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MENTALLY ILL PATIENTS, VICTIMISATION, LIFESTYLE RISK

Victimisation of Mentally Ill Patients living in the Community: is it a lifestyle issue?

Jane L Wood
Department of Psychology
University of Kent
Canterbury
Kent
CT2 7NP
Kim Edwards
University of East Anglia
Norwich
Norfolk U.K.

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Email: J.L.Wood@kent.ac.uk

kimssedwards78@yahoo.co.uk

Any correspondence, requests for reprints or proofs should be directed to the first author.

Abstract

Purpose. Although crimes against mental health patients has been the little research there is focuses on inpatient samples (e.g. Silver, 2002). This study aimed to compare crimes against mental health patients living in the community with crimes against students who have a high lifestyle risk of victimisation (e.g. Barberet, Fisher, Farrell & Taylor, 2003).

Methods. The samples were selected via community-based mental health services and a university population. Forty participants with mental health problems and eighty students reported experiences of victimisation in the previous 12 months and attitudes towards the police.

Results. Female mental health patients, reported the highest victimisation, but both male and female patients reported more victimisation than did students. Mental health patients also held more negative opinions of the police.

Conclusions. The results show that mental health individuals experience more victimisation when compared to a similar lifestyle risk group. Discussion focuses on the implications for mental health patients living in the community, the support networks available to them and relations between the police and mental health individuals.

The Mental Health Act (1959) spawned the beginnings of Community Care leading to the de-institutionalisation of individuals suffering from mental illness (Dobson, 1998). One aim of the act was to enable patients to live in the community with the support of social and other health care workers. Another was also to extinguish the stigma that has often surrounded mental illness (Dobson, 1998).

Research has focused on the risk, usually of violence, posed by the mentally ill to the community (Hiday, 1997; Silver, 2002; Steadman, Mulvey, Monahan, Clark Robbins, Appelbaum, Grisso et al, 1998; Swanson, 1994). Scant attention has been paid to the criminal victimisation of people suffering from mental illness (Marley & Buila 2001; Silver, 2002). Even victimisation surveys, thought to capture the hidden figures of unreported crime (Hollin, 1992; Sparks, Genn & Dodd, 1977) do not assess the victimisation of the mentally ill. The largest and most regular of these, the British Crime Survey, excludes residents of supported community-based accommodation by regarding their accommodation as an 'institution' (Williams, 1993).

This is surprising since the vulnerability of individuals may explain observed variations in victimisation rates, (Clarke and Felson, 1993). Certain social factors relate to increased vulnerability of victimisation e.g. low socio-economic status (Wohlfarth, Winkel, Ybema & van den Brink, 2001), living in urban areas (Hope et al, 2001) and unemployment (Laub, 1997). Mental illness can result in low socio-economic status (Hiday, Swartz, Swanson, Borum, & Wagner, 1999; Wilton, 2003) and unemployment due to the stigma of mental illness (Hiday et al, 1999) Visible symptoms may exacerbate this vulnerability (Hiday et al, 1999). Bizarre or 'strange' behaviour may result in hostile responses from others (Agnew, 1992; Silver, 2002). The current study aimed to redress some of this imbalance by examining the extent and nature of victimisation of individuals with mental health problems.

Some studies have reported the victimisation of individuals who are mentally ill (Jacobson & Richardson, 1987; Marley & Buila, 2001). In particular, individuals with mental illness are more likely to be violently assaulted than are the general public (Hiday et al, 1999; Jacobson, 1989; Silver, 2002). Hiday et al (1999) revealed that although property crimes experienced by people with severe mental illness was comparable with the general population, the risk of violent victimisation was 2.5 times greater for the mentally disordered group than for the general population. Women with mental illness have also been found to be more at risk from sexual victimisation than general population females (Darves-Bornoz,

Lemperiere, Degiovanni & Gaillard, 1995; Jacobson & Richardson, 1987; Marley & Buila, 2001). Similarly, mentally ill males were more frequent victims of robbery or assault than general population males (Lehman & Linn, 1984; Marley & Buila). These findings reinforce arguments that those with mental illness are particularly vulnerable to victimisation. Hiday, (1995) suggested that this vulnerability stems from being mentally ill and the lifestyle or social context mentally ill people experience.

The vulnerability of those with mental illness need not result solely from strangers. Cascardi, Mueser, DeGiralomo and Murrin (1996) looked at violence and physical aggression directed at psychiatric patients by family members or partners. They found nearly half (45.8%) reported being physically victimised by a relative and more than half (62%) by a partner. Jacobson and Richardson (1987) found 81% of their sample of psychiatric inpatients had at some point, been the victim of serious physical or sexual assault.

The current study

There are limits to the conclusions that can be drawn from victimisation research conducted on populations with mental illness. Many studies are based on data gathered from clinical populations (Hiday et al, 1999; Jacobson, 1989; Silver, 2002; Steadman et al, 1998) often recruited from psychiatric hospitals, which are a highly selective homogenous population, so may not be representative of people with mental illness. Walsh, Buchanan and Fahy (2002) point out that the research is ‘dominated by data on hospitalised/discharged patients, but most individuals with mental disorder are not hospitalised’ (Walsh et al, 2002, pp.493). It is likely that those in hospital represent the extreme end of the mental illness continuum and this may make them unrepresentative of the majority of people who suffer from some form of mental illness. Also, individuals recently discharged are likely to be less experienced and consequently more vulnerable than those who live solely in the community. Also, much of the research has been conducted in the U.S. (e.g. Cascardi et al, 1996; Hiday et al, 1999; Marley & Buila, 1999). This may not be representative of the experiences people with mental illnesses have in the U.K. Bearing this in mind, the current study aimed to assess the experiences of a community-based sample of people with mental illness in the U.K.

The present study further explored the reporting rates of those with mental illness. This issue has received little consideration and so little is known about mental health victims’ disclosure of their victimization to the police or others (Marley & Buila, 1999). To the current authors’ knowledge, only one study (Marley & Buila, 1999) has looked at disclosure of victimization by individuals with mental illness. This may be an important

issue relating not only to assessing the action taken by the victims, but also the responses and actions taken by those to whom the victimization was disclosed. If people with mental illness receive negative responses from the police, this may affect future disclosure of victimization. This may have long-term consequences particularly if the victimization is ongoing (Sparks et al, 1977). Also, many studies have focused on specific aspects of victimization, such as frequency or type (Marley & Buila, 1999). To gauge a broader picture of this form of crime, the current study examined frequency of victimization, repeat victimization, specific types of victimization and the relationships between the victim and the offender.

Past research has compared the victimisation of mentally ill individuals with the general population (e.g. Hiday et al, 1999; Jacobson, 1989; Silver, 2002; Darves-Bornoz, Lemperiere, Degiovanni & Gaillard, 1995; Jacobson & Richardson, 1987; Marley & Buila, 2001; Lehman & Linn, 1984). However, people suffering from mental illnesses are often from low socio-economic backgrounds, leaving them vulnerable to victimisation through lifestyle (Hiday, 1995; Silver, 2000). The current study compared mental health individuals with a sample of undergraduate students. Students often experience low socio-economic status and a lifestyle, which leads them to be more at risk from victimisation through exposure. Indeed, studies have found that students experience high victimisation relative to the general population (Barberet, Fisher, Farrell & Taylor, 2003). Consequently, it is necessary, to gauge a meaningful assessment of the victimisation of mental health individuals, to compare them to others with similar lifestyle risks.

Research Questions

The study focused on a number of research questions:

1. Do mental health and student samples differ in rates of victimisation? It may be expected that people with mental illness experience more victimisation than others (e.g. Jacobson, 1989; Silver, 2000). Few studies have looked at this within a community sample and no other studies known to the researchers have compared a mental health population with another 'lifestyle risk' group.
2. Do mental illness individuals and students experience different forms of victimisation? Research suggests mental health samples experience more personal victimisation than the general population (Hiday et al, 1999; Jacobson & Richardson,

1987). Nevertheless, these levels might not differ from other ‘lifestyle risk’ individuals.

3. Are there gender differences in rates and types of victimisation between the two samples? Previous work reveals women with mental illness are more at risk from sexual assault than the general population, and that men are more at risk from assault than the general population (Jacobson, 1989; Marley & Buila, 2001). However, these differences may not occur between ‘lifestyle risk’ groups.
4. Do mental health individuals and students differ in attitude to the police? If those with mental illness display more negative attitudes to the police than the student sample, they may be less likely to report victimisation (Sparks et al, 1977).
5. Do mental health individuals and students differ in reporting their victimisation to the police? This question has implications for the perceived levels of victimisation experienced by individuals with mental illness.

Method

Participants:

One hundred and twenty participants participated in this study. The mental health sample consisted of 40 participants (22 female and 18 male). The student sample consisted of 80 participants (46 female and 34 male), none of who had mental health problems. The mental health participants were service users from 21 national charities and organisations and had a mean age of 42.28 years (SD = 11.27). Of the sample 32.5% suffered from depression, 15% suffered manic depression, 12.5% suffered schizophrenia and 12.5% had a dual diagnoses. Individual diagnoses included personality, anxiety and eating disorders. The mental health participants were mainly white (97.5%) the remainder were Black (2.5%). The student sample was recruited by opportunity sampling at a university campus. The mean age of the students was 22.14 years (SD = 2.74) and they were predominately white (87.5%). Other ethnic backgrounds included, Asian (5.1%), Black (2.5%), and Other unspecified (4.9%).

Materials

A fifty-five-item victimisation questionnaire was adapted from the British Crime Survey (BCS, 2000) and the National Crime and Victimization Survey (NCVS, 2000). Reliability

analysis revealed the scale had a high internal consistency (Cronbach's alpha = .82). The scale had four sections. The first two focused on property and personal crime experiences in the previous 12 months and included quantitative and qualitative items. Six property offences and five personal offences required 'yes'/'no' responses. If participant responded 'yes' to any item they were asked to complete four follow-up questions. The frequency of each crime was also assessed. An open-ended response revealed if they knew the perpetrator. Other items included whether the crime had been reported to the police and satisfaction with the police response.

The third section was a quantitative assessment adapted from the National Crime and Victimization Survey (NCVS, 2000). Reliability analysis revealed the scale had high internal validity (Cronbach's alpha = .87). It measured perceptions and experiences of the police by asking participants how much they agreed with statements such as, 'I think that the police are never around when you need them. Questions in the first half were positively worded and items in the second half negatively worded to control for acquiescence biases.

The final section consisted of ten demographic items assessing age, sex, occupation and ethnicity.

Procedure

A pilot study conducted using 20 students revealed no comprehension problems with the scales. The materials were then sent to service users via the 21 mental health organizations. Participants were given an information sheet about the study, an informed consent form, a de-briefing sheet and a participant number, which could be used to identify the questionnaire should the participant decide to withdraw from the study. The mental health sample was supplied with pre-paid envelopes to return completed questionnaires. The students were approached directly by the researchers and after consenting to take part in the study completed the questionnaires alone returning them directly to the researcher when complete.

Ethical considerations

Several ethical issues had to be considered in conducting this study due to its sensitive nature and the potential vulnerability of participants. The voluntary nature of participation was made clear throughout the information, consent forms and debriefing sheets. Participants were fully informed of their rights to withdraw at any time. Informed consent was sought from all participants. To ensure confidentiality and anonymity, questionnaires were

numbered and kept separate from consent forms. Respondents were given the researchers details should they want to withdraw or ask any further questions

Results

Demographic data:

Demographic data showed that 86.95% of the mental health sample was not employed. Of these 32.5% claimed they were unable to work because of their illness. A further 10.5% were in part-time employment and 2.6% claimed to be studying, and none were employed full-time. In contrast, 16.3% of students had full time jobs and 3.8% had part time jobs. Of the mental health sample 40% rented property from the council and 15% lived in residential homes or units. Most of the student sample (62.6%) rented a house or flat from a private landlord and a further 26.3% lived in halls of residence. Nearly a third of the mental health participants (32.5%) and 61.3% of students owned either a car or bicycle.

Victimisation rates:

Of the total sample 42.5% had experienced victimisation in the previous 12 months (N = 51). Half (50%) the mental health sample and just over a third (39.7) of students reported being victimised at least once.

Repeated victimisation:

Of those who reported victimisation, 25.8% were victimised more than once (N = 31). Of these, 9 (5.8%) reported being victimised more than four times in the previous 12 months. An Independent t-test revealed that mental health participants experienced more repeat victimisation (M= 5.56) than students (M=3.27), $t(21.57) = 2.624$, $p < .05$.

Victim offender relationship:

Of the repeat victim students 14% were victimised by their friends or partners, 52% were victimised by strangers and 4.8% were victimised by people they knew by sight, such as neighbours. None of the student sample reported being victimised by a family member. Of the mental health repeat victims 23.8% were victimised by family members, 19% by friends or partners, 33.3% by strangers and 19% by people they knew by sight.

Research Questions:

1. Do mental health and student samples differ in rates of victimisation?

An Independent t-test with equal variances not assumed, revealed that mental health participants experienced higher rates of victimisation in the previous 12 months ($M= 1.89$, $SD= 2.82$) than did students ($M=0.81$, $S=1.44$), $t(46.4) = 2.23$, $p < .05$, $\eta=.06$, $power=.78$.

2. Do mental illness individuals and students experience different forms of victimisation?

The forms of victimisation were collapsed into either ‘personal’ (e.g. physical and sexual assault) or ‘property’ victimisation. An Independent t-test using equal variances not assumed revealed that mental health participants experienced more personal victimisation ($M=1.03$, $SD=1.97$) than students ($M=.35$, $SD=.90$), $t(44.5)=2.02$, $p<0.05$, $\eta=.05$, $power=.72$. There was no difference between the mental health groups’ ($M=.92$, $SD=1.34$) and students’ ($M=.46$, $SD=1.01$) experiences of property victimisation, $t(57.93) = 1.87$, $p = .0067$, $\eta=.03$, $power= .78$.

3. Are there gender differences in rates and types of victimisation between the two samples?

To examine gender differences in rates of victimisation a 2(Gender: male, female) x 2 (mental health group, students) ANOVA was conducted on victimisation scores. Results revealed a main effect of gender, $F(1, 117) = 8.48$, $p < .005$, $\eta=0.07$, $power=.82$ and a main effect of the two groups $F(1,117) = 7.20$, $p < .01$, $\eta=.06$, $power=.76$.

There was an interaction between gender and the two groups, $F(1,117) = 13.33$, $p < .001$, $\eta=.10$, $power=.95$. revealing that mental health females experience higher levels of victimisation than mental health males or students of both genders (see Figure 1).

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FIGURE 1 TO GO HERE

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A further 2(Gender: male/female) x 2(Mental health group/students) x 2(Personal/property victimisation) ANOVA was conducted to examine if type of victimisation was relevant. However, no main effects of victimisation type, $F(1, 114) = .02, p=0.89, \eta=.008, \text{power}=.052$, or interactions between victimisation type and group, $F(1,114)=.52, p=.47, \eta=.005, \text{power}=.11$, or victimisation type and gender, $F(1,114)=2.31, p=.47, \eta=.02, \text{power}=.33$, were found.

4. Do mental health individuals and students differ in attitude to the police?

An Independent t-test revealed that mental health participants ($M=33.42, SD=7.54$) had more negative perceptions of the police than did students ($M=26.12, SD=6.49$), $t(116)=3.25, p<0.005, \eta=.084, \text{power}=.89$.

5. Do mental health individuals and students differ in reporting their victimisation to the police?

An Independent t-test was used to examine differences between the two groups in reporting victimisation to the police. Results showed that mental health participants ($M=1.08, SD=1.30$) did not differ from students ($M=.79, SD=.1.13$), $t(116)=1.24, p=.21, \eta=.01, \text{power}=.23$.

Participants who reported crimes to the police were asked how dissatisfied they were with the police response. An Independent samples t-test using equal variances not assumed revealed mental health participants ($M=5.18, SD=2.89$) were more dissatisfied with police response than were students ($M=2.41, SD=1.31$), $t(21)=2.91, p<.05, \eta=.30, \text{power}=.82$. Dissatisfied participants were asked to state why they felt this way. Typical reasons offered by students included:

‘They just filed the incident and didn’t follow it up’ (Student, 15)

‘They said they could not do anything as there was not enough officers, they said that they had too many officers in the office being pen pushers’ (Student, 71)

Although both groups expressed dissatisfaction with the speed with which the police responded, or their ability to help at all, only mental health participants expressed dissatisfaction with the way that the police responded to them on a personal level. For example:

‘They don’t take action or take you seriously if you suffer from mental health problems’ and ‘they were very bullying towards me’ (Mental health participant, 112)

‘They didn’t really believe me and couldn’t do anything’ (Mental health participant, 140)

Discussion

The aim of this study was to compare victimisation experiences of mental health individuals recognised as facing a lifestyle risk of victimisation (Hiday, 1995), with students, who also face lifestyle risk of victimisation (Barberet, 2003).

The first research question this study addressed was whether mental health and student samples differ in rates of victimisation. Results showed that mental health participants reported higher rates of victimisation than did students. The mental health sample also experienced more repeated victimisation. These results support previous findings comparing mental health individuals with the general population (e.g. Hiday et al, 1999; Marley & Buila, 1999; Silver, 2002). Although the student sample and the mental health sample were arguably equally vulnerable to lifestyle risk, there were some fundamental differences between the two groups. None of the mental health sample had full time occupations and most received some form of State Benefit. Most mental health participants rented property from the local council. In contrast, many students worked full or part time and either rented property from private landlords, or lived in university halls of residence. Consequently, the mental health sample may have encountered additional social factors associated with risk of victimisation, such as, unemployment (Laub, 1997; Wohlfarth, 2001) and renting from a local council (Hope et al, 2001). Nevertheless, the mean age of students was considerably lower than the mental health sample. Research reveals that age is negatively related to victimisation (Laub, 1997; Mawby, 1988) and so it could be expected that students’ risk of victimisation would be increased because they were younger. If students’ age risk and lifestyle risk are taken into consideration, the higher rate of victimisation experienced by mental health individuals is particularly surprising.

The second research question addressed by this study examined the type of victimisation experienced by the two groups. Results revealed mental health participants experienced higher levels of personal victimisation than did students. This also supports earlier findings that individuals with mental illness experience more personal victimisation

than the general population (Hiday et al, 1999; Jacobson, 1989; Silver, 2002). Previous work employed participants with severe mental illness, or psychiatric inpatients (Cascardi et al, 1996; Hiday et al, 1999; Jacobson, 1989). In contrast, participants in the current study lived in the community and suffered from less severe illnesses. Previous work suggests that visible symptoms (e.g. Hiday et al, 1999) or bizarre behaviour (e.g. Agnew, 1992; Silver, 2002) increases chances of victimisation. For instance, someone who is suffering from active psychosis may be more vulnerable to personal victimisation than someone with depression. The current study's results dispels this possibility by revealing that all forms of mental ill health result in vulnerability to personal victimisation by others and that this applies as much to community-based individuals as it does to hospitalised patients.

The third research question examined gender differences between and within the two groups. Results showed that women in the mental health group were victimised more frequently than any other sub sample. Mental health men and male and female students did not differ from each other on rates of victimisation. This is consistent with previous research (e.g. Darves-Bornoz et al, 1995; Marley & Buila, 2001). This finding gives cause for concern especially if it is considered in light of consistent findings that, except for sexual abuse, men experience higher personal victimisation than women (Laub, 1997; Lauritsen, 2001). The finding that mental health men and women and male and female students did not differ across type of victimisation would suggest that mental health females' overall victimisation stands out. If these results are considered together with the high levels of family victimisers cited by the mental health participants, it could be suggested that mental health females are particularly vulnerable to victimisation in a personal and material sense perhaps by family as well as friends and strangers. Clearly, the results indicate that women with mental health problems living in the community are especially vulnerable to victimisation in a way that mental health men and male and female students are not. This finding may also be an underestimation, since domestic or sexual abuse, crimes often committed by a partner or family members, frequently remain unreported (Cascardi et al, 1996; Kilpatrick et al, 1987; Young, 1988).

However, it must be borne in mind that men are less willing to report victimisation than women (Walklate, 1997). Perhaps, the men in the current study were also reluctant to reveal the extent of victimisation they experienced and this shaped the results. Nevertheless, the high levels of victimisation experienced by mental health females reveal a vulnerability that warrants further examination.

The fourth research question addressed in this study concerned attitudes to the police. The mental health group held more negative attitudes to the police than did the students. Interestingly, previous research shows that people of all ages, including adolescents (Murray & Thompson, 1985) often hold favourable attitudes to the police (Aye Maung, 1995; Sparks et al, 1977). However, victims of crime tend to express more negative opinions of the police than non-victims (Sparks et al, 1977) as do people living in high crime areas (Mawby, 1980). As a result, the higher crime rates experienced in the mental health sample and the areas in which they live could explain the negative attitudes expressed.

A further point to consider could be the experiences mental health individuals had of the police. Some claimed to be continually stopped by the police for no obvious reason. Other mental health individuals claimed that because they had a mental health problem the police were unhelpful. In contrast students, who were dissatisfied with the police did not claim the police were unhelpful. Instead, they felt the police were hindered by lack of resources resulting in an inefficient service. This requires further attention. Poor relations between the police and individuals with mental illness may affect reporting of crimes by this group (Sparks et al, 1977).

Finally, the present study investigated differences between the two groups in reporting victimisation to the police. No differences were found. This is surprising given the more negative attitudes to the police held by mental health individuals. However, if an offence is perceived as serious, it is more likely to be reported to the police (Laub, 1997). For instance, all the women in the mental health sample who reported that they had been the victim of sexual assault maintained that they had been raped and reported the offence to the police. In contrast, female students who reported being sexually assaulted did not mention rape and many claimed the incident was too trivial to report. Thus, it seems mental health individuals often experience more serious crimes they feel compelled to report. Other than to speculate on this possibility is beyond the scope of the current study, however, this is an area that clearly requires further attention.

Implications of this study

The findings reported in this study have wider implications. The high level of victimisation reported by the mental health sample is cause for concern. Currently it is not clear if those who live in supported housing are included in the British Crime Survey. If they are not then the victimisation of these individuals will remain a hidden figure. Even if they

are they are not considered as a distinct group and so the issue of their victimisation remains cloudy at best.

A further implication concerns the negative perceptions of the police evident in the mental health sample. This finding points to the importance of improving police relations with mental health individuals. One of the main ways in which police are alerted to criminal activity is through reporting (Greenberg, Ruback & Westcott, 1982). However, if the police fail to take seriously the complaints of those with mental health problems then they are likely to remain oblivious to at least some crimes. A further consequence could be that mental health patients stop reporting to the police with obvious consequences for the clean-up rates of crimes against this particular group. Similarly, perpetrators of crimes against mental health individuals may be aware of police responses and be encouraged to select victims with mental health problems as easy targets. In this way, mental health individuals are doubly vulnerable: perpetrators target them and the police doubt them. Awareness of this group's vulnerability should also be a focal point for those working with mental health individuals. Training on how to assist victims may help the way victimisation is dealt with. Recognising the vulnerability of individuals with mental health problems may help challenge the stigma that those with mental illness are a danger to the public by pointing out the less obvious contrary position.

Methodological Limitations

There are several limiting factors associated with the present study. Methodological limitations of self-report studies must be borne in mind. Instances such as forgetting and telescoping, or recalling incidents that happened more than 12 months ago, may have influenced results (Wohlfarth et al, 2001). Schneider (1981) underlines that minor offences are less likely to be telescoped than major offences and this could mean a larger proportion of serious victimisation was reported compared to less serious offences. An interesting point suggested by Winkel et al (2003), concerns mood congruence effects. This suggests unhappy individuals may be more inclined to recall negative events (Winkel et al, 2003). In the current study many individuals in the mental health sample were suffering from depression that may have shaped their responses according to their mood. Nevertheless, although such possibilities need to be considered there was nothing in the current study to suggest that mental health patients' responses were influenced by anything other than facts.

A further limitation could be that individuals may have agreed to take part in the study because they had experienced victimisation. This may have biased the results to

include a higher proportion of victims of crime. Coleman and Moynihan (2000) state that the ‘incentive to participate in a victimisation survey could have been stronger for victims than non-victims’ (pp. 76). On the other hand, it could also be suggested that victims are less inclined to participate (Mayhew, Aye Maung, & Mirrlees-Black, 1993). Nonetheless, such response biases would apply to both mental health individuals and students and so comparisons are still justified.

Finally, the present study required respondents were literate in order to complete the questionnaire. This may mean individuals who were less literate did not take part. To overcome this problem, future studies should, perhaps, adopt an interview design, such as that used in the British Crime Survey.

Future Research

_____ There are a number of promising avenues for future research. Future studies should perhaps focus on the outcomes of victimisation for people with mental health problems. Future studies could broaden the issues raised in this study by examining victims’ perceptions not only of the police, but also of other areas in the Criminal Justice System. A larger sample size would allow more detailed analysis and to separate out different mental health problems to see if levels of victimisation relate to specific mental health problems. It may be possible also to examine perpetrators of crime to see if people with mental health problems are targeted because of their illness, and if so could these be classed as hate crimes. Hate crimes are defined as ‘harm inflicted on a victim by an offender whose motivation derives primarily from hatred directed at some apparent characteristic of the victim’ (Garofalo, 1997).

To conclude, the present study has examined victimisation experienced by individuals with mental health problems in comparison to a student sample. It found that individuals with mental health problems are frequently the victims of crime and experience higher victimisation rates than a student population. Women in the mental health sample experienced the highest victimisation rates in the study. The mental health sample held more negative attitudes to the police than did students. Clearly, victimisation of people with mental health problems requires more attention. This may lead to improving services for victims of crime with mental health problems and ultimately a reduction in the levels of crime this vulnerable group of people experience.

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Figure Captions

Figure 1: Victimisation by group and gender.