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Mental health in Sexual Assault Referral Centres: A survey of forensic physicians

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ABSTRACT

A national survey of Forensic Physicians (FPs) working in Sexual Assault Referral Centres was undertaken. The survey was advertised in the weekly bulletin sent out by the Faculty of Forensic and Legal Medicine. Response was relatively low (n = 45). It is estimated that this figures represents about 12% of the workforce. The aim of the survey was to investigate FPs experience of accessing mental health pathways out of a SARC for complainants of all ages. The results concurred with a previous survey of SARC clinical managers with mental health services proving unresponsive. Informed co-commissioning between NHS England and Clinical Commissioning groups can only improve if aspects of complainant's mental health are routinely assessed within SARCs using structured outcome measures. Structured outcomes should be integrated into NHS England's Sexual Assault Referral Centres Indicators of Performance (SARCIP).

1. Background

People who allege sexual assault can attend a national network of Sexual Assault Referral Centres (SARCs) for physical examination, the collection of evidence and sign-posting onto other appropriate services. The impact of being sexually assaulted on mental health is not always assessed comprehensively in SARCs despite national policy guidance.[1,2] This, despite the fact, that a number of studies worldwide have estimated the prevalence of mental health problems in adult SARC attendees to be approximately 40%.[1,3–6] The range of these mental health problems have been more fully investigated in a recent English study[7] - a one year mental health audit of all attendees at a SARC outside London in the Thames Valley. This study found 36% were moderately or severely depressed; 30% experienced moderate to severe anxiety; 28% were drinking at hazardous/harmful levels; and 12% had a drug problem that was moderate to severe. Self harm affected 45% of the sample with the greater majority cutting themselves and self-harming before the age of 17. 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. 42% of the total sample were being prescribed medication for their mental health problem. The paper concluded that: there should be agreement nationally on the use of a standardised set of mental health outcome measures which are used in all assessments; there should be a move towards the commissioning of expert psychological support that is offered in a SARC and the pathways for specialist mental health care out of the SARCs. Finally, forensic physicians and general practitioners need a greater awareness of the mental health sequalae of sexual assault and they then need to make prompt referrals to the appropriate services.

At present the NHS England commissioning guidance for mental health in SARCs is under-developed and states in relation to mental health[8] that:

> 'The SARC will ensure the provision of appropriate psychosocial support according to the clients' needs. When clients' mental health needs exceed the remit, i.e. needs are greater than Improving Access to Psychological Therapies (IAPT) level 3 support, the SARC will refer them to local community mental health services or acute services as appropriate. Referrals should be with consent or, in the case of adults without capacity, in their best interests.
>
> Clients aged under 18 will be referred to their local safeguarding team. Provision for further paediatric services such as medical care and psychosocial support must be available'. (page 17 of Specification No 30, NHS England).

The key role in the assessment of mental health and substance misuse needs in a SARC is that of the forensic physician/nurse examiner.

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2. Method

2.1. The questionnaire

A short questionnaire was designed and posted on Survey Monkey. The aim of the survey was to elicit forensic physicians' (FPs) views about the assessment of mental health in a SARC (both for children/young people and adults). A further aim was to obtain FPs' views about the adequacy of mental health pathways out of a SARCs for follow-up care (please contact the main author if you would like a copy of the questionnaire).

2.2. The sample

A briefing about the survey was included in three consecutive weekly copies of the Bulletin of the Faculty of Forensic and Legal Medicine. The sample targeted forensic physicians working in a SARC in England.

2.3. Analysis

Data were exported from Survey Monkey and analysed in SPSS using descriptive statistics. Qualitative responses were manually organised into key themes.

2.4. Results

2.4.1. The sample

A total of forty five forensic practitioners responded. The characteristics of the sample are given in Table 1.

The majority were female (80%); with a relatively even spread of the types of membership of the Faculty of Forensic and Legal Medicine. The greater proportion (73%) of the sample were located in the North or the Midlands. The whole sample had worked in a SARC for an average of 9 years and assessed on average 4.45 adults (SD = 4.379) and 3.71 children/young people (SD = 4.452) per month.

2.5. Forensic physicians working with adults

2.5.1. Expertise

Respondents were asked whether they felt that they had the expertise to undertake mental health or a substance misuse assessment in their SARC. Here, the majority of respondents (80%, n = 36) felt that they had. Of the remainder, three did not answer this question, and six felt that they did not have this expertise in their SARC. Two of these six stated that they do not see adults in their SARC. Of the remainder of those stating that they did not have this expertise in their SARC, one wanted "more in depth training around both issues", one wanted "more mental health assessment training and how to respond", one stated that a brief assessment for mental health is done with all clients, but not a full one, and there is limited experience in drug/alcohol assessment. The final respondent in this group felt that more teaching and shadowing would be helpful.

Table 1
The characteristics of forensic physicians who responded to the survey.

Characteristic		N	%
Gender	Male	9	20%
	Female	36	80%
	Total	45	100%
Membership Type	Affiliate	11	25%
	Fellow	8	17%
	Member	11	25%
	Other (includes 8 non-members)	15	33%
	Total	45	100%
Location	Midlands	10	22%
	North West	11	24%
	North East	12	27%
	South West	4	9%
	South East	5	11%
	London	2	5%
	Total	45	100%

2.5.2. Resources

Similarly, respondents were asked whether they felt that they had the resources to provide an assessment for mental health or substance misuse in their SARC. Here, 80.0% (n = 36) of respondents stated that they had the resources for this, 11.1% (n = 5) stated that they did not, and 8.9% did not answer this question. Those respondents stating that they did not have the resources that they needed stated that they would like physical examination tools like a blood pressure cuff; drugs tests, and for more medications to be stocked in SARCs to deal with substance abuse.

2.5.3. Access to mental health pathways

Respondents were asked to rate the accessibility of a number of mental health services in relation to their work in the SARC. Here 'access' was defined as access to the service for the patient following assessment in the SARC. A summary of responses is given in Fig. 1.

For GPs, the majority of respondents rated access for adult patients as either 'moderate' (24.4%, n = 11) or 'good' (55.6% n = 25). For IAPT, most respondents rated access for adult patients as either 'poor' (31.1%, n = 14) or 'moderate' (28.9%, n = 13). Eight respondents rated this as 'unknown'. Access to approved mental health practitioners for adult patients was rated 'poor' by 35.6% (n = 16) of respondents. Nine respondents rated this as 'unknown'. Access to mental health services for adult patients was rated 'poor' by 28.9% (n = 13) of respondents, and 'moderate' by 16. Access to in-house counselling for adult patients received quite positive ratings, with 53% (n = 24) rating this as 'good'. Access to drug and alcohol teams for adult patients received more mixed ratings, with 17.8% (n = 8) respondents rating this as 'poor', 35.6% (n = 16) as 'moderate', and 20% (n = 9) as 'good'. Nine respondents rated this as 'unknown'. Access to voluntary sector counselling for adult patients received quite positive ratings, with just 6.7% (n = 3) of respondents describing this as 'poor', 33.3% (n = 15) as 'moderate', and 31.1% (n = 14) as 'good'. Ten respondents rated this as 'unknown'.

Respondents were asked to describe the main problems with accessing local mental health or substance misuse services. Here, the following themes were identified in the data:

- It can be difficult to gain access to both immediate and ongoing care as access has to be via a GP (unless a patient is already known to mental health services). Accessing services this way takes a long time, and the service provision on offer varies by postcode
- Pathways into care are not always clear
- SARCs teams often work out of hours, and it is particularly difficult to access urgent support for patients with mental illness out of hours. It is not always clear whose responsibility care for these patients is out of hours
- Resources – many services are stretched or at capacity – there is a need for increased funding and staffing. There are long waiting lists for a variety of mental health services – both adult and CAMHS
- Mental health teams can be reluctant to engage with SARC cases

2.6. Forensic physicians working with substance misuse in adults

Respondents were asked to describe how they would manage substance misuse withdrawal in a SARC. This showed the following themes:

- Variation in medication available: There is limited medication (if

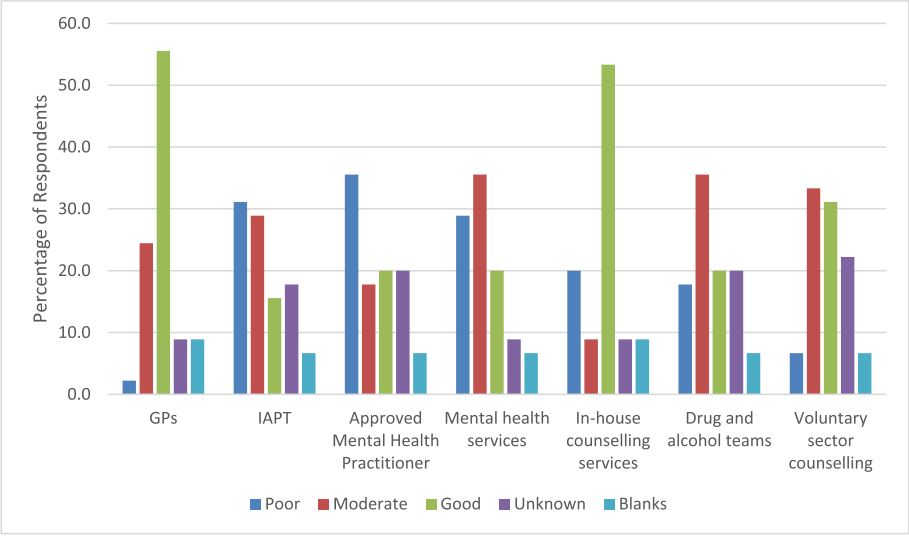

Fig. 1. Ratings of service accessibility for adult patients.

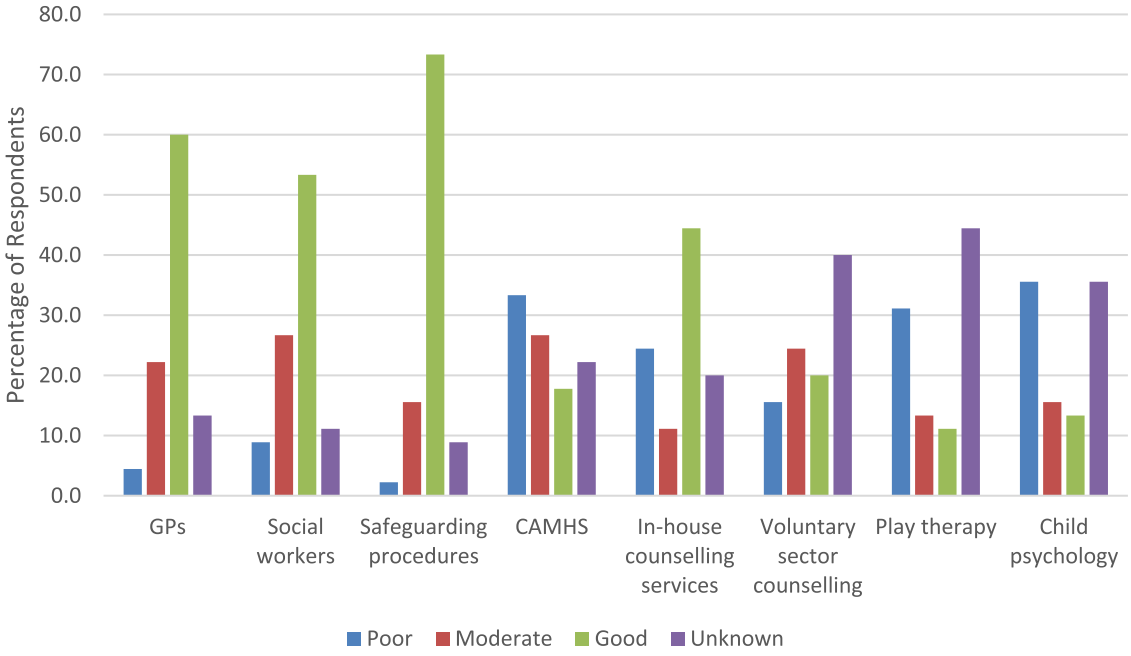

Fig. 2. Ratings of service accessibility for children.

any) available in some SARCs – e.g. 'only paracetamol', 'We do not stock Diazepam, Chlordiazepoxide or Dihydrocodeine. If we needed this I would have to write a private prescription', 'Currently it is difficult to manage substance abuse at the SARC Level. This is mainly due to limited stock of substance abuse substitution medications being available to medical practitioners in most SARC environments'. Others do stock medication e.g. 'stock Diazepam and Dihydrocodeine as per PGD's'

- Patients may be given alcohol as this is stocked, and examinations can be timed around drug or alcohol needs
- These cases would be admitted to a hospital ward or A&E e.g. 'no medication - need to call ambulance and send to A&E'

2.7. Forensic physicians working with children/young people

2.7.1. Expertise

Respondents were asked if they felt that they have the skills to undertake a mental health/substance misuse assessment with children/young people in their SARC. Here 60% (n = 27) of respondents stated that they did, 28.9% (n = 13) stated that they did not, and 5 respondents did not give yes/no answers to this question. Two of these respondents stated that this question was not applicable. For those answering 'no', more training or refresher training was seen as helpful, whilst others stated that they work with other professionals such as pediatricians.

2.7.2. Resources

Respondents were asked if they felt that they had the resources to provide an assessment for mental health/substance misuse for children/

young people in their SARC. Here, 64.4% (n = 29) stated that they did, 24.4% (n = 11) stated that they did not, and three people stated that this was not applicable. Two people did not provide a yes/no/not applicable answer to this question, choosing to leave qualitative comments instead. In some cases, respondents noted that whilst they have the resources to do an assessment, onward referral can be problematic. Those stating that they did not have the resources that they needed said that they would find training and supervision, access to experienced staff (e.g. CAMHS workers), access to equipment such as blood pressure cuffs and access to medication helpful.

2.7.3. Access to mental health pathways

Respondents were asked to rate the accessibility of a number of services in relation to their work with children/young people in the SARC. Here 'access' was defined as access to the service for the patient. A summary of responses is given in Fig. 2.

Just over a fifth of respondents (22.2%, n = 10) rated access to GPs for children as 'moderate', and 60% (n = 27) rated this as 'good'. Access to social workers was rated similarly, with 26.7% (n = 12) of respondents rating this as 'moderate', and just over half (53.3%, n = 24) rating this as 'good'. Access to safeguarding procedures for children was also rated well, with 73.3% (n = 33) of respondents rating this as 'good'. Just one respondent rated this as 'poor'.

Access to CAMHS services appears to be problematic in some cases, with a third of respondents rating this as 'poor', 26.7% (n = 12) as 'moderate', and 17.8% (n = 8) as 'good'. Similarly, access to in-house counselling services received mixed ratings, with 24.4% (n = 11) of respondents describing this as 'poor' whilst 44.4% (n = 20) described it as 'good', and 20% (n = 9) were unable to rate this.

Access to play therapy was rated as 'poor' by 31.1% (n = 14) of respondents, and 'good' by 11.1% (n = 5). The majority of respondents (44.4%, n = 20) were unable to rate access to this service. Access to child psychology was fairly poorly rated with over a third of respondents (35.6%, n = 16) describing this as 'poor'. The same proportion of respondents were unable to rate access to this service.

Respondents were asked to describe the main problems with accessing local mental health/substance misuse services. Here the following themes were apparent: Reluctance of services to engage with sexually assaulted victims; waiting times; inadequate resources and lack of funding – services do not have the capacity to meet demand. This was listed for both mental health and substance misuse services e.g. 'demand outstrips provision', 'no play therapy available'.

A patient's location affects the services that they can access e.g. 'Children seen from our city have access to in house psychology. This service is not available to children from other areas of the city. They are referred back to GPs/local pediatricians to arrange CAMHS review', 'potential difficulties when patients come for SARC medical from out of area. Psychology services here are available only to those local residents', 'variation of services across geographical area - some areas have much better services, or CSA-specific services, which work much better than other areas where the only option is for a general referral into CAMHS (who more frequently do not accept referrals as not meeting criteria'.

Patients do not always meet the threshold for referral to child/adolescent mental health services as resourcing issues mean that this is set very high, e.g. 'thresholds for CAMHS, 'like adults, services are stretched and as a consequence the "threshold" for accepting referrals is very high'.

3. Discussion

It is interesting that there is no formal estimate for the size of the sexual offences SARC physician workforce in the United Kingdom. The Faculty of Forensic Legal Medicine commented on the original survey draft used in this study and confirmed that this figure was unknown. However, the Faculty did comment as follows:

> *The FFLM has done some work to try and find the numbers of FPs working in forensic medicine (both General Forensic Medicine and Sexual Offence Medicine) for the first stage bid for specialty status and this comes to nearly 1000 but we don't have a split for GFM and SOM.*

If the sexual offence medicine (SOM) sub-group is approximately 400 in size then the this survey response represents about 12% of the workforce. The data presented in Table 1 shows that that response was significantly lower in London, the South West and the South East. The survey results are not representative of these areas and thus the estimates are unlikely to be representative of the national picture.

Nonetheless the results do confirm other studies undertaken previously on this topic. For example, a survey of SARC managers looked specifically at issues related to mental health.[1] This study found that, although 40% of SARC referrals were known previously to mental health services, two-thirds of SARCs in England found it difficult to access mental health services following examination in a SARC:

> *'the majority of respondents stated that they do not have the facility to make direct referrals into mental health services. No partnership agreements or referral pathways into mental health services were in place. Instead, GPs and A&E act as gatekeepers, often resulting in clients experiencing long delays before accessing health services'*

In this survey, clearly FPs faced similar difficulties across the complainant's age range with 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 rating 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 FPs 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.

All these difficulties seem to stem largely from the lack of negotiated pathways between SARC and the different types of mental health services/substance misuse services. Despite NHS England commissioning guidance on this topic described earlier in the background to this paper (see Page 3) onward mental health pathways for SARCs complainants would require active pathway design between NHS England SARCs commissioners and local Clinical Commissioning Groups. This is an extra layer of commissioning which is rarely undertaken.

However, before better pathways can be designed the full range of mental health needs of SARCs attendees should be understood and there is little research or detailed local health needs assessment that achieves this objective. However, a recent study has reported an audit of mental health outcomes in the Thames Valley SARC over a 12 month period (7). The evaluation showed that 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 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. (See Fig. 3)

They will often not accept complex trauma (i.e. someone abused as a child and latter seriously sexually assaulted), they will not accept those with drug or alcohol problems and scores for depression and anxiety (measured using the GAD-7 [15+] and the PHQ-9 [15+]) have

- Patient Health Questionnaire score under 15 and General Anxiety Disorder score under 15
- No co-existing alcohol or drug problem
- No childhood sexual abuse (Complex Trauma)

Fig. 3. IAPT services exclusion criteria (level 3).

to meet certain thresholds, i.e. scores 15 or higher. These facts should be actively discussed in co-commissioning meetings between NHS England and CCGs if mental health needs are to be met for this group of clients.

In order to understand the mental health needs of SARCs attendees who have been seriously sexually assaulted so that the right care pathways might be designed two issues should be addressed: detailed psychiatric histories should be taken in every case; mental health needs should be assessed using a core set of outcome measures. Pilot work in order to determine the core set of outcome measures that might be used is currently being undertaken in the five SARCs in the North East Region and will be reported on.

Statement of interest declaration

This is to confirm that none of the authors have any interests to declare.

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