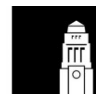

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Sexual Violence and Mental Health Services: A call to action.

Rape and sexual assault is a not an uncommon experience in the general population. According to the National Crime Survey in England and Wales (NCSEW) 20% of women and 4% of men have experienced some type of sexual assault since the age of 16, equivalent to an estimated 3.4 million female victims and 631,000 male victims (H.M.Government., 2007, Office for National Statistics, 2018). Assaults are significantly under reported with some studies identifying between 80 – 90% of victims never disclosing abuse; and in males this can be as high as 95%. Radford (2011) estimates that a third of children sexually abused by an adult didn't tell anyone at the time. Therefore can be difficult to determine the full extent of sexual assault in the population.

Sexual assault is a traumatic experience that can leave long term physical and psychological effects including the triggering or exacerbation of serious mental health and substance use issues. According to the National Crime Squad of England and Wales (NCSEW), almost two thirds of victims reported experiencing mental or emotional problems as a result, and 1 in 10 victims attempted suicide as a result. The most common mental health sequelae is post-traumatic stress disorder (PTSD) and possibly 50% of people who have experienced rape will experience PTSD at some point in their lifetime (Creamer et al., 2001) Other mental health problems include depression, suicidality (13x more likely) and substance use problems (26 times more likely) as reported by Kilpatrick et al. (1997) in a 2 year longitudinal study of the long term impact of sexual violence. . Other psychological problems arising from sexual assault include relationship problems, low self-esteem, sexual problems, self-harm and emotional problems such as anxiety, guilt and shame.

Given the significant psychological impact of sexual assault, it is not surprising that a many people presenting to mental health and substance use services will have experienced a sexual assault (as children and/or adults), and these experiences are likely to be an important contributing factor to their current mental health problems. Khalifeh et al. (2015) found that there was a 6- to 8-fold elevation in the odds of sexual assault among both men and women with a serious mental illness (SMI) compared with the general population. The experience of sexual violence is also common in people who seek treatment for substance use with an estimated 50–75% of women in substance use treatment who are survivors of sexual violence. A Cross party report (H.M.Government., 2007) suggested that 50-60% of inpatients and 40-60% of outpatients in mental health services have been victims of sexual violence and / or child sexual abuse (p16). In some cases, the history of sexual assault may be apparent at the referral stage, or disclosed as part of the assessment process; but often it

is only disclosed, if at all, in the context of a trusting and supportive contact with a health professional.

There have been recent concerns raised that service users may be exposed to sexual violence within mental health inpatient settings. Foley and Cummins (2018) undertook a Freedom of Information (FOI) request exercise to 45 police forces and 23 of those provided some data. Following this, another FOI was sent to 38 mental health NHS Trusts in the UK to try to establish the types and levels of sexual assault and rape that occurred to people who were inpatients. Of the 38 mental health trusts, 12 reported they did not record such data; 13 provided a nil return (no reported sexual assaults) and 12 provided some data. Only 1 NHS trust refused the FOI request. There was a a wide variation in the type and quality of data obtained. For the period between 2011 and 2015 they identified 32 assaults (20 were women and 12 were male victims). There was often limited information about the incident, but where this did exist, the perpetrators were evenly split between fellow patients and fellow staff. Ten incidents occurred in the person's own bedroom, but 13 occurred in communal areas, or the hospital grounds. Men were more often perpetrators (where recorded). Foley and Cummings (2018) conclude that sexual assaults do occur in hospitals and that in order to address this, better data on these incidents are required including whether these allegations become prosecutions is required by both the police and mental health services.

A recent report by the Care Quality Commission (2018) (health and social care inspectorate in the England) highlighted concerns about sexual safety in inpatient mental health wards. The report was based on descriptive analysis of "sexual incidents" identified from healthcare incident reporting records between April and June 2017 Of the 60 000 incidents recorded, 1.2% were deemed to be related to sexual behavior and about a third of these related to exposure and public masturbation. There were 29 alleged rapes recorded. Whilst this report is useful in raising awareness of the issue, caution must be taken in the interpretation of the data. This was a retrospective audit of routine data using key words to mine the text. It may be that many incidents are not recorded on this system or not found due to inconsistent use of language to describe the events. In addition, sexual assault is often under reported by up to 80% so this may be an underestimate of the problem. It was also not clear from the data as to the actions taken as a result of the 29 allegations of rape found in the records. The CQC recommended that guidelines need to be developed that will inform practice and workforce development to improve sexual safety in inpatient settings. However, despite these limitations in the methodology, the CQC report findings do mirror a prospective study of sexual incidents that occurred during in the first 2 weeks of admission. Bowers et al. (2014) undertool an analysis of prospective data collected in the first two weeks of admission related to incidents that had resulted in conflict and containment incidents arising

from inappropriate sexual behaviours. The study included a study cohort of 522 who have consent for their data to be included. Of the 522, 68 patients had been involved in 147 incidents however by far the most frequent behavior was exposing self to others (n=78 incidents). However they also found 1 in 20 (26 patients perpetrated 42 incidents) had engaged in 'non-consensual sexual touching' of another person. The data was not detailed enough to know the context around these incidents, such as details of the victims and the severity of the incident, but knowing how many people have a history of sexual assault, this type of behaviour could be very frightening and re-traumatising for patients. It is also unclear how many of the sexual incidents were related to being unwell, confused and disinhibited. Bowers et al (2014) found that most incidents occurred in communal areas and that there were no differences in rates of sexual incidents between same sex and single sex wards.

There is emerging evidence from research undertaken in Australia and the UK that mental health staff avoid the general topic of sex, and generally feel very de-skilled in this area. Quinn et al. (2011) found that the reasons why mental health nurses avoid the topic were partly because they had concerns that it would destabilise or upset the service user, and partly because they don't know what to do with disclosures of sexual problems (such as sexual abuse, dysfunction, sexual health issues). In order to explore if there were similar issues in the UK, Hughes et al. (2018) undertook a study involving 4 focus groups with mental health staff in two different NHS Trusts in England, and found that despite staff being aware of sexual issues of concern (sexual exploitation abuse and broader sexual health issues), they were reluctant to broach the topic and expressed very similar concerns to the Australian nurses in Quinn's study. These concerns can be broadly divided into internal and external barriers. Internal barriers included lack of confidence and comfort in talking about sex, and concerns of upsetting, angering or destabilising the person. External factors included not being aware of the local services relevant to sexual issues (such as sexual health clinics, family planning, sexual assault services etc) as well as a lack of organisational/policy drivers to undertake this enquiry.

There is also evidence that mental health staff are not routinely enquiring about sexual violence. Hepworth and McGowan (2013) undertook a review of the literature to gauge whether mental health staff enquire about sexual abuse. A total of 11 papers recorded the prevalence of routine enquiry and/or asked mental health staff about their practice. Across the 11 studies, the consistent finding was that asking about Child Sex Abuse (CSA) was not part of routine enquiry, and that significant proportions of mental health staff had not received any training (and even those who had, felt that the training had not completely prepared them to undertake routine enquiry). Twenty years ago, Lab et al. (2000) found that

in a South London NHS trust, that a third of respondents never ask about CSA; and two thirds had never received any training in this matter. The most common concern for not asking was that the topic would be distressing (including destabilising mental state, evoking anger or distress). Some were concerned that asking about CSA was “irrelevant” to the presenting mental health problem, and others cited concern regarding lack of resources to deal with CSA should it emerge. More recently, Read et al. (2018) reviewed the literature on enquiry about childhood abuse and neglect and similar themes emerged: it was not routine to ask, and there were significant concerns that enquiry would cause distress, “open can of worms” and a fear of making things worse. None of the studies identified how mental health professionals felt themselves about engaging with this topic or about vicarious traumatisation.

The Care Programme Approach (Department of Health, 2008) (the UK process for ensuring effective and coordinated care for, and in partnership with, people with serious mental illness), advocates routine enquiry for sexual abuse and assault and for this to be formally recorded. Brooker et al. (2016) undertook a review of routine enquiry about sexual abuse using data from 42/53 NHS Trusts in England, and found that the response to the question was recorded for only 17% of service users. Brooker also highlighted that despite the requirement for staff to have engaged with specific training about asking the question, around a third of the workforce had not received it. Therefore, afternearly two decades since Lab et al. (2000) highlighted the lack of routine enquiry, Brooker’s report demonstrates that things have not really improved despite the policy driver of the CPA and associated roll-out of training.

This lack of training is also a concern In Australia. McLindon and Harms (2011) interviewed 15 mental health crisis workers in Melbourne and found that most of the participants had no training in undertaking enquiry about sexual assault. The participants disagreed that it should be a mandatory question, and had concerns that it would be distressing; and as a topic it should not be raised unless the service user (consumer) raises it first. They felt that there were time barriers due to competing issues they had to address. They also saw the gender of the staff being a barrier, expressing concern about male staff asking females about sexual assault. Despite expressing a desire for this to be a topic that service users brought up, about half felt ill-equipped to deal with a disclosure. Most were aware of the sexual assault services available, but rarely made a referral. So it’s clear that mental health staff have real concerns about asking about sex in general, and specifically, sexual violence so tackling these concerns could be an important part of an overall programme to promote sexual safety in mental health care settings. However, this was a small localized study, and

a larger survey would be able to verify if this is a country-wide issue, or one that is specific to that service.

What can be done to improve routine enquiry

Studies conducted in UK and Australia indicate that routine enquiry about sexual assault is not happening as part of routine care, however, some studies have highlighted that training and, by default, better understanding of the topic and some key skills in enquiry can make a difference. Read et al. (2016) found that, following the introduction of a new policy and mandatory training in mental health services in New Zealand, responses to disclosures of assault were increased in the care notes. However there was no impact on treatment referrals and reporting rates to legal authorities (which remained low).Quinn and Happell (2012) demonstrated that bespoke training aimed at increasing mental health nurses motivation and ability to talk about sexual issues with people in their care. Quinn et al. (2013) found from qualitative interviews at a follow-up time point that staff felt that the training had helped them to overcome their fears and concerns, and that they become more comfortable with having conversations about sexual topics.

Improving responses to Disclosure

It's one thing to improve disclosure, but the next important step is responding appropriately to that disclosure. In a paper by Ashmore et al. (2015) they describe the development of a disclosure protocol for use in mental health. This aimed to provide clearer guidance for staff on the steps they should take following a disclosure and also about how to recognize that disclosures may not always be made in a way that is immediately "plausible" due to the traumatic effects of the assault and any other complicating factors such as current mental state. If a disclosure of sexual assault is met with dismissal or disbelief, real harm can be done. Ashmore (2015) described a case example where an inpatient of a mental health facility disclosed that she was raped by "santa claus". Further investigation found that there was a grounds man with a long white beard who happened to be wearing a red top at the time of the incident, and after questioning admitted that he had had sex with the patient. Ashmore et al. (2015) describes a process for staff to follow after any disclosure. Firstly, all disclosures should be accepted at face value and then investigated (no matter how implausible they may seem). Repeated questioning (especially related to the plausibility) should be avoided. Then there is a need to establish physical and psychological safety, and for attentive listening. Once a disclosure has been confirmed then the person may decide to report the incident (whether recent or not) to the police. In the UK.t his is usually done via a Sexual Assault Referral Centre (SARC). There are more than 47 SARCs located in England

and commissioned jointly by the Police and specialist health commissioning via NHS England. SARCs in England offer an integrated service to the victims of sexual violence irrespective of age or gender. The services initially include access to forensic medical examination and collection of evidence (either police or self-referral). A therapeutic consultation considering the health and wellbeing needs of the individual will also be undertaken. This should include a risk assessment for self-harm and suicidal ideation and a review of any pre-existing mental health problems (as highlighted in the 2018 NHS England Service Specification for SARC services).

It has been estimated that world-wide approximately 40% of those attending SARCs are known to mental health services (Bicanic et al., 2014, Brown et al., 2013, Zilkens et al., 2017). More recent research in England has concurred with this figure (Brooker and Durmaz, 2015). A one year audit was undertaken of the mental health (MH) status of adult attendees to the Thames Valley SARC in 2017 (Brooker et al., 2018). Data was collected by the SARC staff at the time of presentation. Over the study period of one year, there were 351 relevant referrals over the twelve month period of whom 126 (42%) either fully or partially completed the mental health assessments. There was a high level of non-response to the study and no data from SARC staff on why it was declined (46%) nor whether they had been offered the study information. A further 53 declined to take part due to being too anxious, tired, it was deemed inappropriate by the SARC clinician or the person was intoxicated (1 person) (Admission to a psychiatric in-patient unit was not uncommon and 19% had been admitted an average of three times each. The figure of 19% admitted to a psychiatric hospital is 90 times higher than for the general female population, and 42% of the total sample were being prescribed medication for their mental health problem. The study argued that, in terms of mental health status, there were three main groups attending SARCs, all of approximately equal size: a group characterised by a formal history of mental health service use; a group being treated in primary care by a GP for anxiety/depression; and finally a group with no history of mental health intervention who were now, following a sexual assault, at risk of developing a mental health condition.

Coordination and continuity between services is also important. It is unclear if the mental health services are always aware that someone under their care has attended a SARC to report an assault, and it's also unclear what the pathway to ongoing or enhanced mental health support is for those who have experienced sexual assault. The MIMOSA Study (NIHR, 2018) aims to examine the mental health and substance use needs of people who attend SARCs over a 6 month period and follow them up to see what services they were offered and accessed. Within these case study sites, the response to sexual assault across services for mental health, substance use, and the voluntary counselling sector will also be

examined. It is anticipated that this research will be able to highlight what sort of services survivors need and value, the mechanisms by which these needs are met, and the barriers. It is also anticipated that a more standardised method of identifying those who have pre-existing mental health and substance use problems, as well as those who are at risk of developing severe mental health problems, can be utilised at the time (or shortly after) attendance at a SARC.

Conclusion

The experience of sexual violence is common for people who use mental health and substance use services. There is evidence that this is a significant factor in mediating mental health issues and impeding recovery as well as a factor in re-victimisation. In the UK, as in other parts of the world, it is embedded in national policy to undertake routine enquiry in mental health, and provide adequate training to equip staff with skills and confidence to undertake this in a sensitive and effective manner. However, it is clear that there is much work to be done to convert this aspiration into reality. There is hope that things can improve; as studies have shown, that when staff are offered appropriate training and support they will be more comfortable in having conversations about sexual issues including assault. Embedding routine enquiry and management of disclosure is only the first step. Ensuring that there are appropriate treatment services to offer ongoing help after disclosure is another issue. It is vital that local services offer a clear pathway that includes key agencies such as SARCs, voluntary rape counselling as well as statutory mental health and substance use providers. Whilst the focus in this editorial has been on mental health services, it is also important to recognize that these recommendations also apply to substance treatment services where a significant number of service users will have experienced sexual violence. Sexual violence is an important area with significant long term impact on mental and emotional well-being, and the topic should not be avoided just because it feels too complex or difficult.

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