

Safeguarding in mental health: towards a rights-based approach

abstract

The current adult safeguarding system is failing people with mental health problems. Despite the introduction of the Department of Health's *No Secrets* guidance in 2000, abuse is still widespread in private homes, the community, and health and social care settings. New research from Mind demonstrates the urgent need for a shift in focus towards a prevention model of safeguarding, with service user involvement at its core. Currently, people feel disempowered by and frustrated with a paternalistic system that labels them 'vulnerable' and fails to take account of their preferences in making decisions about their safety. This has led to a real lack of faith among people with mental health problems in current procedures to ensure their safety, which undermines the entire safeguarding project. Mind conducted survey and focus group research that highlights three key areas where adult safeguarding is failing people with mental health problems: the system disempowers individuals and excludes them from participating in decisions about their level of risk; there is a systemic lack of engagement with safeguarding by the NHS, meaning institutional abuse is widespread and unchecked; and discrimination at the heart of the criminal justice system means that people with mental health problems are being denied equal access to justice, which poses a risk to their human rights. In light of these findings, Mind is calling for a wholesale revision of the current approach to adult safeguarding towards a rights-based approach, which is underpinned by user involvement.

key words

Adult safeguarding, mental health, abuse, human rights, user involvement, prevention

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Introduction

People with mental health problems are not the bread and butter clients of the adult safeguarding system. This is despite the fact that many people with mental health problems fall easily within the definition of 'vulnerable adult'¹. In part, this is because adult protection is still primarily seen as the preserve of social services – hospitals and community mental health teams, being NHS-led, tend to rely on internal investigations and complaints systems to deal with incidents of abuse. Police are seldom called to inpatient settings and adult protection referrals for mental health service users are a very rare occurrence, even in the community². Risk assessment is seen as the mechanism for keeping patients safe in the NHS – people with mental health problems are supervised, treated and sometimes detained for their own (and others') safety and in return, so the theory goes, professionals will ensure that they are not at risk of abuse.

The NHS approach reflects the other fundamental problem with the adult safeguarding system as a whole, namely that it disempowers the very people it seeks to protect. Until now, adult safeguarding procedures have been based on a paternalistic intervention model – adult protection is something that is done to 'vulnerable adults' by everybody else, namely health, social care and criminal justice professionals. This principle underpins the current authoritative voice on adult safeguarding, the Department of Health's *No Secrets* guidance (Department of Health, 2000). Yet this traditional model of safeguarding, built around inter-agency crisis intervention, is clearly failing. Despite the introduction of *No Secrets* in 2000, abuse is still widespread in private homes, the community, and in health and social care settings³.

New research by Mind (2009) demonstrates the urgent need for a shift in focus towards a prevention model of safeguarding, with service user involvement at its core. Our consultation with people with experience of mental distress yielded unexpected results about where the responsibility for keeping people safe should lie, and what should happen in the event of abuse occurring. What we found also pointed towards a clear vision for the future of adult protection – a system that must be rooted in empowering people and upholding their human rights.

Mind is calling for a wholesale revision of the current approach to adult safeguarding towards a rights-based approach, in line with the *UN Convention on the Rights of Persons with Disabilities*, which the UK Government ratified in June 2009:

‘The Convention marks a “paradigm shift” in attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as “objects” of charity, medical treatment and social protection towards viewing persons with disabilities as “subjects” with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.’ (United Nations Department of Economic and Social Affairs & Office of the High Commissioner for Human Rights, 2009)

This article outlines the extent of abuse and victimisation experienced by people with mental health problems, before setting out the methodology used in Mind’s new research. It then discusses the findings of our research and the consequent implications for a new, rights-based approach to adult safeguarding.

Experiences of personal safety, abuse and victimisation

The current adult safeguarding system is failing. Research by Mind and others has consistently found that too many people

experiencing mental health problems feel unsafe at home, in the community and on mental health wards. In 1999, Mind published *Silenced Witnesses*, a report highlighting the extent to which people with mental health problems experienced discrimination, harassment and abuse. This often resulted in people being unable to work, being driven away from their homes, or feeling terrorised and scared to leave their houses.

Mind’s *Ward Watch* research (Mind, 2004) revealed a shocking picture of patient safety on mental health wards – 20% of patients reported physical assault, 18% reported sexual harassment and 5% reported sexual assault. The National Patient Safety Agency report (2006) highlighted similarly disturbing levels of sexual harassment and assault on wards and the *National Audit of Violence* (Healthcare Commission and Royal College of Psychiatrists, 2007) also revealed worrying levels of physical assault in inpatient settings. As Patel (2005) records, the Mental Health Act Commission, in its regular interviews with detained patients and annual visits to all hospitals, identified ‘serious abuses of patients’ rights each week’.

Subsequent research by Mind has shown that, for people with mental health problems, a high risk of abuse is not limited to mental health wards, but is also prevalent in the community. Our report, *Another Assault* (Mind, 2007), found that 71% of survey respondents had been victimised in the community at least once in the past two years. Of these, more than 25% were targeted in their own homes. In their community, 18% of survey respondents rarely felt safe and only 36% felt safe all or most of the time. In their home, only 19% of respondents felt safe all the time.

The literature in this field corroborates Mind’s findings about the extent of abuse experienced by people with mental health problems and, crucially, the apparent inability of mental health services – in hospitals and

in the community – to prevent and/or deal with incidents effectively. As Faulkner (2005) demonstrates, poor treatment and abuse on acute adult psychiatric wards is all too common, and complaint or redress is rarely fruitful. Brown and Keating (1998) identify a traditional resistance by mental health workers to generic adult protection procedures, which have been viewed as potentially conflicting with specialist risk assessment processes such as the care programme approach and supervised discharge. Williams and Keating (2000) also note the reluctance of mental health services to tackle the problem of abuse, arguing that this is rooted in the *'huge asymmetry of power between service user and service provider'*, meaning that the relationship is inherently unequal and, potentially, abusive in itself.

Why is the adult protection system failing so spectacularly? Mind's new research suggests an answer – people feel disempowered by and frustrated with a system that labels them 'vulnerable' and fails to take account of their preferences in making decisions about their safety. This apparent lack of faith among mental health service users in existing procedures to keep them safe potentially undermines both the principles and practice of adult safeguarding.

Methodology

As part of the review of the *No Secrets* guidance in early 2009, Mind was commissioned by the Department of Health to consult with people who have direct experience of mental distress about their experiences of abuse and what steps respondents would like to be taken by the authorities to keep them safe. Mind produced a short questionnaire based on the main issues raised by the government's consultation. The questions focused on experiences of vulnerability or feeling at risk of abuse, issues around personal safety, and the appropriate role of agencies to intervene to protect adults. We opted for a short survey based on closed-ended

questions to maximise the sample, as Mind often finds that lengthy surveys that require a number of answers in full prose discourage people from responding, or are returned incomplete. We used Likert scale questions as we were largely interested in assessing respondent's attitudes towards personal safety and the role of agencies. To minimise the bias that results from closed-ended questions, we also gave respondents an opportunity to explain their answers further in full prose through two open-ended questions.

Questionnaires were sent to our networks comprising 2,000 people with experience of mental distress (Mind Link), 180 local Mind associations (voluntary organisations providing services to people with mental distress), and 150 black and minority ethnic people with experience of mental distress (Diverse Minds). We received 84 completed surveys, which was a response rate of 3.6%. Although this is a relatively low response rate, it is unsurprising given the sensitive, personal and potentially distressing nature of the issues in the questionnaire. Eighty-four responses is also a fairly good total for a survey of this nature distributed via Mind's networks, particularly given that the period for responses fell over the Christmas holidays. Although a sample of 84 responses is not statistically significant or generalisable, our findings provide valuable data and useful insight into people's experiences of abuse and their attitudes towards personal safety and the involvement of statutory agencies.

Mind's survey research was complemented by two focus groups involving people with experience of mental distress. The sessions each involved five participants and two facilitators, and were held in urban areas. Participants were recruited by staff at local Mind associations and each group was mixed in terms of age, gender, ethnic background, and mental health diagnosis. Any anonymous quotations included in this article are from the people who took part in the focus groups.

The focus groups allowed for more in-depth discussion and used hypothetical vignettes to explore some of the issues. This was to ensure that people did not feel that they had to disclose their own experiences in order to illustrate their arguments. The case studies we used were fictional but based on scenarios that are commonly experienced by people with mental health problems living in the community. Both sessions discussed a vignette involving an isolated person who is 'befriended' by a group of boys who then exploit his hospitality, culminating in theft, which explored the role of social workers and other agencies. In addition, one session focused on issues of risk relating to personalisation and direct payments, while the other used an example of family abuse to explore what service users want in terms of protection and empowerment to keep safe from abuse.

Our research related to issues that were potentially distressing and difficult for individuals to discuss or disclose, such as experience of abuse and sense of vulnerability. Therefore, Mind took the following steps to ensure that we had due regard to ethical considerations and that people were kept safe. We ensured that all written responses to the questionnaires were anonymous and participants could not be identified from any written report of the focus groups. We informed all respondents that they could find out about mental health support in their area via Mindinfoline and Mind's website, and provided them with the Samaritans phone number should they wish to talk to someone further. The focus groups were deliberately small, with two facilitators available and an identified quiet space for people to go to if they needed time out. We made sure that focus group participants were not expected or encouraged to disclose their own experiences, but were supported if they chose to do so. Finally, focus group facilitators had relevant CRB checks for working with vulnerable adults.

The starting point for our research was: what do service users want to happen if they are at risk of abuse? Given that the *No Secrets* guidance rests on the premise that there is an identifiable group of 'vulnerable' adults, who the rest of society – primarily health, social care and criminal justice agencies – has a duty to protect from abuse, Mind wanted to investigate whether this approach was the right one, from the perspective of the people it ostensibly protects. What we found, as outlined below, is that the paternalistic nature of current safeguarding policies in itself contributes towards their failure to reduce the high incidence of abuse.

Findings and recommendations for change

Mind's research found that 84% of respondents felt that they were vulnerable or at risk of abuse some or all of the time. Only 16% of respondents said that they did not feel at risk. We heard anecdotal evidence of shocking levels of abuse perpetrated by family, friends, neighbours, carers, health professionals, care home staff and, most worryingly, of a consistent failure by the authorities to deal with these incidents effectively.

Our findings point towards three key areas where adult safeguarding is failing people with mental health problems. First, the system disempowers individuals, excluding them from participating in decisions about their levels of risk, and thus fails to pursue a preventative approach to safeguarding. Second, a systemic lack of engagement with safeguarding by the NHS means that institutional abuse is widespread and unchecked; dealt with internally rather than referred to the police or adult safeguarding teams. Third, discrimination at the heart of the criminal justice system leads to abuse not being reported by victims – or victims not being believed when they do report it – so people with mental health problems are being denied equal access to justice, which

poses a risk to their human rights. These areas will now be addressed in turn, setting out Mind's findings and our consequent recommendations for change, which should underpin a new rights-based approach to adult safeguarding.

Empowering individuals

An important finding yielded by our research was that people with mental health problems resist being automatically labelled as 'vulnerable' by virtue of a diagnosis. Although the vast majority of respondents (70 out of 84) did feel vulnerable or at risk of abuse some or all of the time (often because of their mental health), at the same time people strongly felt that their vulnerability is not constant, but may fluctuate in line with their condition. As one focus group participant with a diagnosis of bipolar disorder said:

'If I have a breakdown, then yes I am "vulnerable" but not when I am strong. I am only vulnerable at certain times and in certain circumstances.'

The current definition – which is the gateway to referral to adult protection teams – is based on people's diagnosis, identity, personal characteristics, or eligibility for services. This tends to place people firmly in either the 'vulnerable' or 'not vulnerable' camp. Thus, some people with mental health problems are not referred to adult protection teams when they should be, because the current definition is often interpreted as those 'who meet the high level of need required for access to local authority social care services' (Mind, 2008). On the flipside, others are deemed to have a permanent high level of vulnerability, when this is inappropriate due to the fluctuating nature of their condition and their needs.

The latter consequence is emblematic of the broader problem with the adult safeguarding system. By prejudging people's

level of risk based on their mental health or other characteristics, professionals make safeguarding decisions based on assumptions, without assessing the circumstances of each case and without the input of the individual in question. A strong message from our research was that people wanted to have a say in decisions that are made if they experience abuse. Perhaps surprisingly, the vast majority of survey respondents felt that they were responsible for their own safety – sometimes in partnership with professionals (see **Table 1**). Focus group participants strongly felt that an individual's right to choose and make decisions for themselves must be protected as far as possible, even if others think they are at risk from abuse:

'It's the individual's choice at the end of the day, even if they have mental health problems.'

As a corollary, respondents did not want social workers to have extra powers to enter someone's home, or remove them from their home, without their consent.

'It's very difficult because social workers can advise but not control someone. It's Peter's⁴ choice in the end – he has the right to say "It's my house, and I will let in who I want to". Perhaps the social worker could get Peter's neighbours to check on him, something more informal than involving the police, because in the end it's still his home.'

'Why should she move? It's her home! Why should she have her life turned upside down?'

Fifty-seven per cent of survey respondents (43 out of 75) either agreed or strongly agreed that they would like the right to refuse any interference by the authorities, even if they were the victim of abuse. Only 18% (15 out of 75) would waive this right.

The current *No Secrets* model of safeguarding as 'everybody's business'

(Department of Health, 2000) – except, that is, the business of the individual being safeguarded – is therefore flawed and undermines the government’s commitment to ensuring that people have greater ‘*choice and control*’ over their own care (Ministers *et al*, 2007). It sets up a power imbalance between the professional – who protects – and the service user – who needs protection – which is particularly problematic in relation to mental health, due to people’s negative experiences of intervention, compulsion and detention.

A new approach to safeguarding must strike a balance between autonomy and protection. Individuals should have the right to make potentially risky decisions – when they have capacity and are supported to manage their personal safety – but still have the right to be protected under safeguarding procedures when things go wrong. There is no need for new legislation to enable professionals involved in safeguarding to weigh these rights. The *Mental Capacity Act (MCA) 2005* (HM Government, 2005) already provides a legal framework for assessing an individual’s capacity to take decisions and communicate their wishes. Crucially, in the event that someone does lack capacity, the MCA provides a checklist to ensure that decisions are made in the best

interests of the person, as well as recourse to an independent advocate for those requiring additional support. The MCA offers an approach that is sensitive to fluctuating needs and determines capacity on a case-by-case basis each time a decision needs to be made. Only when a person legally lacks capacity under the MCA should professionals go against the stated wishes of the individual. Otherwise, safeguarding decisions should be taken jointly by professionals and individuals, as described subsequently.

A rights-based approach to safeguarding recognises that people have the right not to be subjected to inhuman or degrading treatment (Article three of the *Human Rights Act 1998* (HM Government, 1998)) but also the right to respect for a private and family life (Article eight). In practical terms, this leads to the following recommendations for change. First, a new approach to safeguarding must have user involvement as its core principle. On an individual level, developing a personalised definition of when a person feels vulnerable – and what steps that person would like to take and be taken by others in case they are at risk of abuse – should be an integral part of every service user’s care planning and support process. People should be encouraged to

Table 1 Who has responsibility for keeping you safe?

People were asked to tick all answers that applied to them.		
Answer	Percentage	Number of respondents out of 84
Me	86%	72
Health professionals	55%	46
My family	43%	36
My friends	37%	31
Police	35%	29
Social workers	30%	25
Housing workers	27%	23
General public	23%	19

assess their own risk and set out, in the form of advance statements, how they can stay safe and who they would prefer to be (or not be) involved if abuse occurs. Alongside this, the definition of 'vulnerable adult' should be scrapped and replaced with one that takes account of fluctuating conditions, focuses on people's circumstances, and articulates their *right* to be protected under safeguarding guidance, should they be vulnerable or consider themselves to be so, rather than one that defines them as vulnerable *per se*.

At an institutional level, agencies have a duty to involve users in their recruitment and management procedures, as the risk posed to people with mental health problems comes all too often from health and social care professionals working in the community and in hospitals and care homes. Respondents felt that CRB checks were an inadequate safeguard and other criteria – such as someone's personality, behaviour or approach to providing care – were more important than a list of past convictions in making them feel safe. Eighty-nine per cent of respondents (69 out of 77) also said that they would feel safer if they were able to choose who provides their care, which indicates that personalisation has a key role to play in a preventative approach to adult safeguarding.

An example of good practice in user involvement is Mersey Care NHS Trust. Their human resources department employs a manager with specific responsibility for service user and carer involvement, whose job includes ensuring that a service user or carer sits on every recruitment panel. Out of 4,000 workers at the Trust, 2,000 have now been recruited with the involvement of a user or carer (Equality and Human Rights Commission, 2009). In relation to the personalisation agenda, which is the most developed form of user involvement, local authorities should provide mechanisms to support people who choose to direct their own care in becoming an employer. This might

include offering rooms so that interviews can take place on neutral ground, a template of questions and assessment criteria, or a 'rent a panel' service for people interviewing potential personal assistants, which might be provided by voluntary organisations or a peer support group. In this way, people can access the benefits of personalisation while being supported to manage the associated risks and keep themselves safe.

Another crucial aspect of an approach to safeguarding that empowers individuals is a focus on prevention and social inclusion. Focus group participants felt that intervention by the authorities already amounts to a failure of adult safeguarding policies, because effective adult protection centres on reducing the risk of someone being in a position of vulnerability in the first place.

'The CPN should also see if he can get more support, get him into day centres, so he isn't so isolated and reliant on the boys' company to be happy. [The authorities] need to deal with the root of why the abuse is happening – which is loneliness and isolation.'

'I just didn't know who to go to for help. I was so desperate for company that just having them in for a coffee was worth it, even though I knew that they were stealing from me and taking advantage.'

'If I'd been at a day centre at the time, that would have helped. Abuse happens because you are so lonely and desperate for company – there is the fear that if you have a fit, you don't want to be alone, and the fear of not having support, alongside your physical and mental problems.'

Isolation within the community was identified as a key risk factor by respondents, because people may be so lonely that they permit abuse to continue, even if they are aware they are being exploited, in order to maintain the

human contact. Once these 'friendships' have been formed, intervention by the authorities in the event of escalation is more difficult. It is crucial, therefore, that a new approach to safeguarding includes a right for people who do not meet the high levels of need under the fair access to care services (FACS) criteria (Department of Health, 2003) but do need support to live independently and to access social inclusion services, where this is likely to reduce the risk of harm or abuse.

Finally, for those situations where abuse is not prevented, a safeguarding system that empowers individuals must include a right to an independent advocate for all victims of abuse, to support them in reporting the incident and ensuring that it is handled through the appropriate channels. Mind's *Another Assault* research (Mind, 2007) shows that people with mental health problems are reluctant to report crimes because they do not expect anything to be done or even to be believed. Abuse itself creates disempowerment, which can make it very difficult for the victim to come forward, for fear of reprisals, losing their care package or betraying the abuser. It is crucial that victims of abuse are empowered to know their rights, understand what safeguarding procedures and criminal justice processes might involve, and are signposted to support and information. It is equally important that whatever remedy is applied to prevent further abuse and bring the perpetrators to justice is agreed with the full involvement and in the best interests of the victim.

There is already the precedent to use advocacy as a tool to rebalance the system in favour of service users. People who are detained under the *Mental Health Act 2007* (HM Government, 2007), people making complaints about health and social care services, and people who lack capacity to make decisions about their health and social care needs have a right to an advocate under recent government legislation. As part of

a rights-based approach to safeguarding, it would be consistent to extend this right to victims of abuse.

Engaging the NHS in safeguarding

Our research found that, for people with mental health problems, institutional abuse remains prevalent and often unchallenged. Although we did not directly ask for details of people's own experiences, over half of survey respondents (44 out of 84) opted to disclose that they had experienced abuse, largely by health and social care professionals or in institutional settings. According to testimonies shared in survey responses and focus groups, this kind of abuse manifests itself in multiple ways: in misuse of medication, in disproportionate use of restraint, in discrimination, aggression and bullying towards patients, in sexual and physical assault, and in failure to act when abuse is perpetrated, either by other patients or by staff. Whether people are voluntary or detained patients on mental health wards, everyone has the right to receive treatment in a therapeutic and safe environment – but our research starkly demonstrates that this right is not being upheld by the NHS.

In many instances, the NHS is simply failing to engage with the adult safeguarding process, as the government has recognised (Department of Health, 2008). Incidents of abuse are either not dealt with at all or are seen as internal incidents and not referred either to the police or safeguarding teams. The following quotations indicate the extent of the problem.

'My mum had her arm broken on the ward by another patient, but it wasn't dealt with. The staff attitude was just – "we can't watch them all".'

'Once in hospital I had been punched in the face several times and a patient tried to hit me with a pool cue... It was weird because the nurses

were standing around and witnessed it, and they just said I should have hit him back.'

'Abuse by mental health patients towards other patients, especially on the wards, isn't taken seriously. Staff say that we have to avoid these patients but it isn't always possible.'

Our research uncovered reports of a disturbing sense of complacency within mental health wards with regards to the occurrence and prevalence of abuse – it is often seen by staff as 'part of the territory'⁵. This undermines the entire premise of adult safeguarding, which presumes that the system is the vehicle for protecting 'vulnerable' adults. Yet, for people with mental health problems, the system itself can often be the abuser. Mental health patients have the right not to be subjected to inhuman or degrading treatment while in hospital – and they also have the right to expect that such treatment will be reported and dealt with properly, when it does occur. A new approach to safeguarding must articulate these rights, underpinned by strengthened duties on health professionals to co-operate with adult safeguarding procedures. This must be accompanied by new guidance for mental health services on how to implement effective adult protection procedures internally, as well as engage with the wider safeguarding network. The leadership and responsibility for adult safeguarding must be clearly located in all NHS trusts, at both delivery and senior management levels, to achieve NHS buy-in to the safeguarding process.

Health care settings do not have different rules from wider society, and abuse should be dealt with appropriately, involving the police if a crime has been committed. There should be stronger duties on all agencies to co-operate under adult safeguarding guidance including, crucially, to share information between agencies about potential or actual incidents of abuse at an early stage, a measure that was supported by two-thirds of survey respondents

(50 out of 73). To tackle the 'mental health system problem', a right for all patients to clear and accessible information and advice on where to report abuse, whether internally or externally, must be enshrined in a new approach to adult safeguarding.

Tackling discrimination at the heart of the criminal justice system

It is not just in health care settings, however, where the abuse of people with mental health problems is swept under the carpet. A key barrier to the effective operation of the adult safeguarding system is discrimination at the heart of the criminal justice system, which results in a failure to act on instances of abuse. Our research findings show that this is manifest in several ways. First, abuse is often not seen as, and is therefore not dealt with as such a crime. It is a welcome step forward that section 44 of the MCA established the criminal offence of ill treatment or wilful neglect. However, this move does not sufficiently address the problem that the current approach to adult safeguarding effectively defines 'abuse' as something separate, an experience that only happens to 'vulnerable' adults. In reality, 'abuse' by another name may be domestic violence, neglect or mistreatment, grooming, theft, sexual assault, or hate crime under the *Mental Health Act 2007* (HM Government, 2007) or the MCA. Talking about 'abuse' can lead to action not being taken, when people have in fact been the victim of a crime, such as in these examples from our research.

'I have reported severe sexual abuse to the authorities for many years and no action has ever been taken.'

'Four people I know have reported serious [hospital] injuries from abuse – two were ignored, two were left with the abuser and made even more vulnerable, no one gave ongoing support, no one was prosecuted.'

‘[Because of my agoraphobia] I had to trust my neighbours with my bank card and my PIN – they were getting their shopping on my credit card as well as mine... The police can’t do anything, because I had given my neighbours a key, so even when they stole property from my house, the police said they couldn’t take action.’

Second, stigma within the police force may lead to disproportionate treatment of people with mental health problems, even when they are a victim, resulting in a vicious cycle of mistrust and low reporting rates. Focus group participants felt strongly that they would be unlikely to go to the police if they experienced abuse, because of previous negative encounters. As one participant summed it up:

‘The problem is that some police officers assume someone with mental health issues is trouble – so their approach is wrong.’

People felt that the police may not always be the best agency to intervene in cases of abuse where the victim has mental health problems, as police officers have a tendency to assume a link between mental health problems and violence. Therefore, they act pre-emptively, with a lack of sensitivity and perhaps with aggression or misuse of force. Mind repeatedly hears accounts of the police being rude, dismissive and patronising, or in some instances verbally abusive or physically aggressive. When people disclose their mental health diagnosis, police officers sometimes lose sympathy or harden their attitude.

Third, people with mental health problems are often deemed, by both the police and the Crown Prosecution Service (CPS), to be unreliable or non-credible witnesses, so their cases may be dropped, denying the victim their right to equal access to justice. Many respondents felt that they were more vulnerable because of their mental health, because if abuse did happen, they would not

be believed by the authorities – some had experienced this discrimination firsthand.

‘I have experienced sustained sexual abuse from another person with mental health problems [but] the police couldn’t prosecute because CPS said I wasn’t a credible witness as I had mental health problems.’

A recent landmark judgement by the High Court has established that assuming a lack of credibility by virtue of someone’s mental health diagnosis is unacceptable and potentially a risk to their human rights (*R (FB) v Director of Public Prosecutions (EHRC intervening)* [2009] EWHC 106). The court found the CPS to be in breach of Article three of the *Human Rights Act*, because they failed to pursue an assault case on grounds that the victim had schizophrenia and was deemed to be an unreliable witness. The victim had experienced a serious physical assault, which was effectively condoned by the failure to secure any justice in his case.

Our research consistently demonstrates that criminal justice agencies are failing to play their part in adult safeguarding. This is due to discrimination being at the heart of the criminal justice system, which means that people with mental health problems are being denied their fundamental right to see justice done where they are the victim of abuse. A new approach to adult safeguarding must reinstate this right and secure it in practice through a number of measures. Prosecutors need clear guidance on the appropriate and sensitive use of psychiatric evidence, and when and how mental health conditions can affect the validity and accuracy of evidence. Mind welcomes the CPS’s recent publication of a new policy on *Supporting Victims and Witnesses with Mental Health Issues* (Crown Prosecution Service, 2009), but this must now translate into a change of attitude on the ground if the barriers to justice faced by people with mental distress are to be truly overcome.

All police officers should receive mental health awareness training delivered by someone with experience of mental distress. This should include specific reference to the relevance of safeguarding, so that police officers are reminded that referral to the adult protection team is one of the tools that they have at their disposal for responding to crisis situations involving a victim with mental health problems. There are good examples in some areas of police forces working with third sector organisations, like local Mind associations, to deliver training and build relationships to break down stereotypes and improve trust. In Hackney, for example, the Metropolitan Police's mental health liaison officer has set up training for new recruits, delivered by mental health service users. He provides a monthly 'surgery' at City and Hackney Mind, where people can report crimes and seek advice informally. Mind is keen to disseminate this good practice across the country in order to improve the way that the police respond to situations involving victims experiencing mental distress.

According to our research, people with mental health problems have a lack of faith in statutory systems to report crime or abuse, because of low expectations of being taken seriously, but also due to a lack of trust in the police to deal with their cases sensitively and appropriately. People should have a right to access third-party reporting schemes, which provide an independent, accessible and safe space where both inpatients and those receiving care in the community can report abusive incidents. Statutory agencies have a duty to encourage the development of these schemes in every local area and to ensure their sustainability where they already exist.

Fundamentally, a rights-based approach must bring about an end to the misperception that safeguarding is somehow outside the mainstream criminal justice system. Everyone has a right to expect crimes against them to be treated as crimes. This means that the police

and other agencies should apply the criminal justice powers that already exist to intervene in cases of abuse. Mind strongly rejects government proposals to extend police powers or introduce new powers for social workers. Such an approach would further disempower people who experience abuse, and also risk setting up a parallel system to deal with abuse against 'vulnerable' adults. This wrongly implies that abuse is a lesser offence than other crimes – in a similar way to how domestic violence was historically perceived as a lesser crime to assault or grievous bodily harm. The police already have clear operating procedures around the criminal offences typically referred to as 'abuse', as well as criteria for intervention. Decisions to intervene against a person's wishes in the most serious cases should be made on a case-by-case basis that weighs up people's human rights, which is in line with the approach to case handling in the domestic violence field. In these instances, a specialist officer with dedicated training in mental health and human rights could be called on to make such decisions.

Conclusion

Adult safeguarding essentially comes down to a balance between autonomy – the right to a family and private life – and protection – the right not to be subjected to inhuman or degrading treatment. A rights-based approach recognises this, takes user involvement as its starting point and uses existing legal frameworks to assess risk and intervene where there is a serious risk of harm. In the most serious cases, Mind believes that the MCA provides a useful framework for making decisions about when it might be necessary to override people's expressed wishes in situations of abuse. Many professionals involved in safeguarding remain hesitant about how to apply the MCA, so guidance should be produced that includes specific reference to safeguarding decisions.

Above all, there must be a shift in focus away from viewing safeguarding as protecting 'vulnerable' people from abuse, towards the principle of upholding everyone's human right not to be subjected to inhuman or degrading treatment. The government's initial analysis of responses to the *No Secrets* review is promising, as it appears to recognise some of the key issues around empowering individuals, user involvement in decision-making, and the need for the NHS and the criminal justice system to play their full role in safeguarding (Department of Health, 2009). However, it is one thing to recognise these imperatives, but quite another to follow them up with concrete action. Mind is lobbying the Department of Health to take forward the recommendations we make in this article through its review of the *No Secrets* guidance.

Shifting to a rights-based approach is not just about government guidance, however. It is incumbent on each professional involved in adult safeguarding – whether a carer, social worker, GP, mental health professional, housing officer, police officer or CPS prosecutor – to build user involvement into their individual working practices. People with mental health problems must be respected and valued by the professionals providing their care, and service users need to feel involved and listened to rather than stigmatised, marginalised and abused. That is the only way to make safeguarding a reality in mental health.

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Endnotes

¹ The current definition of 'vulnerable adult' in the *No Secrets* guidance is a person 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself, or unable to protect him or herself against significant harm or exploitation' (Department of Health, 2000).

² The Commission for Social Care Inspection (2008) found that people using mental health services, as well as black and minority ethnic people, are still particularly under-represented in safeguarding referrals.

³ The government itself acknowledges the prevalence of abuse in both community and institutional settings (Department of Health, 2008), while Mind's research has consistently found considerable evidence of abuse against people with mental distress, as outlined in this paper.

⁴ Peter was the fictional name given to one of the protagonists in the vignettes used in the focus groups.

⁵ The Commission for Health Improvement (2003) found that staff in some mental health trusts accept violent behaviour on wards as the norm, and Mind's research (2004; 2009) has confirmed that this is an all-too common attitude among staff.

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