminal justice…housing and health care… [need to] start talking the same language (Participant, Focus Group 2).

> …you know if we actually sort of go cap in hand and start to offer our services collectively…it requires individuals in that process to go above and beyond (Participant, Focus Group 2).

Staff desensitisation to targeted violence and abuse, particularly towards female service users with a history of trauma, multiple needs and unstable lives was reported as a potential factor in individual blaming or not believing people, refusal of services or lack of referral adult safeguarding.

3.6 | Findings from two Twitter discussions (Responses *N* = 585 and *N* = 139)

The first Twitter chat largely confirmed the themes identified in the preliminary analysis of the service user interviews. A number additional and expanded points were made by the discussants. The Twitter chat findings suggested that service users live with and manage fear and stigma, as well as mental distress and isolation, loneliness, homelessness or neglect by family and friends are risk factors for victimisation. Discussants said that "being different" or 'not belonging' can lead to the victimisation of people with mental health problems and trauma of previous abuse can be replayed in mental health services and supported accommodation. Austerity and political victim blaming were seen as creating a permissive culture for abusing people with mental health problems. The invalidating effects of diagnoses such as "personality disorder" and being "written off" by services were seen as posing a risk of exposure to targeted violence and abuse. The importance of a safe home and supportive network for protection and prevention was emphasised.

The second Twitter chat largely confirmed the themes identified in the preliminary analysis of the mental health and adult safeguarding focus groups. Again, a number of additional and expanded points were made as a result of the facilitated discussion. Discussants recommended that the possibility of individuals having histories of trauma and abuse should be accounted for in adult safeguarding in mental health and that individuals and situations not fitting "criteria" for support can put them in vulnerable positions. Practitioners and services were seen as needing to respond quickly to reports of targeted violence and abuse, to mitigate the risk of disengagement and further harm. Service users, carers and staff can feel "lost in the process", confused and disempowered and people who "speak up" can fear reprisal.

4 | DISCUSSION

A notable number of the study findings on mental health service user concepts and experiences of targeted violence and abuse are consistent with the existing social care literature included in the study scoping review (Carr et al., 2017), and from research located in criminal justice disciplines (Koskela, Pettitt, & Drennan, 2016; Pettitt et al., 2013). The findings on reporting, self-worth and "psychiatric disqualification" are specifically highlighted in this and other studies as particular issues for victims of which need to be considered in both adult safeguarding and criminal justice responses (Carr et al., 2017). "Psychiatric disqualification" occurs when people are discredited or delegitimised because of their mental health or diagnosis, here resulting in under-reporting and significant inequalities in accessing adult safeguarding. Koskela et al. (2016) indicated that when reporting crime to the police, people with mental health problems often found that "their mental health problems were often seen as a label that stigmatised them, and their reports were discredited and disbelieved" (Koskela et al., 2016 p.1014). An analysis of Pettitt et al. (2013) research into the criminal victimisation of people with mental health problems concluded that this group experiences "further loss of voice and agency when interfacing with agencies of the state" because of their mental health status (Carver, Morley, & Taylor, 2017 p.43). It is officially recognised that victims of hate crime in general fear not being taken seriously or being blamed and may be less likely to report incidents, often owing to experience or expectation of negative responses from criminal justice agencies (CPS, 2018; HM Government, 2012b). The findings from this study suggest that these agencies are not limited to those in the criminal justice system, but also include mental health and social care agencies, particularly adult safeguarding.

The study findings show that mental health service user experiences and concepts of vulnerability and risk from others are different to those considered by practitioners, which more commonly focus on "mate crime", coercive control by family and financial abuse.

The interviews highlighted mental health services and supported housing as places of risk and increased vulnerability to targeted violence and abuse. Service user reporting of violence and abuse in mental health services and on wards have been explored for sexual violence (Foley & Cummins, 2018) and patient safety (Berzins, Louch, Brown, O'Hara, & Baker, 2018). The findings of this study indicate that neglect can be experienced as targeted abuse in such settings. Reported risks included those posed by closed or semi-segregated environments (such as wards or supported housing) and by staff either as actively perpetrating, condoning by inaction, discouraging or intervening on incident reporting to the police (see also Koskela et al., 2016), or failing to report safeguarding concerns. This implies the need for adult safeguarding to reach into those environments. Practitioners in this study reported that they are not confident to use mental health adult safeguarding procedures and partnerships to their best effect. This can result in slow, unnecessarily complicated, inadequate or fragmented responses. Mental health service users have little awareness of adult safeguarding, their legal rights or how to raise a concern.

The research reveals a number of factors that can prevent hate crime recognition, raising safeguarding concerns, reporting to the authorities and accessing safeguarding and criminal justice support for victims with mental health problems. This has important implications for the implementation of the Care Act 2014 person-centred adult safeguarding in mental health social care (LGA, 2015) and its principles of empowerment, prevention, proportionality, protection, partnership and accountability (NHS England, 2017). Multi-agency partnership working with housing staff and the police is expected (SCIE, 2015). There are also implications for the fulfilment of associated professional and service standards in mental health. The Health Care Professions Council for England and Wales standards of conduct, performance and ethics for registered practitioners who will have adult safeguarding responsibilities are explicit about promoting and protecting the interests of service users and carers, managing risk and reporting safety concerns (HCPC, 2016). The Care Quality Commission has safety as a fundamental regulation standard. Policy on hate crime has a focus on addressing under-reporting and promotes inter-agency working to support more victims of hate crime to report it, and make the necessary information available (HM Government, 2012b).

Study findings suggest a number of areas for practice improvement. An increased awareness of what adult safeguarding is in relation to "hate crime" is needed so that mental health professionals with responsibility for adult safeguarding are in a position to fulfil the safeguarding legislation and criminal justice policy imperatives for people with mental health problems who are victims of targeted violence and abuse. Further clarity is needed on how adult safeguarding functions to protect people who experience targeted violence and abuse, including neglect, in mental health services and settings. Mental health service users' experiences and concepts of risk from others, vulnerability and neglect should be central to adult safeguarding, and experiences of targeted violence and abuse in defining disability hate crime. Histories of trauma, multi-factorial abuse, living with fear and stigma as well as mental distress, "psychiatric disqualification" and individual blaming should be addressed in adult safeguarding practice in mental health. This implies that mental health adult safeguarding should be trauma-informed (Sweeney, 2016). Service users reported wanting mental health and adult safeguarding practitioners to listen and believe them; be accountable and responsible; to take ownership of the issue; and help them pursue justice. They recommended having independent peer workers and advocates who can provide person-centred and consistent support for navigating complex mental health, adult safeguarding and criminal justice processes to resolution stage.

4.1 | Study limitations

The vast majority of the service user interview participants were women, so the findings largely reflect the concepts and experiences of a relatively diverse group of women. The lack of men's experiences and perspectives constitute a significant limitation in the study. The inclusion of two carer proxies to improve the inclusion of perspectives from male and rurally based service users presents another limitation because responses are mediated and interpreted rather than direct. Because recruitment was predominantly conducted through service user networks and groups, interview participants were more likely to be engaged in various types of self-help and mental health activism, creating a potential bias. These interview participants were also self-selecting, which means that they were not representative of the general population of mental health services users in England. The use of Twitter for gathering qualitative data is still novel and largely untested, and it has been noted that it is very difficult to make general assumptions based on Twitter discussion (Ruiz-Soler, 2017).

5 | CONCLUSION

This study indicates that service users who experience targeted violence and abuse because of their mental health are falling through a number of gaps in the various social and service systems that surround risk management and safety, adult safeguarding and disability hate crime. Service users may discount their own experiences of violence and abuse, not expecting to be believed or not believing that safeguarding or "hate crime" applies to them. They are also discounted by others on the grounds of their mental health status: their lack of credibility is often reflected back to them by mental health services and professionals operating the safeguarding systems, the police, friends and family, neighbours and the general public. Equally, mental health and safeguarding professionals are often failing to fill those gaps through a lack of ownership and a reluctance to take individual or collective responsibility for pursuing safeguarding alerts. This is partly because of a lack of confidence to take ownership or advocate for individuals in such a system. Establishing collective and individual responsibility between agencies and individual practitioners, sharing information, trauma-informed working, developing a common language and open cultures are needed if adult safeguarding

is to be person-centred, accessible and effective for people with mental health problems who are at risk or victims of targeted violence and abuse. Staff need to feel supported and confident to take responsibility, raise concerns and challenge bad practice.

Having a psychiatric diagnosis is a powerful message to services and society that an individual lacks credibility and it appears that the systems and services themselves may have absorbed the lack of credibility felt by service users. And yet, the lives and backgrounds of the service users interviewed for this study demonstrate that these are people with significant previous experience of violence, abuse and discrimination, people who surely should qualify for adult safeguarding support.

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CONFLICT OF INTEREST

None.

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