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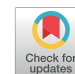
Review

Mental health pathways from a sexual assault centre: A review of the literature



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ABSTRACT

The recent long-term NHS plan calls for improvements to the mental health of those attending a Sexual Assault Referral Centre (SARCs). The assessment of mental health is currently the subject of a systematic review being undertaken as part of the MiMoS project. However, there is a literature that examines mental health outcomes following attendance at a SARC. We review these studies and consider the implications for SARCs in England.

1. Introduction

The first Sexual Assault Referral Centre (SARC) in England was established at St Mary's Hospital in Manchester in 1986 in association with the Greater Manchester Police Force. Since those early days the number of SARCs in England has grown and there are now 47 country-wide. SARCs in England aim to provide a one-stop health shop for those who have been sexually assaulted. SARC services provide support to complainants of sexual assault and rape 24 h a day and 7 days a week, including health care and onward referral to other health and social care services. A SARC provides services to complainants of rape or sexual assault of any age and gender, and whether the victim reports the offence to the police or not, and can provide onward referrals to other health and social care services according to need. SARC services can deliver services to both recent and non-recent victims, and can offer complainants the opportunity to assist in a police investigation of the sexual offence against them, including a forensic medical examination with consent.

Sexual assault is highly traumatising and so onward referral from a SARC might ideally include: crisis care, referral for psychological therapies, usually to IAPT (Increasing Access to Psychological Therapy Services), CAMHS (Child and Adolescent Mental Health Services) and specialist adult mental health services, and to Third Sector/Voluntary Sector specialist sexual violence support, including advocacy.[1] The assessment of mental health in a SARC is a key consideration and a systematic review[2] is currently being undertaken as part of a study funded by the National Institute for Health Research (NIHR)[3] to examine the way that mental health is assessed in sexual assault referral centres world-wide – the MiMoS (Mixed Methods Evaluation of SARCs) study. Apart from the trauma that can arise from sexual assault itself it is clear that many who are sexually assaulted and attend SARCs are, concurrently, being treated for a mental health problem or have a history of attending mental health services.[4,5] A secondary analysis of the Adult Psychiatric Morbidity Survey data, in England, has also shown that complainants of rape were significantly more likely to be dependent on drugs and alcohol, admitted to mental health wards and at risk of suicide when compared to the general population.[6]

This review moves beyond the world of the SARC and examines the published literature in relation to pathways for mental health services out of a sexual assault service. A number of the papers were identified from the MiMoS review cited above. The method used is described in more detail below.

2. Method

A formal systematic review was not performed. Seven papers from the MiMoS systematic were identified that related to mental health follow-up care pathways after attendance at a sexual assault centre. These papers were part of the excluded papers from the MiMoS review because they evaluated mental health outcomes for SARC service users but without reference to a non-SARC comparison group. They do not, therefore, relate to that review. Hand-searching was then undertaken

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Table 1
The course of mental health problems following a sexual assault: a review.

Authors	Year	Setting	Sample	Method	Main Findings
Witkemper et al.[7]	2018	Referred from Emergency dept, North Carolina, US	338 women who completed at 6-month follow-up	Prospective study looking at the relationship between resilience and mental health outcomes	Those with a higher resilience one week after a sexual assault had reductions in depression and general health status but not PTSD or anxiety
Sullivan et al.[8]	2018	The SANE programme at Albuquerque, Tulsa, North Carolina	411 women who completed follow-up to six months	Assessed MH symptoms using screening tools	91% has significant post-traumatic stress symptoms at 6 weeks but only 38% of these are seeing a mental health specialist/or MH service
Nickerson et al.[9]	2012	Women recruited within 4 weeks of a sexual assault, Boston, US	126 women	Sample was followed-up prospectively for four months	Decreasing proportion met the criteria for PTSD over time: month 1–43.7%; month 2–24.6%; month 3–12.7% and month 4–7.1%. If you target PTSD for treatment co-morbid depression and anxiety improve too.
Resnick et al.[10]	2013	The Medical Unit, South Carolina, US	255 women who had been assaulted in the previous 4 weeks	A mental health assessment of the sample at 4 weeks post assault	35% had an alcohol problem before the assault; 19% used alcohol and marijuana before; 12% had received drug or alcohol treatment prior to the assault. Post assault such referrals could be important.
Rosenberg et al.[11]	2001	Literature Review			15–40% of people, post assault, experience PTSD importance of such assessments

from the citations from those seven papers to identify papers that met the following criteria:

Inclusion if

- Participant had presented to a sexual assault service that provides forensic and medical care
- Intervention – any kind of mental health care after a forensic examination
- Outcomes of interest – types of mental health problems, types of mental health services accessed.

3. Findings

In addition to the seven originally discarded papers a further seven were identified that met the inclusion criteria. All the papers reported on services in the United States. The findings are sub-divided into two main categories. The first set of papers concern the course of mental health problems following a sexual assault (See Table 1). Two of the papers were reviews and did not address a specific research question[11,18] and were reported in 2001 and 2007 so are likely to be out of date. One of these papers[11] focuses on the role of trauma in those with a severe mental illness and the likelihood of post-traumatic stress disorder (PTSD) is unrecognised in this group. The second review[18] examines the barriers that may exist in obtaining mental health services following a sexual assault.

The second set of papers concern the specific use of mental health services following an assault (See Table 2).

All the papers draw on research undertaken in the United States notably in North Carolina, Chicago, Boston and Vermont. In particular in North Carolina there seems to be a strong research collaboration between service providers and academics (Albuquerque SANE [Sexual Assault Nurse Examiner] Collaborative; the University of Birmingham; and the University of North Carolina). The identified research should be cautiously interpreted in the context of UK SARC services and indeed any other SARC world-wide outside of the United States.

4. Discussion

In 2019 a vision for the next decade of the health service was published by NHS England.[20] The document mentions SARCs and makes the following recommendation:

> *'Across England, 47 sexual assault referral centres currently provide health support for people who have been a victim of sexual assault. We will expand provision to ensure survivors of sexual assault are offered integrated therapeutic mental health support, both immediately after an incident and to provide continuity of care where needed'.*

Clearly this statement recognises the importance of mental health following a sexual assault but is obviously a statement of intent rather than a detailed operational plan. To what extent does the literature identified here, mostly from the United States (US), contribute to this future debate in England?

Table 1 confirms that PTSD is a key issue affecting many. One study in this review found that as many as 91% had significantly severe symptoms of PTSD after six weeks. Less than half this group were engaged with mental health services.[8] Even those with higher resilience had reductions in depression and general health status but not anxiety or PTSD.[7]

However, there is some evidence that the symptoms of PTSD reduce over time with no intervention. One study found that the 44% of the sample diagnosed with PTSD four weeks after an assault reduced to 7% after four months.[9] An important paper in Table 1 also demonstrates that one-third of those assaulted in South Carolina had an alcohol problem prior to the assault and for a smaller sub-group, 12%, there were problems with both drugs and alcohol.[10] In a three-month follow-up, post-assault, past drug/alcohol use was related to recent use of

Table 2
Use of mental health services following attendance at a Sexual Assault Centre: a review.

Authors	Year	Setting	Sample	Method	Main Findings
Price et al.[12]	2014	Referred from Emergency following sexual assault in Vermont, US	442 women who consented to an RCT within 72 h of a sexual assault	Education videos vs treatment as usual (counselling received in both groups)	Data collected at 3 and 6 months. Mental health service use decreased from 43.5% at 3 months to 31.4% at 6 months. Those who used MH services were: privately insured; more depressed, used more alcohol (pre-assault); and had received previous MH treatment
Alvidrez et al.[13]	2011	Emergency Dept at San Francisco Hospital	104 women assessed within 72 h of a sexual assault	PTSD and MH symptoms assessed and comprehensive MH offered	Engagement was 82% for white women but only 40% for black women. Black women more likely engage when ethnically matched with a case manager
Amstradter et al.,[14]	2008	University	3001 women recruited nationally	Telephone survey to examine 'help-seeking' after a sexual assault	60% had ever sought help. 38% had seen a medical doctor; 54% had seen a MH specialist; 15% had sought spiritual help. Those that sought out the help of MH professionals were: suffering from PTSD; using alcohol; white; unmarried; aged 45–54 years.
Simmel et al.[15]	2016	Prisons and SARCs	423 women	Data collected across the life span through face-to-face interviews to examine victimisation	Three groups created for the analysis those that improved the most over time were: the most victimised; used MH services; found them helpful and had a higher level of education
Ullman and Breckley[16]	2002	Based on a national co-morbidity study	619 women	Interview schedule	The highest users of mental health of MH services post-assault are those with medical insurance; a history of drinking; who are older. The lowest users of MH services are lower educated women from ethnic minority groups who are the 4 highest risk of PTSD.
Campbell et al.[17]	1999	University Department, Chicago	102 women recently sexually assaulted	Data collected on sexual assault and the extent of involvement afterwards with the Criminal Justice System; Medical Help and Mental Health Services	- Most women were able to access short and long-term counselling - Sustained involvement with MH services reduced PTSD and long-term impact
Brooker and Tocque[6]	2016	Desk-based research	General population sample of 7403 (Adult Psychiatric Morbidity Survey, England)	The severity of sexual assault was examined in relation mental health service use	Those who are raped are generally a disadvantaged group: overweight; non-white; live in deprived areas; smoke; drug dependent. 32% of those raped has received MH care and were 1.8 more likely to have been in-patients and twice as likely to attempt suicide
Ullman[18]		2007	Review of studies on mental health service use after sexual assault		
Campbell[19]	1998	University Dept, Chicago	165 managers of advocacy services	All asked to give details of their most recent sexual assault case	Three clusters were observed – best outcome (89% short-term counselling; 65% long-term counselling), 'one saving grace' cluster' (had supportive family/friends) a final group called 'an exercise in futility'

substances.

It should also be remembered that two English studies have now found that 70% of those presenting for an examination, pre-assault, were experiencing mental health problems prior to seeking an examination at a SARC.[4,5] This has important implications for assessment of mental health problems in a SARC.

The studies identified in Table 2 focus on the use of mental health services after a forensic examination. Although the rates of mental health service engagement vary from 43 to 80% the higher figure was only true for white women and for black women in this study the figure was much lower, i.e. 40%.[12–14] Several of the studies in Table 2 have tried to identify the factors associated with higher use of mental health services. The following variables have been amongst the important: having private insurance; being more depressed; using alcohol pre-assault; in receipt of mental health services previously, unmarried and women who were older.[11–14] In a key review undertaken in 2007 it has been pointed out that survivors can have PTSD for months or years without seeking help.[19] Even when help-seeking occurs the issue of victimisation might not be raised by either the survivor or the therapist/key worker. This review also cautions against 're-victimisation' and how those untrained in the field of trauma can unintentionally trigger symptoms of PTSD.

Clearly there are limitations of this review. It was not a systematic review so it is entirely possible that some papers have not been included. However, in England where no research of this type has ever been reported that we could ascertain this might not be the issue. What is of greater importance, perhaps, is that the papers from the US literature illustrate the importance of following people up after a sexual assault to ensure they obtain the right treatment and help. An issue that has begun to be addressed by the NHS.

In England, the latest guidance on the mental health pathway comes from the NHS England Service Specification published in 2018 which states the following in relation to mental health and SARCs[1]:

> *'There are also health interdependencies with mental health services and it is essential that service users have a choice of care provision in on-going support and counselling. When service users' mental health needs exceed the remit of SARC provision i.e. needs are greater than Improving Access to Psychological Therapies (IAPT) level 3 support, the SARC will need to refer the individual to local community mental health services or acute services. Referrals should be with consent or, in the case of adults without capacity, in their best interests. Where such services do not exist discussions will need to be held between the relevant commissioners and partners.'*

There are challenges in implementing services in line with the above guidance. First, referral to any IAPT service is problematic. IAPT services will not accept referrals where the individual is misusing alcohol or drugs. Furthermore, IAPT services will not accept referrals for trauma where the person is assessed as suffering from complex trauma, (defined as experience of sexual abuse as a child.) Not meeting the two criteria above will discount many and a further complication is added by an often-lengthy waiting list for IAPT teams. The guidance next suggests that a referral should be made to mental health services. A recent study asked forensic physicians/nurses to rate their experiences of referring to mental health services. They rated many aspects of such provision as 'unresponsive' with Child and Adolescent Mental health Services receiving especially low scores.[21] Indeed, in England formal referral protocols between SARCs and mental health services only exist, at best, in 14% of all cases.[22]

There remains much to be done. A starting point would be to construct a set of mental health standards that could be adopted nationally by all stakeholders. These standards should focus on adults and children and young people and be in two parts. What standards should apply to the assessment of mental health problems in a SARC? What standards should apply to the mental health pathway out of a SARC? Until such standards are developed and agreed no-one can audit the performance of SARC in relation to mental health.

5. Conclusion

Research from the United States has been reviewed which examines mental health service use following a sexual assault. Little such research has been published in Europe. In England, the NHS long term plan states that mental health care following a sexual assault is a priority. This poses a series of challenges for commissioners and service managers. The key task is to engage mental health services in this agenda. A further challenge is to obtain agreement on a set of national standards for mental health assessment in a SARC and mental health care that people receive on the pathway out of a SARC. Finally, current research does not allow us to predict the course of a mental illness following an assault and therefore to provide the range of appropriate services. More research is urgently needed.

Conflicts of interest

This is to state formally that none of the authors has any conflict of interest.

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