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*Title Page (WITH Author Details)

The contribution of mental health services to a new strategic direction for sexual assault and abuse services

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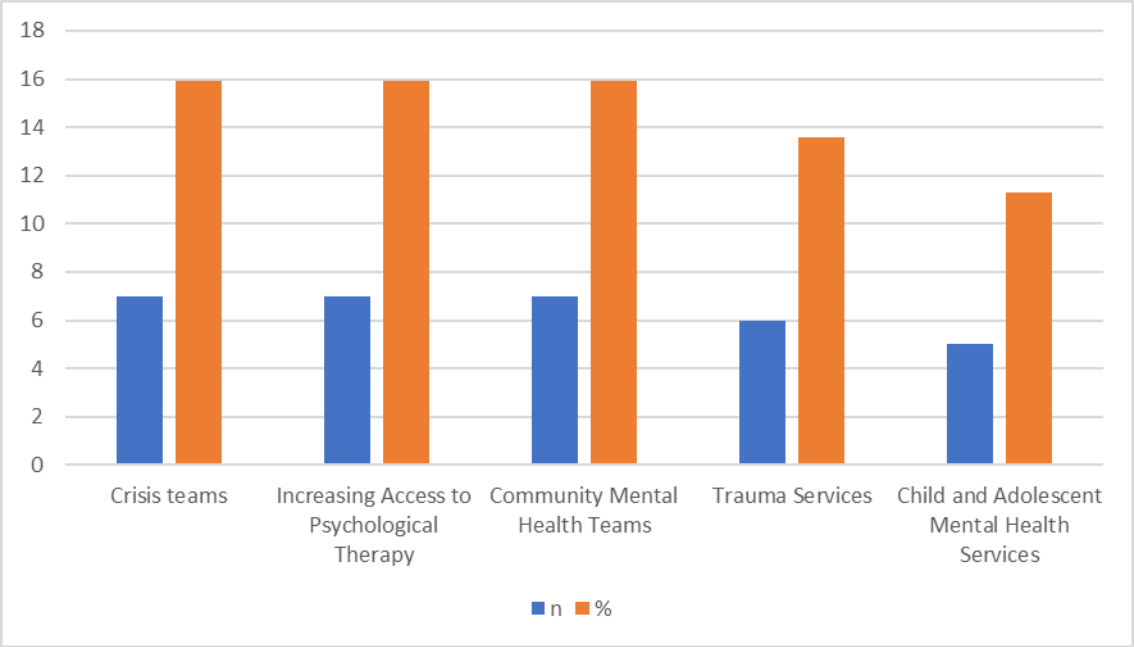
Figure(s) and caption(s)

Figure 2 Mental health Trusts with a formal pathway with the SARC



Figure(s) and caption(s)

Figure 1 The Freedom of Information (FOI) sent to Mental Health Trusts in England

1.	Does your Trust have a strategy in place that addresses the needs of the victims of sexual assault, referred from a SARC, who might require mental health care? **If YES**, Is there an accountable officer at Trust Board level responsible for the implementation of this strategy?	Yes / No Name/Title
2.	Does your Trust train staff in the use of an assessment tool that elicits the severity of the trauma a SARC service user might have experienced? E.g. The Trauma Screening Questionnaire? **If YES,** what tool does your Trust use?	Yes / No
3.	Does your Trust have a formal pathway in place as follows: • Between a SARC and Crisis Teams • Between a SARC and any IAPT service you might provide • Between a SARC and CAMHS Teams • Between a SARC and Community Mental Health Team • Between a SARC and a Trauma Pathway	Yes / No Yes / No Yes / No Yes / No Yes / No
4.	Does your Trust record the number of referrals you receive from a SARC service? **If YES**, can you please let us have the latest figures you have by month, for the last 12 months	Yes / No

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The current contribution of mental health services to a new strategic direction for sexual assault and abuse services

Abstract

A new strategy for sexual assault and abuse services was published by NHS England earlier this year. It called for better coordination of services along the Sexual Assault Referral Centre (SARC) pathway following a sexual assault including mental health services for children, young people and adults. Previous research has highlighted the fact that up to two-thirds of those attending SARCs either have a history of mental health problems or are being currently treated for one. The NHS England commissioning guidance for SARCs calls for clear pathways between SARCs and different types of mental health services including: Community mental health teams (CMHTs); child and adolescent mental health services (CAMHS) or crisis teams (CTs). In this survey of Mental Health Trusts, using freedom of information requests (FOIs) we found that very few mental health services had formally negotiated pathways with SARCs however there were several examples of good practice which it is important to report. We conclude that there is an important role for CCG and NHS England commissioners and the Care Quality Commission (CQC) in improving the relationships between SARCs and Mental Health Services.

Background

Sexual assault referral centres (SARCs) are a one-stop shop for the treatment of people who have experienced sexual assault. They are a service that bridges criminal justice and health services in recognition of the range of needs that are presented including forensic examinations, physical and mental health

checks, safeguarding and risk assessment as well as psychosocial support. SARCs are also able to refer or signpost to other agencies in the local area should a need be identified (1).

Mental ill health is common in people who attend Sexual Assault Referral Centres. In Holland (2), the United States (3), and England (4), approximately 40% of SARCs attendees have been estimated to have a mental health problem. A recent audit of Thames Valley SARCs (5) using structured outcome measures found: 69% of attendees could be defined as experiencing a mental health problem; 20% had a history of admission to a psychiatric unit; 32% were drinking at 'hazardous' levels; and 45% had previously self-harmed. In a secondary analysis of data from the Adult Psychiatric Morbidity Survey (6) a consistent relationship was reported between risk of mental health and substance use problems and the level of sexual violence experienced. The authors concluded that having mental health expertise in SARCs was crucial but so were dedicated mental health pathways out of the SARC into mental health services.

Mental health pathways were a specific feature of a national survey of forensic medical/nurse examiners (7) who were working in SARCs. This study asked examiners about the ease of accessing different component elements of mental health service provision such as CAMHs and CMHTs. The study concluded that examiners faced serious difficulties across the complainant's age range. Access to approved mental health practitioners (AMPHs); Increasing Access to Psychological Therapies (IAPT) programmes; mental health services; child and adolescent mental health services (CAMHs); child psychologists and generic mental health services all rated poorly when compared to GPs, social workers, voluntary sector/in-house counselling or safeguarding procedures.

Pathways to drugs and alcohol services were also problematic with access to formal drug/alcohol services best described as mediocre. In the SARC itself examiners commented that there was marked variation in the medication available with substance substitution drugs such as diazepam, chlordiazepoxide or dihydrocodeine not available in some SARCs but available to prescribe in others.

These problems were underlined in a recent Service Improvement Project (SIP) undertaken in the North East. The SIP aimed to improve mental health assessment in five SARCs and the mental health pathways out of the SARCs. It was evident in this project that not only did SARCs and Mental Health Services not liaise with each other but also there were no negotiated pathways at the point in time when the project baseline was assessed (8).

Early in the year NHS England published a new strategy for sexual assault and abuse services (9). The strategy, in the section on the 'Introducing consistent quality standards' (page 18) states the following intention:

> 'to work with other commissioners to ensure that interdependencies throughout pathways of care are reflected in the associated service specifications, in particular around access to: paediatrics, including GUM services for children under the age of 13 and *specialist mental health services which children, young people and adults can access (our italics)'*

Thus, it is clear, both from recent research and current national strategy, that the pathways between SARCs and Mental Health Services need improvement but from what baseline? The survey here attempts to seek an answer to this question.

Aim of the Study

The aim of the study was thus twofold:

a) To examine the extent to which Mental Health Services had developed a response to the recent national strategy for sexual assault and abuse

b) To study the formal written pathways that existed (or otherwise) between SARCs and Mental Health Services

Method

Freedom of Information (FOI) requests were sent to all Mental Health Trusts in England (n = 54). A response rate of 83% (n=45) was obtained. Full for details of the FOI (see Figure 1). In addition, consent was sought in the FOI to follow up the respondent. Four clinical managers gave this consent where their services had the most formal pathways with a SARC. Short telephone interviews took place with this smaller sub-group. It should be noted that there is a discrepancy between the number of existing pathways (for example n=7 for Crisis teams) and the number of managers who consented to being contacted (n=4) for an interview.

Ethical permission was not sought as there was an obligation under the Freedom of Information Act (2000) for these data to be provided.

(Figure 1 about here)

Results

Response to the Survey

A response rate of 83% (n=45) was obtained.

7% (n=3) of the responding Mental Health Trusts reported having a strategy in place that addresses the needs of the victims of sexual assault, referred from a SARC, who might require mental health care. A further 5% (n=2) reported having a strategy in development.

Training in the use of measures to assess Trauma

32% (n=14) of the responding Mental Health Trusts reported training staff in the use of an assessment tool that elicits the severity of the trauma a SARC service user might have experienced. Use of the following assessment tools were reported: The Trauma Screening Questionnaire (TSQ), Impact of Events Scale (IES), Impact of Events Scale – Revised (IES-R), The Functional Analysis Care Environments Risk Profile (FACE Risk Profile), The Safety Assessment and Management Plan (SAMP), The Historical, Clinical, Risk Management-20 (HCR-20), Life Events Checklist (LEC), PTSD checklist (PCL-5), Clinician Administered PTSD Scale V (CAPS –V) and The Trauma Symptom Scale.

Two Trusts reported using tools for specific groups, for example, the Children's Revised Impact of Events Scale (CRIES 8) with young people and the Dissociative Experiences Scale-II where appropriate, and The Trauma Symptom Checklist for Children. Two Trusts reported use of a range of assessment tools and interventions, and three Trusts reported using their own form(s), for example, "a risk screening form asks about trauma", "a single point of access form", "a dedicated risk needs assessment".

Pathways between the Mental Health Trusts and SARCs

Mental Health Trusts reported the following percentage figures for formal pathways between different aspects of the MH Service and the SARC in Figure 2 below. For example, 16% of Trusts had a formal pathway between the SARC and the MH Crisis Team.

Insert Figure 2

Trusts that record referrals from the SARC

Five of the responding Trusts reported recording the number of referrals received from a SARC service. Of those, only one Trust reported figures for the previous 12 months = 72 referrals over the last 12 months. One Trust reported approximately 15 SARC referrals per month but the data was limited to one locality and collected as part of a pilot (not necessarily over 12 months). The remaining Trusts reported 'yes' to recording the number of referrals but the number of referrals were not given.

Interviews with Clinical Managers of Mental health Services where Pathways are in Operation

Short phone interviews were conducted with the clinical managers/leads of four services where pathways with the SARC existed. The aim of the interviews was to elicit factors that led to pathway development.

Mental Health Trust 1

A number of factors could be identified. The high levels of mental health need found in a SARC Health Needs Assessment undertaken in 2014 persuaded the NHS England commissioner that a new initiative was required. The Mental Health Trust then took over the management of the Trust for a short eighteen-month period and provided clinical supervision for the Forensic Nurse Examiners. These factors in combination led to new psychological treatment service being funded which is led by a clinical psychologist on site in the SARC.

Mental Health Trust 2

The pathways in mental health services were recently introduced in 2018. The impetus came from the SARC who recognised that their staff had training needs in relation to mental health. Commissioners were involved in the first meeting, however, following that, meetings were held directly with the SARC and there was also a Safeguarding team that visited their referral centre. This allowed mental health services staff to gain an appreciation of the potential mental health issues that arose in a SARC.

Mental Health Trust 3

This Mental Health Trust already badged itself as 'trauma-informed'. A clinical specialist worked with families whose children had often been sexually abused had a chance conversation with a local commissioner. The clinical specialist then met with the local SARC manager where it became clear that pathways were needed into mental health services. Further work is required to develop pathways into CAMHS, Forensic and Learning Disability services and this is planned.

Mental Health Trust 4

The pathway was established in June 2018 and it aimed to meet the needs of SARC referrals who require psychological support. The principle objective is to target those most at risk of developing PTSD. Initially, the SARC determined the need for the service and then involved the Trust. The SARC were concerned that there were lengthy waits on the pathway for other services. The Trust were keen to develop the Trauma Pathway which they fund.

Summary of common factors involved in pathway development

The pathway development described above is often recent (two new pathways in 2018) and usually depends on need being identified within the SARC in one case through a formal Health Needs Assessment. Again, in all four cases the local Mental Health Trusts have been highly responsive and often ended up funding new service developments themselves. There has been little involvement from commissioners either the commissioners of SARC services or from Clinical Commissioning Groups (CCGs).

Discussion

The aim of this survey, which was undertaken using FOIs, was twofold. First, to assess the extent to which Mental Health Services in England had responded to the new national strategy for sexual assault and abuse (9). To date very few had such a plan in place but the strategy was launched only in March 2018 thus perhaps it is still early days.

Second, we sought to examine how far Mental Health Services had progressed in the design of pathways between a SARC and their constituent services. In order to design pathways between SARCs and Mental Health Services it is important to understand the likely mental health needs of those reporting a sexual assault. In a previous paper (5), it has been suggested, that the mental health concerns of SARC attendees fell into one of four main groups as follows:

……There were four main groups of roughly equal size: those not screening positive for a mental disorder; those screening positive for a mental health disorder and being treated in primary care; those screening positive and already being treated by specialist mental health services and those screening positive but no further information recorded about the nature of their treatment. At the most basic level approximately 25% of SARCs attendees are known to mental health services and they should be referred back to mental health services having experienced re-traumatisation. Another 25% are being treated in primary care often through a GP prescribing medication when they would probably benefit more from psychological therapies. However, IAPT are restrictive about referral criteria although 'high intensity' IAPT programmes claim they treat trauma' (page 120)

More recent research on pre-existing mental health conditions in SARC attenders confirms the findings from the study above (10) . In the report of the Manchester SARC 69% of SARC attenders self-reported a pre-existing mental health condition most often depression and anxiety. In the Thames Valley study, the percentage reporting was very similar (5). In the latter study these data were confirmed by outcome measures and did not rely on self-report.

In addition to the groups outlined above in Thames Valley there will also be a need at times for forensic examiners to refer on to Crisis Services and Drug/Alcohol Teams. Thus, it seemed reasonable to ask mental health services to what extent pathways currently existed to a range of mental health services.

Figure 2 makes it clear that very few formal pathways exist with just five Mental Health Trusts reporting their existence. The most common pathways in place were for Crisis Teams (n=7), IAPT services (n=7) and community mental health teams (n=7) with Trauma Services and CAMHs less frequently cited. These are very small numbers given that there are 54 Mental Health Trusts in England.

We sought to explain the existing pathways using short telephone interviews with the relevant clinical managers. How was it that pathways existed in a small number of services but not in the vast majority? The key factors seemed to be: need for a psychological service being established in the SARC; contact being made to a responsive Mental health Trust who resourced the pathways; local interested clinicians often psychologists; and finally, its maybe worth noting that commissioners, i.e. NHS England or CCGs, had very little to do with pathway development – the SARCs and Mental Health Trusts 'just got on with it'.

Conclusion

What are the implications of the study in the context of the new strategy for 'Sexual Assault and Abuse'? A key aim of the national plan is to increase partnership working. This small study provides a baseline for the amount of formal contact between Mental Health Services and SARCs. It would be worthwhile revisiting this issue in several years' time to see if there has been an increase in pathways. Second, it is clear that there is a long road to travel in relation to improving mental health care for SARC attendees. Third, we would argue there is a role for the Care Quality Commission (CQC). The CQC has

stated in its key lines of enquiry, under its ‘Safety’ sub-heading, it will assess services in to establish that there are ‘reliable systems in place to keep people safe and safeguarded from abuse’. Can this be achieved meaningfully without pathways between SARCs and Mental Health Services in place?

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