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# Title

The experiences of people with mental health problems who are victims of crime with the police in England: a qualitative study

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# Abstract

Despite public beliefs to the contrary, people with mental health problems are more likely to be victims of crime than perpetrators. Dominant media representations of the mentally ill person who murders, has deflected attention from the victim with mental health problems including their experiences of accessing the criminal justice system. The qualitative study explored the experiences of 81 people with mental health problems in their decision making and experiences of reporting the crime to the police. Many of their experiences were the same as other victims. However, their mental health problems were often seen as a label that stigmatized them, and their reports were discredited and disbelieved. This study offers insights relevant to policy and professional practice and education.

# Key words

victim, mental health problem , criminal justice system, police

## MANUSCRIPT FILE Version 2

## Introduction

Mental health problems are common in all societies. Despite public beliefs to the contrary, people with mental health problems are more likely to be victims of crime than perpetrators (Schnittker 2013). The moral panic (Cohen 1972), generated by the dominant media representations of the mentally ill person who murders, has deflected attention away from the much more common experience of the person with mental health problem as victim. A number of countries have published government reports and policies addressing people with mental health problems when they are offenders (see for example Bradley 2009; Correctional Service Canada 2010). However, less attention has been paid to issues within the criminal justice system when the person with mental health problems is the victim. Mental health problems are known to be socially stigmatizing (Goffman 1963) and this frames the study reported here which explores the experiences of people with mental health problems in accessing the criminal justice system, focusing on their experiences with the police.

### Mental health problems and victimisation

Mental health problems range from depression to schizophrenia and are the result of both individual determinants and also social, cultural, economic, political and environmental factors (World Health Organization 2013). Prevalence estimates for high income countries are one in four or five of the adult population (World Health Organization 2013). Common across all societies is the often negative view taken of people with mental health disorders leading often to stigmatizing of individuals (Crisp et al. 2000), that is they are marked as not ‘normal’ and rejected by others in society (Goffman 1963). The consequences of having a character stigma and a place outside of the ‘normals’ (Goffman 1963) is discrimination in many areas of social life (Thornicroft et al. 2009). A widely held public belief is that people with mental health problems are likely to commit acts of violence and those with serious mental illness (SMI), such as schizophrenia, are likely to kill others (Schnittker 2013), despite evidence to the contrary (Taylor & Gunn 1999). Analysis of the media portrayal of the people with mental health disorders shows this stereotype is common in many countries (Nawková et al. 2012; Thornicroft et al. 2013) and supports the creation of ‘moral panics’ (Cohen 1972). One consequence has been that policy, research and clinical practice have focused on the risk of violence that people with SMI pose to others and relatively little attention has been paid to violence committed against those with mental health problems (Choe, Teplin, & Abram 2008).

A growing body of evidence shows that people with mental health problems experience high rates of violent and non-violent victimisation and are more likely to experience victimisation than the general population (Bengtsson-Tops & Ehliasson 2012; Teplin et al. 2005). Women with SMI are particularly vulnerable (Khalifeh et al. 2015a). There is also some evidence of higher rates of re-victimisation (Teasdale, Daigle, & Ballard 2014). The impact of being a victim of crime is dependent on the type of crime, the context and resilience of the individual (Walklate 2007). There is, however, a growing body of evidence in the USA and the UK that people with severe mental illness experience a more adverse effect from victimisation than the general population (Khalifeh et al. 2015b; Lam & Rosenheck, 1998).

Mawby and Walklate (1994) have argued that socio-structural processes make some victims visible and others invisible and that understandings of victimisation should be located within specific historical, socio-economic, cultural and political contexts (Walklate 2007). In recent decades, a number of countries have developed policies to enable victims of crime greater opportunities for participation in the criminal justice process and to ensure they are treated in a fair and respectful manner by criminal justice professionals (Walklate 2007). These policies have incorporated an increased consideration of vulnerable victims and witnesses with the provision of special protections and support during the criminal justice process (Groenhuijsen & Pemberton 2009) and in England this includes victims with mental problems (Minstry of Justice 2013).

In the UK, the mental health advocacy group Mind drew attention to difficulties that people with mental health problems could experience in reporting crimes and having the case prosecuted in court (Mind 1999; 2007). A systematic review of the criminal justice experiences of adults with mental health problems as victims of crime (McCracken & Perry 2009) identified only one study of American police officers views (Watson, Corrigan, & Ottati 2004). There is therefore very little evidence from the perspective of the victim who has mental health problems, as to the experiences of accessing the criminal justice process and the factors which might inhibit or facilitate access. This study addressed the question of what is the experience of accessing criminal justice processes by people with mental health problems who have been victims of crime and focuses on their experiences with the police.

This study was part of a larger project which also investigated issues of prevalence of victimisation (Pettitt et al. 2013). It was supported by an advisory group of experts-by-experience who had both long term mental health problems and had been the victim of crime(s).

## Methods

The study drew on interpretive approaches which emphasises multiple experiences and interpretations of individuals in social interactions (Creswell 2007). Semi-structured interviews were the method chosen as their flexibility made them suitable for exploring complex sensitive issues with vulnerable groups (Liamputtong 2007). A topic guide was used, designed to focus on the criminal justice access experience rather than the crime itself, in particular to try and avoid re-victimisation and minimize distress (Kavanaugh & Ayres 1998). The topic guide and participant information sheets were developed in collaboration with the advisory group. Particular attention was paid in the planning of the interviews to issues of research ethics and managing any distress (Keogh & Daly 2009). The study was approved by a NHS Research Ethics Committee. With permission, interviews were audio recorded and then transcribed. Anonymised transcripts were imported into the software package NVivo 9 (2010, QSR International Pty Ltd, www.qsrinternational.com). Thematic analysis was used (Braun & Clarke 2006), involving two researchers with a third to help resolve points of difference. This allowed codes to emerge inductively from the data or be theoretically driven, influenced by the research questions, and previous literature (Braun & Clarke 2006). The advisory group reviewed and commented on the findings and interpretations of the study helping to ensure the validity and credibility of the researchers’ account (Seale 1999).

**The participants**

A purposive sample (Seale 1999) was planned to ensure diversity in experience by virtue of gender, age and ethnicity. Participants had to have been a victim of crime/s in the last three years, have mental health problems, and had capacity to consent to participating as defined by the Mental Capacity Act 2005. The experiences of crime were time bounded to the last three years to facilitate recall. Participants were recruited via organizations already working with individuals of interest to the study such as Mind and Victim Support. Initially recruitment was in Greater London and then in other locations in the Midlands and South West of England. Interviews were held in a private room at local Mind, Victim Support or community mental health team offices. Written consent was obtained from all participants. The average length of the interviews was two and half hours.

Eighty one participants were interviewed. The majority (82%) of the sample lived in Greater London. The sample captured substantial diversity in terms of gender, age, ethnicity, disability and sexual orientation, as well as the type of mental health problem and crimes experienced. We interviewed slightly more women than men (57% vs. 43%) and the majority of participants (78%) were aged between 25 and 54 years. Fifty six percent of the participants described themselves as White British, 22% as Black or Black British, 9% as Asian or Asian British, 9% as mixed or other and 5% as White non-British. The majority of participants described themselves as heterosexual and 14 described themselves as gay, lesbian or bisexual. About a third of the participants described themselves as having another type of disability as well as their mental health problem. Seven had a learning disability and 19 described having a physical disability or illness, such as epilepsy or diabetes. The majority were not economically active with only a fifth in work. Just over half described themselves as long-term sick/ill or temporarily sick/ill. Participants were asked to describe the mental health problems they experienced in their own words, the most frequently reported being depression (Table 1). Two thirds of the sample reported that they were accessing support from community mental health services. Just under a third had had experience of being detained under the Mental Health Act 2007.

Table 1: Types of mental health problems reported by participants.

|  |  |
| --- | --- |
| **Type of mental health problem** | **Number of participants (n=81)** **\*** |
| Depression | 40 |
| Anxiety disorder (including OCD) | 28 |
| Schizophrenia | 15 |
| Bipolar disorder | 14 |
| Personality disorder | 10 |
| Depression with psychosis | 9 |
| Post-traumatic stress disorder (PTSD) | 8 |
| Schizoaffective disorder | 4 |

\* The majority of participants described experiencing more than one type of mental health problem.

Participants described being victim to 184 crimes in the interviews. The most commonly described crime by participants was assault (Table 2). More women described being the victim of sexual violence than men.

Table 2: Type of crime reported by gender.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Crime type** | **Female** | | **Male** | | **All** | |
| **No.** | **%** | **No.** | **%** | **No.** | **%** |
| **(n=46)\*** | **(n=35)\*** | **(n=81)\*** |
| Assault | 23 | 21.9 | 31 | 39.2 | 54 | 29.3 |
| Threats and harassment | 13 | 12.4 | 12 | 15.2 | 25 | 13.6 |
| Theft from person | 15 | 14.3 | 9 | 11.4 | 24 | 13.0 |
| Sexual violence | 19 | 18.1 | 2 | 2.5 | 21 | 11.4 |
| Anti-social behaviour | 10 | 9.5 | 9 | 11.4 | 19 | 10.3 |
| Burglary | 8 | 7.6 | 9 | 11.4 | 17 | 9.2 |
| Partner violence | 11 | 10.5 | 3 | 3.8 | 14 | 7.6 |
| Family violence | 5 | 4.8 | 0 | 0.0 | 5 | 2.7 |
| Fraud | 1 | 1.0 | 4 | 5.1 | 5 | 2.7 |

\* Participants reported multiple types of victimisation.

## Findings

We report the findings first of all in relation to the decision to report the crime and then on the experience of reporting the crime to the police and subsequent events.

### Decision making in reporting the crime to the police

A fifth of crimes discussed in the interviews were not reported to the police. The police were reported to know about the other four fifths of the crimes through a variety of routes (Table 3). Participants described reporting half of the crimes they experienced themselves while a fifth were reported by someone else. The non-reporting of offences to police is well-documented in all populations and rates vary by country, type of crime, gender, employment status and ethnicity (Maguire 2012).

Table 3: The way in which the crimes became known to the police

|  |  |  |
| --- | --- | --- |
| **How the crimes became known to the police** | **No. of crimes (n=184)** | **%** |
| ***Self-reported*** |  |  |
| Without support | 92 |  |
| With support from others | 8 |  |
| *Total* |  | 54.3 |
| ***Reported by another*** |  |  |
| Reported by formal service (e.g. health professional) | 11 |  |
| Reported by witness | 11 |  |
| Reported by informal supporter (e.g. friends or family) | 10 |  |
| Reported by member of the public | 5 |  |
| Reported by perpetrator | 4 |  |
| *Total* |  | 22.3 |
| ***Police discovered the crime*** |  |  |
| Police found the stolen items s | 2 |  |
| Police were on the scene | 2 |  |
| *Total* |  | 2.2 |
| ***Not reported to the police*** | 39 |  |
| *Total* |  | 21.2 |
| ***Overall Total*** | 184 | 100 |

We identified four themes of positive influences on the participants’ decision to report the crime and four which deterred reporting the incident.

#### Themes positively influencing the decision to report a crime

The four themes identified as positive influences on decisions to report crime were: 1) the views and support of others, 2) the perceived degree of seriousness and impact of the incident, 3) the accessibility of the police and 4) the desire to prevent re-occurrence to themselves or others.

Friends, family, mental health professionals and care staff were described as playing an important role in validating the seriousness of the incident and the need to report to the police. This has been noted before in relation to women experiencing intimate partner violence (Davies, Block, & Campbell 2007) and rape (Paul et al. 2014). They were described as providing advice and support, sometimes reporting the crime themselves or physically accompanying the person during the reporting as in these exemplars.

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]

The perceived degree of seriousness of the incident and associated impacts, or the threat of further harm to themselves or others was a factor influencing whether they reported the incident, as in the exemplar below. Perceptions of crime seriousness cut across the range of crime types. This influencing factor has been noted before in studies of women experiencing rape, sexual assault and intimate partner violence (Davies et al. 2007; Resnick et al. 2000) as well as in large national victimisation surveys (Tarling & Morris 2010).

[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]

The police being easily accessible to the participant was reported as assisting in reporting, for example, by their presence in accident and emergency departments and at community events. Several participants described the benefits of having community police officers they were familiar with and felt happy to talk to, which is supportive of research reporting that a localized neighbourhood policing approach can improve public confidence in the police (Lowe & Innes 2012).

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, anti-social behaviour, threats and harassment]

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]

#### Themes negatively influencing the decision to report a crime

In some instances the non-reporting related to the perceived trivialness of the crime or likelihood of recovery of stolen items, such as pick-pocketing of a mobile phone, a factor well described in other studies (Tarling & Morris 2010). Beyond this we identified four themes of negative influences to reporting to the police which include some mirror opposites to the positive influences. They all relate to social interactions and are: 1) previous negative experiences of the police, 2) fear of not being believed or blamed, 3) the emotional and mental health impact of the crime, 4) the participant’s relationship to the perpetrator, including while resident in psychiatric facilities.

*Previous negative experiences*. Many participants cited how having prior negative experiences with the police prevented them from reporting crime. A number described previous experiences of attempting to report crime(s) which were either not taken forward or did not result in a satisfactory outcome, which deterred them from reporting subsequent incidents. This is a negative influence identified in the existing literature (MacDonald 2001; Skogan 1994). Many said they had not been believed when they reported previous crimes because of their mental health problems as in the exemplar below, which is consistent with earlier research by Mind (Mind 2007).

*To be honest, I don’t trust [the] police anymore. [...] their track history is shit with me, like I said I’ve never once gone to court for any crime that’s happened to me. Never. I mean, I haven’t even given a statement when it’s been a rape.* [Int77, female, partner violence, sexual violence and assault]

Several described their previous encounters with the police during times of mental health crisis as a barrier, particularly being removed to a place of safety (known as ‘*being sectioned’)* under the Mental Health Act 2007. These experiences were reported as frightening and humiliating, as in the exemplar below, and the officers involved were commonly perceived as lacking empathy and understanding.

*I went home and told my support worker [about the attempted rape]. And she was like, you need to report it. And it was her that actually phoned the police because like I’ve had dealings with the police in the past, and it’s usually been around my mental health and I just always had like a rubbish response [...] Like with sectioning me and stuff like that [they’ve] just been really horrible to me.* [Int74, male, sexual violence]

A few participants reported that they felt targeted by the police themselves, having been stopped and searched on several occasions. Others with a history of offending commented that poor experiences with police in that context also acted as a deterrent to reporting crime. Prior negative experiences with the police are not unique to people with mental health problems and personal contact plays an important role in shaping public trust and confidence in the police (Bradford, Jackson, & Stanko 2009). In the UK studies show that confidence in the police is lower in those with recent contact (Bradford, Jackson, & Stanko 2009) and victimisation surveys consistently show that recent victims of crime are less likely to have confidence in the police compared to non-victims (Office of National Statistics 2014).

*The fear of being not being believed or being blamed.* Participants reported that an inhibiting factor to reporting crime was their perception that they would not be believed because of their mental health problem, as in this exemplar:

*[I worried] that they [the police] would have the same attitude as a lot of people have, the minute you hear about oh, someone has a mental illness, they think that they’re a nutter and that their word can’t be believed.* [Int54, male, assault]

In addition participants said they worried that they would be blamed for the incident or that they might be sectioned if they reported the crime to the police as in this exemplar.

*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, a risk to yourself to the community and end up getting sectioned or something and that’s not what I want.* [Int33, male, assault and anti-social behaviour]

The non-reporting of crime for fear of being blamed or disbelieved have been found in general population studies of victims of intimate partner violence (Wolf et al. 2003) as well as women with mental health problems who were victims of domestic violence (Rose et al. 2011). However, in this study this was found across the types of crime and related to participants’ understandings and experiences of societal stigma towards mental health problems (Thornicroft et al. 2009).

*The emotional and mental health impacts of the crime.*

Feelings of shame, embarrassment and self-blame were described as deterrents to reporting crime as in this exemplar.

*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]

Non-reporting of crime because of embarrassment and shame is well document in the general population (Hoyle 2012), particularly for sexual and domestic violence (Fugate et al. 2005). These feelings may result from beliefs that becoming a victim has diminished the presentation of the adult self-identify (Goffman 1959) or be a result of the crime itself being seen as shameful and social discrediting (Goffman 1963). Participants in this study also recounted that the impact of the crime on their mental health left them feeling too unwell, too shocked, scared or distressed to approach the police, particularly those who were victimised during times when their mental health problems were severe.

*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]

The emotional and mental health impacts of criminal victimisation are well documented (Kilpatrick & Acierno 2003; Shapland & Hall 2007), and people with pre-existing mental health problems are more severely affected that those without (Khalifeh et al. 2015a).

*Knowing the perpetrator, including while resident in psychiatric facilities.*

Participants reported that knowing the perpetrator was a deterrent, for example neighbours, partners, family or friends, and this was most common for the crime types of domestic violence and anti-social behaviour (ASB). They reported fear of repercussions or an escalation of the situation as detailed in this examplar:

*I didn’t phone the police, I was too scared to phone the police. I was like all they would do is arrest him and then they’d end up letting him out that night then he’d come back looking for me. I thought if I phone the police he’s going to know I phoned the police and that is going to make things worse.* [Int34, female, partner violence]

Some were concerned about getting the perpetrator into trouble something often reinforced by the reactions of those they told about the crime. A number were actively deterred from reporting by perpetrators threatening further violence or disruption, particularly in cases of ASB and domestic violence. This deterrent is well documented in the general population particularly in cases of domestic violence (Felson et al. 2002; McHugh & Frieze 2006) and has been noted in relation to people with mental health problems (Marley & Buila 1999).

When the crimes took place in psychiatric facilities, as was the case for nine participants, participants described some very specific barriers, particularly when the perpetrator was a staff member. Some described being actively prevented by staff from reporting to the police as in this exemplar:

*I went to the staff and I told them what happened [being raped by another patient] in the morning. And they basically just dismissed it. They wouldn’t let me make a phone call. They wouldn’t let me see an advocate. They wouldn’t let me talk to the police. They wouldn’t let me go to A&E* (Accident and Emergency Department) *so I could get myself medically checked out [...] And then they refused to let me off the ward which was very frightening because being a voluntary patient I assumed that I had rights to come and go as I wanted. [Int2, female, sexual violence and theft from person]*

Most described receiving unsympathetic or disbelieving responses from staff on the ward they disclosed to which discouraged them from going to the police. Two participants reported that on telling staff about the crime, this was then dealt with under policies for the protection of a vulnerable adult and the hospital’s internal complaints system rather than a criminal justice matter. Four UK based qualitative studies with in-patients in psychiatric facilities have described experiences of violence while an in-patient and how staff could not be relied upon to keep patients safe. (Jones et al., 2010; Kumar, Guite, & Thornicroft 2009; Mezey, Hassell, & Bartlett 2005; Quirk, Lelliott, & Seale 2004). These studies do not provide much detail about how violence is dealt with, or explore experiences where a staff member is the perpetrator.

### Experiences of reporting crime to the police and subsequent events

We turn now to the findings about the experience of reporting the crime(s) to the police. The two overarching themes are of positive and negative experiences, although it should be noted that often an individual received both positive and negative responses related to the same incident.

#### Positive experiences of reporting and subsequent events

Three quarters of participants mentioned some positive element in their contact(s) with the police. These have been grouped into two themes: 1) non-stigmatizing response to the mental health problem, 2) taking action on the report and follow up, and these are now discussed in turn.

*Non-stigmatizing response to the mental health problem.*

Participants described that police officers became aware of their mental health problems in different ways. For example whilst some made a conscious choice to disclose to the police themselves, others said this information was shared by another person without their consent, or how they were already flagged as having mental health problems in the police database.

Participants viewed the responses positively when they did not discriminate once they became aware of their mental health problems; showed empathy; demonstrated understanding; and took appropriate actions. Participants indicated that these sorts of responses demonstrated to them they were taking the crime and their mental health condition seriously.

*the police were so nice and so supportive that I actually started crying…”Don’t worry, chap, we’ll get an ambulance”, nice and touched me physically, and calmed me. Didn’t restrain me, but very gentle contact. (Int33, male, assault and anti-social behaviour)*

Many participants in this study spoke specifically about good interpersonal treatment, highlighting the importance of being listened to and receiving validation from police officers. Validation was described as being helpful in reinforcing to participants that they were being taken seriously, that the crime was wrong and their reactions to the crime were reasonable, as in this exemplar:

*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, so I felt weak. Almost like a victim. And they [the police officers] said actually they didn’t blame me, she was quite intimidating. [...] They said she is very, very overpowering and they can understand why I felt the way I did. [...]* *It did help me to hear that it’s not because I’m just weak and I’ve been almost an easy target for her. It did make me feel better.* [Int46, female anti-social behaviour]

Other general population studies have found that good interpersonal treatment and emotional responsiveness by police officers is important to victims of crime (Laxminarayan et al. 2013; Chandek 1999). This study supports findings from a recent Australian study which found that police validation of participants’ victimisation experiences was important to victims of a range of crime types and helped alleviate some of the negative feelings associated with victimisation (Elliott, Thomas & Ogloff 2013). Validation may be particularly important to people with mental health problems in order to counteract their expectations of being treated inequitably because of their mental health problems (Farrelly et al. 2014).

The following two themes are also linked to evidence of positive experiences being linked to non-stigmatizing and discriminatory responses because of their mental health problems.

*Taking action on the report and follow up.*

For participants, the demonstration of a non-stigmatizing response was also in ‘taking action’ on the report. It helped to convey that they were being taken seriously and in some cases it helped them start to rebuild lost feelings of safety. Participants spoke positively about police taking actions to investigate the crime including collecting evidence, attempting to find the perpetrator, talking to, arresting or charging the perpetrator. Many also valued the police taking actions to ensure they were safe in the immediate aftermath of the crime and via follow-up contact. This included being provided with safety equipment or receiving follow-up visits to check they were feeling safe, as in this exemplar.

*The police officers were wonderful [when I got mugged], they came round straight away. We went to see if we could find the kid who had stolen the phone and then someone visited me a week later at my friend’s house and they organised a rape alarm being sent to me.* [Int1, female, sexual violence and theft from person]

The importance to victims of the police taking action has been noted before and has been shown to influence victim’s perceptions of fair treatment and their overall satisfaction with the police (Chandek 1999; Elliott, Thomas & Ogloff 2013).

Positive experiences of taking action did not end with the actual reporting but in the continued follow up by police officers. Being kept informed and updated on their case reassured participants that the police were doing what they could and had not given up, as in this exemplar.

*He [police officer] took a lot of time to explain things and do things like give me his name and his number and he was very kind of, he, he kind of acknowledged that it must have been very hard for me […] he let me know when he’d be back in touch next, ….Which I really appreciated. ……*. [Int79 female, theft from person and partner violence]

Previous studies have highlighted victim’s needs for information across crime types in the aftermath of crime (ten Boom & Kuijpers 2012). Existing evidence shows that having these needs met is valued by victims and associated with more positive judgements of the criminal justice system (Laxminarayan et al. 2013).

For some participants the positive experience was where the police activity supported them in obtaining assistance to cope with the aftermath of crime or in other related aspects of their lives such as through referral to other services such as to Victim Support, health services, neighbourhood policing teams or local council services, as in this exemplar.

*They [the police] contacted my psychiatrist [with my permission] because it was making me unwell. I mean, they wrote a letter as well recommending that I move house for my safety and my health.* [Int66, female, anti-social behaviour]

In the UK, as in many other European countries, the police are required to provide victims with information and directly refer victims to victim services (Minstry of Justice 2013). The key role the police can play in helping victims to connect with services and support after crime has been noted before (Zaykowski 2014), and is of particular relevance for people with complex problems which require a multi-agency response.

#### Negative experiences in reporting crimes and subsequent events.

Ninety percent (61) of participants who had contact with the police said they had at least one negative experience during this contact. These have been grouped into six themes: 1) poor responses to disclosure of mental health problems , 2) perceived lack of empathy and respect , 3) perception of being blamed, 4) feeling they were disbelieved and discredited, 5) lack of action, lack of communication and dropping cases , and 6) the impact of the negative experience with the police.

*Poor responses to disclosure of mental health problems.*

Over a third of participants (32) described receiving negative responses from police officers on disclosure of a mental health problem which is double the number who said they received a positive response. Some participants described receiving reactions from officers they felt were lacking in empathy and sensitivity, including instances where participants had their disclosures ignored as in this exemplar,

*They [police officers] didn’t say anything [*when I told them I had post-traumatic stress disorder*]. The thing was like just a non-event, sort of like alright, kind of thing. […] if they could have just acknowledged it and made me feel a bit more at ease,* just *saying ‘that’s okay’. Because I, I literally had no idea what they thought.* [Int79, female, partner violence and theft from person]

A number suggested that the attitudes and behaviours of the police officers changed towards them in a negative way after disclosure and felt this reflected negative public stereotypes about mental health problems. This included police officers automatically blaming participants for the crime or not believing their version of events, being treated in a patronising manner, and being told they stood no chance of justice because their mental health problem deemed them unreliable in the eyes of the legal system. Several said this caused them emotional distress.

*They [the police] asked me if I had mental health [problems] and when I said yeah they said to me because of my mental health my case might not be taken seriously in court because anyone with mental health they, I don’t know, it’s like anyone with mental health is not seen as a good witness, they said that.* [Int34, female, partner violence]

Existing research into disclosure of mental health problems in other contexts highlights that disclosure is a critical dilemma for individuals (Corrigan & Matthews 2003) and that openness about mental health problems can result in stigmatising and discriminatory responses and negative outcomes for the person with mental health problems (Keogh 2014; Korsbek 2013).

*Perceived lack of empathy and respect*

Police officers were described by some participants as lacking empathy and consideration in their contacts with them, even in the case of serious violent crimes like rape. Some felt the police were disinterested in their case and disrespectful of their concerns. Several described police officers normalising or playing down the incident and not appreciating its significance for them.

*I was called in by this [police officer] at one point she was actually shouting at me. [...] 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 that she composed herself.* [Int43, female, assault and anti-social behaviour]

Police lack of empathy and care has been noted by other studies exploring the experiences of victims of sexual and domestic violence (Jordan 2001; Stephens & Sinden 2000).

*Feeling they were disbelieved and discredited.*

Many participants reported not being believed when they reported incidents to the police and it was common for participants to perceive this as being directly related to having a mental health problem and the prejudice 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, it 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, anti-social behaviour, threats and harassment]

In several cases the participants described being accused by the police of being ‘*time wasters*’ – implying that they either did not believe them, or that the incident was not serious enough to warrant their attention. Some participants 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 noted in domestic violence situations, in incidents of ASB, and incidents of abuse in institutions.

*I know the first time I called the police for my son, 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 anti-social behavior, threats and harassment and family violence]

Some participants noted that they had other aspects of their identity which were perceived as discrediting, for example having a history of drug addiction or a criminal record, and suggested this also influenced such poor treatment by the police. Experiences of people with mental health problems being disbelieved and discredited have been noted before (Mind 2007; Marley & Buila 1999) and are detailed in studies exploring experiences of victims with disabilities more widely (Child et al. 2011). Other studies have suggested that police officers can hold stigmatising beliefs about people with mental health problems, most notably that mental illness is associated with increased dangerousness and violence i.e. that there is labeling of people with mental health problems as criminally deviant (Godfredson et al. 2011; Watson, Corrigan, Ottati 2004). For many participants in this study, their mental health problems become the deviant label applied by police officers that overshadowed all other aspects of their persona and situation.

*Perception of being blamed.*

Many participants described police responses that they felt suggested they were to blame for their victimisation.

*It was almost as if they were saying like “it’s your own fault” […] without actually saying that. […] The [police officer] said “are you sure this wasn’t just a drunken mistake?” and that was said twice and that’s something a person never forgets* [Int1 female, sexual violence and theft from a person]

Some participants also felt they were being held responsible for 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 officers.

*I think the initial officer I saw thought that I was to blame.[…] he said to me, "We haven’t got time to waste with fraudsters.* [Int12, male, assault and fraud]

Victim blaming responses have been noted in existing literature on the experiences victims of sexual and domestic violence (Jordan 2004; Stephens & Sinden 2000) and in studies exploring the experiences of victims with disabilities (Child et al. 2011). It has been argued that dominant stereotypes of ideal victimhood – a victim as weak, virtuous, blameless, unrelated to the offender etc. – obscure the reality of victimisation, shape societal responses to victims and exclude those who do not live up to these definitions from sympathetic treatment and support (Green 2007).

*Lack of action, lack of communication and dropping cases.*

Many participants reported a lack of action taken by the police. These criticisms included delays in attending and not pursuing the perpetrator, not following up or collecting evidence and poor practice in taking statements. Two participants recounted being told to collect their own evidence, one in a case of a rape, and others were asked to take their own photographs for evidence as police equipment wasn’t working. Failure on the part of the police to keep the victim informed about their case and difficulties contacting officers was another aspect of this, causing anxiety and frustration, as in these exemplars:

*I had to call them (the police) 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?’ …Because …he’d actually got into our home on several occasions.* [Int45, female, sexual violence]

*I made a statement for the police and everything to what happened. And nothing never got done about it. Nothing. I never heard back from them*. [Int24, male, assault and threats]

Participants described having their cases dropped. Some, although disappointed, could accept there wasn’t sufficient evidence. Others discovered that the case had been dropped because the police perceived that they were not fully co-operating. Many 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. I don’t know what they said, something like that. And you hear that a lot from people with mental health, you know, they just leave you.* [Int6, female, assault, harassment and threats]

Police lack of action in certain types of crime and in response to certain types of victims for example domestic violence has been noted in the wider literature on victim experiences (Walklate 2007), as has the lack of information and communication from police post-reporting (Victim Support 2010).

*The impact of negative experiences with the police.*

The impact of having a negative experience with the police was reported as significant for many participants. They described it exacerbating the distress they were already experiencing as a consequence of victimisation. Participants said they were emotionally affected and described feeling frustrated, disappointed, ashamed, anxious, upset and isolated. Several also said it contributed to reduced self-esteem and a worsening of their existing mental health problems as in this exemplar.

*Because of the treatment that I’ve had from the police which has just made me even more anxious, I heard this voice [in my head] which I’ve never had before and that was really scary.* [Int61, female, partner violence, anti-social behaviour and threats]

This resonates both with Link’s studies of negative effects of labeling on people with mental problems (Link et al. 1987; Link & Phelan 2001) and also with the existing literature on secondary victimisation i.e. the psychological effects of crime are worsened by inadequate treatment or negative responses victims receive from others (Parsons & Bergin 2010).

Ultimately for many participants in this study receiving a poor response meant they did not receive the help they required, were dissuaded from seeking help elsewhere and reluctant to engage with the police again. Most of the participants (n=59) reflected on whether they would report crime to the police if they were a victim in the future. Of these about a third said they would report to the police again, a third said they wouldn’t and a third said they were unsure. Those who said they would not report often cited their prior negative experiences as a reason, as in this exemplar:

*But as far as the police were concerned I would never, ever, ever make that call of 999 again. That is how, that is how strongly I feel the police let me down. Because all they did was turn my life upside down [...] I feel that they do nothing to help.* [Int25, female, threats to kill]

Those who felt unsure about future reporting said their decision to report would depend on other contextual factors related to the crime such as the seriousness of the offence, who else was affected and how mentally well they were feeling at the time. Of those participants who indicated they would report to the police again, some said they were not hopeful of receiving a positive response but felt they had a civic duty to report. That the majority of participants said they were unsure or against future reporting is concerning given the evidence showing that people with mental health problems experience high rates of repeat victimisation (Teasdale, Daigle, & Ballard 2014; Pettitt et al. 2013).

## Conclusions

The findings of this study have implications for public policy and professional practices and education within the criminal justice system. Participants’ experiences with the police were a mixture of positive and negative. Unfortunately, negative experiences were more common and had detrimental effects on participant’s emotional wellbeing and mental health. Some of these negative experiences may be related to systematic problems within the criminal justice system, such as a lack of resources to pursue certain crimes. However, our study does suggest that deviant labelling and stigmatising attitudes of police officers contribute to this negative experience. For example their response in dismissing, disbelieving or even blaming the victim with mental health problems. Whilst this paper focuses solely on experiences with the police it should be noted that participants reported going to a range of services for help after victimisation and receiving similarly mixed responses across all services. In many ways this is not surprising given the media, research and policy focus on people with mental health problems as perpetrators of crime – and the resulting stereotyping which perpetuates them as ‘ folk devils’ (Cohen 1972). Mental health stigma has been identified as a key barrier to help-seeking in health service contexts (Clement et al. 2015) and this study suggests this is also the case in the context of criminal victimisation.

This is the only study we know of to explore, in depth, the experiences of people with mental health problems with the police service when they have been victims of crime. Whilst other studies have explored the types of encounters and perceptions of people with mental health problems in relation to the police, they have either overlooked victimisation or drawn conclusions from an aggregation of the different types of contacts this group have with the police. The study has limitations for example, the participants were self-selecting and may have chosen to participate specifically because they had had negative experiences. The breadth of the data, however, belies a purely negative orientation. The study was based on the self-reports of participants and there is consequently a risk of reporting bias, however existing evidence indicates that reports of victimisation by people with mental illness are reliable and valid (Goodman et al. 1999; Teplin et al. 2005). The large and diverse sample of participants in terms of mental health problems, crime experiences and demographic backgrounds adds to the validity of this study, however future research might explore the experiences and perceptions of police officers when they have contacts with victims of crime with mental health problems.

Contacts between the police and people with mental health problems are common and occur under a range of contexts (Livingston et al. 2014) including responding to mental health crises, often as the first responders (Anderson et al. 2013), as offenders, and as victims. Relationships between the police and people with mental health problems are consequently uniquely complex, with tensions existing between the different roles police play in their lives (Cummins 2007) which, as this study shows, influences reporting behaviour in the context of victimisation. This research demonstrates the impact of sympathetic and well informed responses by police officers. A good response also involves taking action and liaising with other agencies to support vulnerable people with complex needs. Research with police officers in the UK reports that they find their role in the mental health arena challenging (Mclean & Marshall 2010) and are concerned by the lack formal mental health training received, recognizing their need for greater knowledge and understanding of people with mental health problems (Cummins 2007). While policy requires greater input from police in the mental health arena, evidence suggests the resources are constrained to do so (Her Majesty’s Chief Inspector of Constabulary 2014). Recent innovations in the UK in collaboration between mental health services and the police, such as mental health nurses assigned to police services (Department of Health 2014), could be extended to address some of the issues highlighted here in working together to support victims with mental health problems.

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## References

Anderson, K. K., Fuhrer, R., Schmitz, N., & Malla, A. K. (2013). 'Determinants of Negative Pathways to Care and their Impact on Service Disengagement in First-episode Psychosis', *Social Psychiatry and Psychiatric Epidemiology*, 48/1: 125–36.

Bengtsson-Tops, A., & Ehliasson, K. (2012). 'Victimization in Individuals Suffering from Psychosis: a Swedish Cross-sectional Study', *Journal of Psychiatric and Mental Health Nursing*, 19/1: 23–30.

Bradford, B., Jackson, J., & Stanko, E. A. (2009). 'Contact and Confidence: Revisiting the Impact of Public Encounters with the Police', *Policing and Society*, 19/1: 20–46.

Bradley, K. (2009). 'Lord Bradley’s Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System', London: Department of Health.

Braun, V., & Clarke, V. (2006). 'Using Thematic Analysis in Psychology', *Qualitative Research in Psychology*, 3/2: 77–101.

Chandek, M. S. (1999). 'Race, Expectations and Evaluations of Police Performance', *Policing: An International Journal of Police Strategies & Management*, 22/4: 675–695.

Child, B., Oschwald, M., Curry, M. A., Hughes, R. B., & Powers, L. E. (2011). 'Understanding the Experience of Crime Victims with Disabilities and Deaf Victims', *Journal of Policy Practice*, 10/4: 247–267.

Choe, J. Y., Teplin, L. A., & Abram, K. M. (2008). 'Perpetration of Violence, Violent Victimization, and Severe Mental Illness: Balancing Public Health Concerns', *Psychiatric Services*, 59/2: 153-64.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Thornicroft, G. (2015). 'What is the Impact of Mental Health-related Stigma on Help-seeking? A Systematic Review of Quantitative and Qualitative Studies', *Psychological Medicine*, *45*/1: 11–27.

Cohen, S. (1972). *Folk Devils and Moral Panics*. London: McGibbon and Kee.

Correctional Service Canada. (2010). *Mental Health Strategy For Corrections in Canada*. Accessed last 19.12.2014 at http://www.csc-scc.gc.ca/health/092/MH-strategy-eng.pdf

Corrigan, P., & Matthews, A. (2003). 'Stigma and Disclosure: Implications for Coming Out of the Closet', *Journal of Mental Health*, *12*/3: 235–248.

Creswell, J. W. (2007). *Qualitative Inquiry and Research Design: Chosing Among Five Approaches.* (2nd, Ed.). Los Angeles: SAGE.

Crisp, A. H., Gelder, M., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). 'Stigmatisation of People with Mental Illnesses', *The British Journal of Psychiatry*, 177/1: 4–7.

Cummins, I. (2007). 'Boats Against the Current: Vulnerable Adults in Police Custody', *The Journal of Adult Protection*, 9/1: 15–24.

Cummins, I. (2013). Using Simon’s Governing Through Crime to Explore the Development of Mental Health Policy in England and Wales Since 1983. *Journal of Social Welfare and Family Law*, 34/3: 325–337.

Davies, K., Block, C. R., & Campbell, J. (2007). 'Seeking Help from the Police: Battered Women’s Decisions and Experiences'. *Criminal Justice Studies*, 20/1: 15–41.

Department of Health. (2014). *Mental Health Crisis Care Concordat: Improving Outcomes For People Experiencing Mental Health Crisis*. London: HM Government.

Elliott, I., Thomas, S., & Ogloff, J. (2013). 'Procedural Justice in Victim-Police Interactions and Victims’ Recovery from Victimisation Experiences', *Policing and Society*, *24*/5: 588–601.

Farrelly, S., Clement, S., Gabbidon, J., Jeffery, D., Dockery, L., Lassman, F., Thornicroft, G. (2014). 'Anticipated and Experienced Discrimination Amongst People with Schizophrenia, Bipolar Disorder and Major Depressive Disorder: a Cross-sectional Study', *BMC Psychiatry*, *14*/1: 157.

Felson, R. B., Messner, S. F., Hoskin, A. W., & Deane, G. (2002). 'Reasons for Reporting and Not Reporting Domestic Violence to the Police', *Criminology*, *40*/3: 617–648.

Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). 'Barriers to Domestic Violence Help-seeking: Implications for Intervention', *Violence against Women*, *11*/3: 290–310.

Godfredson, J. W., Thomas, S. D., Ogloff, J. R., & Luebbers, S. (2011). 'Police Perceptions of Their Encounters with Individuals Experiencing Mental Illness: A Victorian Survey', *Australian & New Zealand Journal of Criminology*, *44*/2: 180–195.

Goffman, E. (1959). *The Presentation of Self in Everyday Life.* London: Penguin.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New Jersey: Prentice-Hall.

Goodman, L. A., Thompson, K. M., Weinfurt, K., Corl, S., Acker, P., Mueser, K. T., & Rosenberg, S. D. (1999). 'Reliability of Reports of Violent Victimization and Posttraumatic Stress Disorder Among Men and Women with Serious Mental Illness', *Journal of Traumatic Stress*, *12*/4: 587–99.

Green, S. (2007). Crime Victimisation and Vulnerability. In S. Walklate (Ed.), *The Handbook of Victims and Victimology* (pp. 91–117). London: Willan Publishing.

Groenhuijsen, M. S., & Pemberton, A. (2009). 'EU Framework Decision for Victims of Crime: Does Hard Law Make a Difference?',*The* *European Journal of Crime, Criminal Law and Criminal Justice*, *17*: 43–59.

Her Majesty’s Chief Inspector of Constabulary. (2014). *State of Policing: The Annual Assessment of Policing in England and Wales 2013/2014*. London: HMIC. Accessed last 12.05.2015 at http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/state-of-policing-13-14.pdf

Hoyle, C. (2012). Victims: the Criminal Process and Restorative Justice. In M. Maguire, R. Morgan, & R. Reiner (Eds.), *Oxford Handbook of Criminology* (pp. 398–426). Oxford: Oxford University Press.

Jones, J., Nolan, P., Bowers, L., Simpson, A., Whittington, R., Hackney, D., & Bhui, K. (2010). 'Psychiatric Wards: Places of Safety?', *Journal of Psychiatric and Mental Health Nursing*, *17*/2: 124–30.

Jordan, J. (2001). 'Worlds Apart? Women, Rape and the Police Reporting Process', *British Journal of Criminology*, *41*/4: 679–706.

Jordan, J. (2004). 'Beyond Belief?: Police, Rape and Women’s Credibility', *Criminology and Criminal Justice*, 4/1: 29–59.

Kavanaugh, K., & Ayres, L. (1998). '“Not As Bad As It Could Have Been”: Assessing and Mitigating Harm During Research Interviews on Sensitive Topics'. *Research in Nursing & Health*, 21/1: 91–7.

Keogh, B. (2014). 'Service Users’ Disclosure Practices Following Discharge From Hospital', *Mental Health Practice*, *17*/7: 14–19.

Keogh, B., & Daly, L. (2009). 'The Ethics of Conducting Research With Mental Health Service Users', *British Journal of Nursing*, 8/5: 277–281.

Khalifeh, H., Johnson, S., Howard, L. M., Borschmann, R., Osborn, D., Dean, K., Moran, P. (2015a). 'Violent and Non-violent Crime Against Adults With Severe Mental Illness', *The British Journal of Psychiatry : The Journal of Mental Science*, 206/4: 275–82.

Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Howard, L. M. (2015b). 'Domestic and Sexual Violence Against Patients With Severe Mental Illness', *Psychological Medicine*, *45*/4: 875–86.

Kilpatrick, D. G., & Acierno, R. (2003). 'Mental Health Needs of Crime Victims: Epidemiology and Outcomes', *Journal of Traumatic Stress*, 16/2: 119–32.

Korsbek, L. (2013). 'Disclosure: What Is The Point And For Whom?', *Journal of Mental Health*, *22*/3: 283–90.

Kumar, S., Guite, H., & Thornicroft, G. (2009). 'Service Users’ Experience of Violence Within a Mental Health System: A Study Using Grounded Theory Approach', 10/6: 597-611

Lam, J. A., & Rosenheck, R. (1998). 'The Effect of Victimization on Clinical Outcomes of Homeless Persons With Serious Mental Illness', *Psychiatric Services*, *49*/5: 678–683.

Laxminarayan, M., Bosmans, M., Porter, R., & Sosa, L. (2013). 'Victim Satisfaction with Criminal Justice: A Systematic Review', *Victims & Offenders*, 8/2: 119–147.

Liamputtong, P. (2007). *Researching the Vulnerable: a Guide to Sensitive Research Methods*. London: SAGE.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). 'The Social Rejection of Former Mental Patients: Understanding Why Labels Matter'. *American Journal of Sociology*, *92*/6: 1461–1500.

Link, B. G., & Phelan, J. C. (2001). 'Conceptualizing Stigma', *Annual Review of Sociology*, 27/1: 363–385.

Livingston, J. D., Desmarais, S. L., Verdun-Jones, S., Parent, R., Michalak, E., & Brink, J. (2014). 'Perceptions and Experiences of People with Mental Illness Regarding Their Interactions with Police', *International Journal of Law and Psychiatry*, 37/4: 334–40.

Lowe, T., & Innes, M. (2012). 'Can We Speak in Confidence? Community Intelligence and Neighbourhood Policing v2.0', *Policing and Society*, 22/3: 295–316.

MacDonald, Z. (2001). 'Revisiting the Dark Figure : A Microeconometric Analysis of the Under-reporting of Property Crime and Its Implications', *British Journal of Criminology*, 41/1: 127–149.

Maguire, M. (2012). Criminal Statistics and the Construction of Crime. In M. Maguire, R. Morgan, & R. Reiner (Eds.), *Oxford Handbook of Crimonology* (pp. 206–243). Oxford: Oxford University Press.

Marley, J. A., & Buila, S. (1999). 'When Violence Happens to People With Mental Illness: Disclosing victimization', *American Journal of Orthopsychiatry*, 69/3: 398–402.

Mawby, R., & Walklate, S. (1994). *Critical victimology: International perspectives*. London: SAGE.

McCracken, K., & Perry, A. (2009). *Access to Justice: A Review of the Existing Evidence of the Experiences of Adults with Mental Health Problems*. London: Minstry of Justice.

McHugh, M. C., & Frieze, I. H. (2006). 'Intimate Partner Violence: New Directions', *Annals of the New York Academy of Sciences*, 1087: 121–41.

Mclean, N., & Marshall, L. A. (2010). 'A Front Line Police Perspective of Mental Health Issues and Services. *Criminal Behaviour and Mental Health*, *20*/1: 62–71.

Mezey, G., Hassell, Y., & Bartlett, A. (2005). 'Safety of Women in Mixed-sex and Single-sex Medium Secure Units: Staff and Patient Perceptions', *The British Journal of Psychiatry : The Journal of Mental Science*, 187/ 6: 579–82.

Mind. (1999). *Silenced Witnesses*. London: Mind.

Mind. (2007). *Another Assault*. London: Mind.

Minstry of Justice. (2013). *Code of Practice for Victims of Crime*. London: The Stationary Office.

Nawková, L., Nawka, A., Adámková, T., Rukavina, T. V., Holcnerová, P., Kuzman, M. R., … Raboch, J. (2012). 'The Picture of Mental Health/Illness in the Printed Media in Three Central European Countries'. *Journal of Health Communication*, *17*/1: 22–40.

Office of National Statistics. (2014). *Crime Statistics, Focus on Victimisation and Public Perceptions, 2012/13*. London: ONS. Accessed last 12.05.2015 at http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-victimisation-and-public-perceptions--2012-13/index.html

Parsons, J., & Bergin, T. (2010). 'The Impact of criminal Justice Involvement on Victims’ Mental Health', *Journal of Traumatic Stress*, 23/2: 182–8.

Paul, L. A., Zinzow, H. M., McCauley, J. L., Kilpatrick, D. G., & Resnick, H. S. (2014). 'Does Encouragement by Others Increase Rape Reporting? Findings from a National Sample of Women', *Psychology of Women Quarterly*, *38*/2: 222–232.

Pettitt, B., Greenhead, S A., Khalifeh, H., Drennan, V., Hart, T., Hogg, J., Borschmann, R., Mamo, E., & Moran, P. (2013). *At Risk, Yet Dismissed: The Criminal Victimisation of People With Mental Health Problems.* London: Victim Support and Mind.

Quirk, A., Lelliott, P., & Seale, C. (2004). 'Service Users’ Strategies For Managing Risk in the Volatile Environment of an Acute Psychiatric Ward', *Social Science & Medicine, 59*/12: 2573–83.

Resnick, H. S., Holmes, M. M., Kilpatrick, D. G., Clum, G., Acierno, R., Best, C. L., & Saunders, B. E. (2000). 'Predictors of Post-Rape Medical Care In a National Sample of Women', *American Journal of Preventive Medicine*, *19*/4: 214–219.

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). 'Barriers and Facilitators of Disclosures of Domestic Violence by Mental Health Service Users: Qualitative Study'. *The British Journal of Psychiatry : The Journal of Mental Science*, 198/3: 189–94.

Schnittker, J. (2013). 'Public Beliefs About Mental Illness', In C. S. Aneshensel, J. C. Phelan, & A. Bierman (Eds.), *Handbook of the Sociology of Mental Health* (pp. 75–93). Dordrecht: Springer Netherlands.

Seale, C. (1999). *The Quality of Qualitative Research*. London: SAGE.

Shapland, J., & Hall, M. (2007). 'What Do We Know About the Effects of Crime on Victims?', *International Review of Victimology*, *14*/2: 175–217.

Skogan, W. (1994). *Contacts Between Police and Public: Findings from the 1992 British Crime Survey, Home Office Research Study No. 134*. London: Home Office.

Stephens, B. J., & Sinden, P. G. (2000). 'Victims’ Voices: Domestic Assault Victims' Perceptions of Police Demeanor', *Journal of Interpersonal Violence*, *15*/5: 534–547.

Tarling, R., & Morris, K. (2010). 'Reporting Crime to the Police', *British Journal of Criminology*, *50*/3: 474–490.

Taylor, P. J., & Gunn, J. (1999). 'Homicides by People with Mental Illness: Myth and Reality', *The British Journal of Psychiatry*, *174*/1: 9–14.

Teasdale, B., Daigle, L. E., & Ballard, E. (2014). 'Trajectories of Recurring Victimization Among People With Major Mental Disorders', *Journal of Interpersonal Violence*, *29*/6: 987–1005.

Ten Boom, A., & Kuijpers, K. F. (2012). 'Victims’ Needs As Basic Human Needs'. *International Review of Victimology*, 18/2: 155–179.

Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). 'Crime Victimization in Adults With Severe Mental Illness: Comparison With The National Crime Victimization Survey'. *Archives of General Psychiatry*, 62/8: 911–21.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global Pattern of Experienced and Anticipated Discrimination Against People with Schizophrenia: a Cross-Sectional Survey. *Lancet*, *373*(9661), 408–15.

Victim Support. (2010). *Left In The Dark: Why Victims Of Crime Need To Be Kept Informed*. London: Victim Support.

Walklate, S. (2007). *Imagining the Victim of Crime*. New York: McGraw‐Hill Education.

Watson, A. C., Corrigan, P. W., & Ottati, V. (2004). 'Police Officers’ Attitudes Toward and Decisions About Persons With Mental Illness', *Psychiatric Services*, *55*/1: 49–53.

Wolf, M. E., Ly, U., Hobart, M. A., & Kernic, M. A. (2003). 'Barriers to Seeking Police Help for Intimate Partner Violence', *Journal of Family Violence*, *18*/2: 121–129.

World Health Organisation. (2013). *Mental Health Action Plan 2013 - 2020*. Geneva: World Health Organization. Accessed last 12.05.2015 at http://www.who.int/mental\_health/publications/action\_plan/en/

Zaykowski, H. (2014). 'Mobilizing Victim Services: The Role of Reporting to The Police. *Journal of Traumatic Stress*, *27*/3: 365–9.