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Sexual violence and mental health services: a call to action

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Abstract

People who experience sexual violence are highly likely to experience psychological and/or mental health (MH) problems as a result. People who use MH services often have a history of sexual assault and are also likely to be revictimised as an adult. Yet despite there being a very clear association, MH services are not yet performing routine enquiry, and even if they do, are not confident about how to record and manage disclosures. There is some emerging evidence that people with MH problems are exposed to sexual violence in inpatient MH settings, perpetrated by both other patients or members of staff. In this editorial, we explore the evidence to support a wider focus on sexual violence as a part of routine care, as well as some recommendations about how staff can more effectively discuss sexual issues including that of sexual victimisation.

Rape and sexual assault is 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 and 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 did not tell anyone at the time. Therefore, it 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 (MH) 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 one in ten victims attempted suicide as a result. The most common MH 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 MH problems include depression, suicidality (13× 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 many people presenting to MH 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 MH problems. Khalifeh *et al.* (2015) found that there was a six- to eightfold 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 MH 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 MH 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 MH 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 MH trusts, 12 reported they did not record such data; 13 provided a nil return

(no reported sexual assaults) and 12 provided some data. Only one NHS Trust refused the FOI request. There was 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 Cummins (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 MH 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 MH 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 behaviour 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 underreported 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) undertook an analysis of prospective data collected in the first 2 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 behaviour was exposing self to others (n = 78 incidents). However, they also found one in 20 (26 patients perpetrated 42 incidents) had engaged in 'non-consensual sexual touching' of another person. The data were 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 MH 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 MH nurses avoid the topic were partly because they had concerns that it would destabilise or upset the service user, and partly because they do not 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 four focus groups with MH 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 MH staff are not routinely enquiring about sexual violence. Hepworth and McGowan (2013) undertook a review of the literature to gauge whether MH staff enquire about sexual abuse. A total of 11 papers recorded the prevalence of routine enquiry and/or asked MH 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 MH 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, 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 MH 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 MH 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 SMI), 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 *et al.* 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, after nearly two decades since Lab *et al.* (2000) highlighted the lack of routine enquiry, Brooker *et al.*'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 MH 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 is clear that MH staff have real concerns 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 MH care settings. However, this was a small localised 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 the 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 MH 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 MH 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 is 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 MH. This aimed to provide clearer guidance for staff on the steps they should take following a disclosure and also about how to recognise 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 *et al.* (2015) described a case example where an inpatient of a MH 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, this 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 well-being 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 MH problems (as highlighted in the 2018 NHS England Service Specification for SARC services).

It has been estimated that worldwide approximately 40% of those attending SARCs are known to MH services (Brown *et al.*, 2013; Bicanic *et al.*, 2014; Zilkens *et al.*, 2017). More recent research in England has concurred with this figure (Brooker and Durmaz, 2015). A 1-year audit was undertaken of the MH status of adult attendees to the Thames Valley SARC in 2017 (Brooker *et al.*, 2018). Data were collected by the SARC staff at the time of presentation. Over the study period of 1 year, there were 351 relevant referrals over the 12-month period of whom 126 (42%) either fully or partially completed the MH 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 (one 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 MH problem. The study argued that, in terms of MH status, there were three main groups attending SARCs, all of approximately equal size: a group characterised by a formal history of MH service use; a group being treated in primary care by a GP for anxiety/depression; and finally a group with no history of MH intervention who were now, following a sexual assault, at risk of developing a MH condition.

Coordination and continuity between services is also important. It is unclear if the MH services are always aware that someone under their care has attended a SARC to report an assault, and it is also unclear what the pathway to ongoing or enhanced MH support is for those who have experienced sexual assault. The MIMOSA Study (NIHR, 2018) aims to examine the MH 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 MH, 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 MH and substance use problems, as well as those who are at risk of developing severe MH 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 MH and substance use services. There is evidence that this is a significant factor in mediating MH 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 MH, 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 MH and substance use providers. Whilst the focus in this editorial has been on MH services, it is also important to recognise 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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