The effectiveness of sexual assault referral centres with regard to mental health and substance use: a national mixed-methods study – the MiMoS Study

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Scientific summary

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Background

Sexual assault is a common but under-reported crime; the consequences can be devastating and wide-reaching, impacting on a person's health, mental health, use of substances, as well as impacting on work, education and relationships. Sexual assault referral centres (SARCs) were established to provide an integrated service, offering forensic examination, sexual health, emergency contraception, pregnancy tests, and post-exposure prophylaxis to prevent HIV. SARC service specifications state that mental health problems should be identified and referrals made to address these needs. However, it is not clear how and when that assessment should happen, or by whom, and how best to offer mental health aftercare. Many people who attend a SARC had prior contact with mental health services (40%), so it is important to consider the needs of those with pre-existing mental ill health and those at risk of developing mental health problems as a result of the assault. An acute trauma response is a normal psychological reaction to sexual assault and many survivors will not require mental health care. However, it is important to identify and offer appropriate support to those with significant needs.

Research aims

To undertake a mixed-methods study using realist methodology to identify programme theories that will seek to identify the contexts and mechanisms involved in the identification, assessment and the pathways to care (outcomes):

1. to undertake evidence reviews of global SARC provision for health outcomes (including mental health and substance use) (work package (WP) 1)
2. to identify what models of SARCs currently exist in England (WP2)
3. to identify the mental health and substance use needs of attendees of SARCs in England (WP3)
4. to identify what services are available in SARCs in England, and to explore satisfaction with care, barriers to access and gaps in provision (WPs 2, 3 and 4)
5. to understand from the perspective of the SARC workforce and their current practice, skills and training needs in terms of recognition of, and referral for, mental health and substance use issues (WP4)
6. to obtain the survivor view on how they felt their emotional well-being was addressed by the SARC as well as by external services (WP4)
7. to compare health outcomes for people who experience sexual assault and access bespoke SARC psychological therapies provision compared to those who experience sexual assault and are in mainstream mental health services (WP5)
8. to produce a range of lay and academic outputs that will aim to identify and share good practice in SARC services related to identifying and supporting substance use and mental health among people who experience sexual assault to have an impact on care delivery.

Setting and participants

Staff who work in SARCs, representatives from relevant partner agencies, and survivors.

Methods

WP1 consisted of a systematic review that sought to address three questions: (1) how mental health and drug/alcohol issues were identified and assessed; (2) evidence for interventions that aimed to improve mental health and/or drug/alcohol issues following an attendance at a SARC; and (3) stakeholder views (including survivors) of how SARCs can promote and support mental health.

WP2 was a national audit of SARCs in England, which collected information about skill mix, assessment, what mental health support was available, and partnerships with other agencies. A cluster analysis was performed to group SARCs by their similar responses to these key variables.

WP3 was a prevalence study. The sample included people who had recently attended a SARC (data were collected between one and six weeks of attendance).

Outcome measures

Outcomes were measured using the following tools:

Clinical Outcomes in Routine Evaluation 10 (CORE-10)
Alcohol Use Disorders Identification Test (AUDIT-C)
Primary Care PTSD Screen for DSM-5 (PC-PTSC-5)
Recovering Quality of Life (ReQoL)
Drug Abuse Screen Test (DAST)
Structured Assessment of Personality Abbreviated Scale (SAPAS).

Procedure

Following informed consent, participants were sent an online questionnaire containing the outcome measures. The online responses were checked by a researcher to pick up any safeguarding issues. If there were any present, the researcher would contact the participant and assess their safety and well-being.

Work package 4 case studies

Documentary analysis was undertaken on policies and local documents including the SARC website and used to create a localised journey map for each SARC, which informed the interviews. Interviews and focus groups were conducted in the six case study sites and involved survivors, SARC staff and partner agencies (mental health services, drug and alcohol services, and third sector counselling and support services, e.g. rape counselling). Interviews were transcribed verbatim and contexts mechanisms and outcomes were coded in NVivo (Lumivero, Denver, CO). Within-SARC and between-SARC case study analyses were performed and programme theories were refined.

Work package 5 secondary data analysis

WP5 involved secondary data analysis of two separate datasets. The first used anonymised data on the outcomes of co-located psychological therapy services within one SARC. The second dataset was extracted from the anonymised Clinical Research Interactive Search (CRIS) anonymised routine data base from one NHS mental health organisation in England. A sample of people was selected who had a sexual assault identified in their notes and a comparison group of people who did not have that

experience documented, who also had baseline and follow-up CORE-10 data following psychological therapy.

Results

1. Review: the most commonly reported method of assessing mental health and alcohol and/or drug use was using an unstructured and often unspecified assessment. Use of validated screening tools was rarely reported and where they were mentioned, this tended to be screening for post-traumatic stress disorder (PTSD) specifically. The most common support offered was 'counselling' but this was poorly described. There was limited mention of evidence-based therapies such as eye movement desensitisation reprocessing or cognitive behaviour therapy. There were five randomised controlled trials (RCTs) which evaluated psychoeducation tools. Overall, there was a lack of robust evidence to inform how best to address mental health and substance use in SARCs. A realist synthesis was undertaken to identify initial programme theories.
2. WP2: In the audit, a 77% response rate was achieved. Few SARCs had mental health expertise in the team and 7% of SARCs had in-house or co-located psychosocial support. There were limited formal care pathways to partner agencies and respondents were less satisfied with level of integration with local mental health and alcohol/drug services compared with rape counselling and domestic violence services.
3. WP3: Prevalence study – of the 275 people who gave consent to contact, successful contact was made with 157 (43%) and, of these, 78 were enrolled on the study; 76% scored moderate/severe distress on CORE-10; 94% of scores indicated PTSD; 63% of scores indicated a possible personality disorder; 12% were drinking at 'risky' alcohol levels (AUDIT-C) and 26% had a moderate to severe drug problem according to the DAST. In terms of quality of life, most (87%) had low quality of life from ReQoL scores.
4. WP4: Case studies – SARC staff identified that the lack of having mental health expertise alongside fragmented care pathways meant that people who were identified as having continuing mental health needs were not able to efficiently get those needs met. In SARCs where there was in-house or co-located psychological support, this seemed to improve the speed and quality in which people received the right care at the right time. In addition, there were wider benefits to having a mental health professional in the team in terms of contributing to team discussions on care planning and referrals, as well as supporting staff in terms of informal support and reflection on practice. Survivors found the experience of the SARCs very helpful, specifically around the trauma-informed practices that helped them reframe their experiences, seeing themselves as survivors rather than victims. The survivors' experiences of past and current mental health services was less positive owing to long waiting lists, limited sessions being offered due to resource issues, or not quite fitting into a service remit.
5. WP5: In SARC 5, there was a stepped care model for counselling and therapy. Between April 2020 and December 2020, 467 people referred to counselling and 229 to psychological therapies. Those on the higher-intensity therapy track had higher needs at baseline and received more sessions than those referred for counselling. Despite this, the average change scores for both groups were similar at end of therapy. Reasons for disengagement with counselling were mainly about difficulty travelling to sessions (SARC 5 covers a large mainly rural area). There was less textual information regarding the therapy service but this information indicated that some referrals were not accepted because the person's needs were too complex and were stepped up to other mental health provision. In the CRIS data analysis, the cohort identified as having been sexually assaulted compared with a control group had higher needs and complexity at baseline. They also had more sessions of therapy than those without a history of sexual assault. However, despite the baseline differences the sexual assault cohort has similar average change scores in the CORE-10 outcome data compared with the control group.

Discussion

There are high levels of mental health and alcohol/drug use needs in people who attend SARC, certainly as measured in the immediate period after SARC attendance, and many had pre-existing mental health or alcohol/drug use issues. However, there was limited evidence of integration of mental health and substance use interventions following SARC attendance, and few SARC staff has expertise in mental health. Most operated referral system to external agencies but this was deemed to be less than ideal as reported by all stakeholders. Survivors valued the support they received at the SARC from staff who used a trauma-informed approach. In comparison, survivors spoke less favourably about mainstream NHS mental health provision, citing a limited number of sessions, long waiting lists and unhelpful attitudes towards people who have been sexually assaulted. The quality of the local care pathways was hampered by complexity of local service providers, a lack of a single point of contact and perceived high threshold to access mental health and psychological therapies. Analysis of outcome data comparing people who had been sexually assaulted and those who had not (WP5) found that average change scores at follow-up were the same for both groups. This is an important finding, as it offers therapeutic optimism that therapy is beneficial for survivors of sexual assault, but also has resource implications that need to be addressed.

Limitations

The study was impacted by the COVID-19 pandemic, especially WP3. The target of 360 people was not achieved and, even after extending recruitment period by three months, only 78 were recruited from four of the six sites. This had a knock-on effect for recruitment for the survivor qualitative interviews. All the data were collected using remote methods, which worked well, and there were no issues related to this method in terms of people declining to participate.

Implications for health care

There is a need to for detailed specification for SARCs with regard to mental health and substance use. This would help address inconsistency in how this service is operationalised nationally. The specification should include raising awareness of SARCs to mental health and alcohol/drug services. The SARC would benefit from having access someone with a mental health background who can support the integration of standard practice in mental health identification and assessment, management of crisis and distress, as well as either providing in-house support or formalising pathways to local mental health, alcohol/drug services, and other relevant services. The implications for mental health services include improving routine enquiry about sexual violence, addressing the gaps in accessing support for those who have experienced sexual violence who may already be in mental health care, as well as being able to provide timely access to evidence based therapies for people who have multiple needs.

Recommendations for research

Further research should investigate whether routine screening improves access to mental health care and outcomes for survivors. There is a need for research to evaluate co-located bespoke therapy using a RCT to establish clinical and cost-effectiveness. In addition, there is a need to investigate how gaps in therapy provision can be addressed and evaluated, specifically for those who are perceived to have more ‘complex’ needs. Further research should investigate how to improve routine enquiry and recording of sexual violence in mental health and substance use.

Conclusion

People who attend SARCs have high levels of need in relation to mental health and alcohol/drug use, and clarity is required as to how these needs should identified and addressed by SARCs and partner agencies. The trauma-informed approach adopted by SARCs aids in survivor recovery and mental well-being. However, some survivors have multiple needs that may require intensive evidence-based therapies delivered by people who understand sexual trauma. There is a clear imperative for SARCs and partner agencies to develop closer relationships and agreed pathways so that survivors have their needs accurately identified and are referred to the right service for those needs.

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Trial registration

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