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Sexual violence and mental health

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Editorials in This Issue

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The scale of sexual violence is staggering. It includes, but is not limited to, rape within marriage or dating relationships; rape by strangers or acquaintances; unwanted sexual advances or sexual harassment, including at work and at school; systematic rape, sexual slavery and other forms of violence, which are particularly common in armed conflicts; the sexual abuse of people with physical and mental disabilities; the sexual abuse of children; and 'customary' forms of sexual violence such as forced marriage or cohabitation and wife inheritance (World Health Organisation, 2012). In the USA, the National Intimate Partner and Sexual Violence Survey reported that 19.3% of women participants – equating to 23 million women nationally – had been raped in their lifetime (Breiding, 2015). In Europe, the European Union's Fundamental Rights Survey found that 5% (9 million) women had been raped since the age of 15 (with prevalence varying from 4 to 17% between participating states) and that 0.8% (1.5 million) had been raped in the last 12 months (European Union Agency for Fundamental Rights, 2014).

Research suggests an association between sexual violence and a range of mental-health problems – including post-traumatic stress disorder, depression, psychosis and substance abuse problems – and also demonstrates that a high proportion of people in contact with mental-health services have experienced sexual violence (Oram *et al.*, 2017). Survey research conducted in the UK by Khalifeh *et al.*, for example, found that 40% female patients in contact with secondary mental-health services had experienced rape or attempted rape as adults, and that 10% had experienced sexual violence in the past 12 months alone (Khalifeh *et al.*, 2015). More than half of those who had experienced rape or attempted rape reported having attempted suicide as a result of their experiences. In this issue of *Epidemiology and Psychiatric Sciences*, two editorials provide a comprehensive discussion of the response of mental-health services to sexual violence, finding it to be, too often, lacking or even actively harmful.

Drawing mostly on evidence from the UK and Australia, Hughes *et al.* report that many mental-health professionals do not routinely enquire about sexual violence (Hughes *et al.*, 2019). Some do not understand the relevance of sexual violence to the development, maintenance and exacerbation of mental-health problems. Others fear causing distress by asking about sexual violence or feel ill-equipped to respond to a disclosure, including because of a lack of time, training and resources. Similar concerns have been raised in relation to enquiry about domestic violence in mental-health settings. Damningly, findings from the UK suggest little improvement in rates of enquiry in the decade since routine enquiry about sexual abuse was introduced into mental-health services.

Hughes *et al.* argue that it is not enough to improve the identification of sexual violence through increased enquiry: ensuring that any disclosure of sexual violence is appropriately received and responded to is vital. Evidence from qualitative research in Australia has highlighted that mental-health service users may not be believed upon disclosing sexual violence, and that support to access criminal justice and specialist support services is often lacking. Hughes *et al.* close by highlighting the important role of Sexual Assault Referral Centres, specialist facilities where people can receive immediate help and support for sexual violence, including access to a forensic medical examination, support from a crisis worker, and help to speak to the police. Research from Australia, Canada, the Netherlands and the UK suggests that up to 40% of people attending Sexual Assault Referral Centres are known to mental-health services, though little is known about pathways between the two. The recently launched MIMOSA study will follow-up people attending Sexual Assault Referral Centres in the UK to improve understanding of mental health and substance use needs and subsequent use of services.

In the second editorial, Sweeney *et al.* explore how mental-health service responses to sexual violence impact on survivors, setting out a vision for an improved approach to care (Sweeney *et al.*, 2019). They report that there is little well-funded support is available for survivors of sexual violence, and that the response of mental-health services can be actively harmful. Failure to ask and to believe mental-health service users about experiences of sexual violence allows continued exposure to violence and abuse, risks psychological harm and jeopardises criminal proceedings. Too many survivors of sexual violence are exposed to practices within mental-health services that replicate experiences of coercion and force, including the

use of restraint, seclusion and forcible injections (Agenda, 2018). And, as also highlighted by Hughes *et al.*, too many experience sexual violence within mental-health services themselves (Care Quality Commission, 2018). Sweeney *et al.* call for an end to the silence that surrounds sexual violence and its effects, for services to embed trauma-informed approaches to care, and for greater recognition – and resourcing – of community-based services that provide specialist and in some cases peer-led support to survivors of sexual violence.

Several factors are likely to contribute to the lack of progress in improving mental-health service responses to sexual violence. Among them is the relatively low priority afforded to sexual violence by researchers and by research funders and publishers. Evidence is limited, for example, on the effectiveness of interventions to improve mental-health outcomes among survivors of sexual violence and to improve community, institutional and societal responses (Bisson and Andrew, 2007; Vickerman and Margolin, 2009). Sexual and other forms of violence are rarely measured or identified in trials of mental-health interventions, even though they are likely to be important moderators of response, and too limited consideration is given to common forms of violence against women in major survey and cohort studies (Oram *et al.*, 2017). *Epidemiology and Psychiatric Science*'s decision to commission these two editorials is a welcome one. Other recent developments may perhaps also give cause for optimism. In the UK, for example, the cross-disciplinary mental-health networks funded by UK Research and Innovation include a network on violence, abuse, and mental health (www.vamhn.co.uk), with a focus on domestic and sexual violence.

As Sweeney *et al.* highlight, research led and co-produced by survivors of sexual violence is needed in order to understand whether and how mental-health services are meeting the needs of survivors and to explore the potential of trauma-informed approaches in transforming care. While underlining the importance of survivor involvement in and leadership of research, they also highlight that participation can be difficult for many people and the need to take seriously the safety and emotional support needs of those involved. As described by Sweeney *et al.*, the recently launched Charter for Organisations for Engaging Survivors in Projects, Research and Service Development sets out principles for safe, meaningful and effective involvement of survivors in research (Perot *et al.*, 2018).

Survivors have been let down by too many and for too long. With the greater prioritisation of sexual violence in mental-health policy, services and research, this could finally change.

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