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Clinical practice

Mental health risk factors in sexual assault: What should Sexual Assault Referral Centre staff be aware of?

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ABSTRACT

Introduction: In England, people who have been raped 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 rape on mental health is not always assessed comprehensively in SARCs despite national policy guidance.
Aim: To highlight the relationship between mental health and rape; thereby increasing SARCs staff and NHS commissioners awareness of the issue and the potential for longer-term risks to mental health.
Method: A secondary analysis was carried out using the Adult Psychiatric Morbidity Survey (APMS) 2007 in England. Sexual abuse was categorised as 'rape', 'touched in a sexual way' or 'talked to in a sexual way' versus 'none'. Bivariate analysis describes the prevalence of various mental health indicators and service use measures by different 'levels' of sexual abuse. Multiple logistic regression was applied to determine independent risk factors for sexual abuse.
Results: There was a consistent increase in the prevalence of mental health problems and in the use of mental health services as the severity of sexual abuse increased. For individuals who had been raped, the prevalence of need was highest in those raped both before and after the age of 16 years. Multivariate logistic regression identified that sex and age were the only demographic risk factors remaining significant. After controlling for these, individuals who had been raped were over 2.5 times more likely to have a history of a neurotic disorder than individuals experiencing no sexual abuse. In addition, rape victims were also significantly more likely to be dependent on drugs and alcohol, admitted to a mental health ward and at risk of suicide.
Conclusion: Rape is likely to have a considerable impact on the use of mental health services, self-harm and alcohol/drug dependency. Full mental health assessments should be undertaken in SARCs and commissioners should ensure accessible pathways into mental health services where appropriate.

1. Introduction

In 2013, a joint report, by the Ministry of Justice, the Home office and the Office of National Statistics, was published on sexual violence.[1] The report showed that: approximately 85,000 women and 12,000 men are raped in England and Wales alone every year; nearly half a million adults are sexually assaulted in England and Wales each year; 1 in 5 women aged 16–59 has experienced some form of sexual violence since the age of 16; only around 15% of those who experience sexual violence choose to report to the police and approximately 90% of those who are raped know the perpetrator prior to the offence.

Sexual violence is a serious problem in society, that often goes unreported and with a complex relationship to mental health problems. For example, child sexual abuse, in particular, non-consensual sexual intercourse, has been shown to be clearly associated with a wide variety of psychiatric disorders in adulthood.[2] Furthermore, in this study half of those reporting abuse under the age of sixteen also reported abuse over the age of sixteen. In the context of the provision of SARCs services in England, it has been estimated that, on average, 40% of those presenting at a SARCs have a pre-existing mental health problem[3] this figure has received confirmation from both Holland[4] and the United States.[5] Those, without mental health problems at presentation to a SARCs, are

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highly likely to subsequently develop depression, anxiety, PTSD, substance misuse, self-harm or suicidal feelings.[6] The overall cost to the raped individual and their family is high. The World Health Organisation (WHO) has reported that rape and domestic violence accounts for 5–16% of health years of lost life in women.

Whilst littleis known about the exact course of pre-existing mental health disorders following the trauma of rape, the NHS SARC service specification makes it clear that NHS England should be commissioning an 'excellent' service for the victims of rape irrespective of age or gender.[6] NHS guidance also states that there should be a risk assessment for self-harm, substance misuse and suicidal ideas and a review of any pre-existing mental health problems. Victims leaving a SARC will usually be referred for Independent Sexual Violence Advocacy (ISVA) however the study cited above[3] makes it clear that negotiated pathways for mental health service provision are rare especially for children with little attention seemingly paid to these pathways by NHS commissioners to date.

The aim of this paper therefore is not to demonstrate the strong, persuasive links between mental health disorders and childhood sexual abuse, this work has already been comprehensively undertaken.[2] The purpose of this paper is to present a secondary analysis of data from the adult psychiatric morbidity study[7] in terms of the specific issues that NHS guidance states should be assessed in a SARC. Whilst the focus in this paper is assessment of individuals who present to SARCs this is no intention to diminish the importance of assessing for sexual violence in all clinical settings including general practice[8] and mental health services.[9]

2. Method

A secondary analysis was conducted on the most recently available data from the 2007 Adult Psychiatric Morbidity Survey.[7] The APMS 2007 was commissioned by the NHS Information Centre for Health and Social Care and carried out by the National Centre for Social Research (NATCEN). The survey was stratified across postcode areas in England to be representative of people aged 16 plus years living in private households (and did not include people living in communal establishments). Computer-assisted interviews were employed to obtain data from individuals on topics including physical health, mental health, service use, religion, social capital, discrimination and sexual abuse. Some of the topics used self-completion questionnaires to obtain the information. The survey was conducted between October 2006 and December 2007 and data were collected from 7403 adults. The full user guide on the survey methods, data coding, weighting and derived variables is published alongside the data.[7]

The survey dataset was obtained from the UK Data Service (UKDS 2015) and a subset of the variables was selected based on their relevance to sexual abuse, mental health and individual demographics or possible confounders. Three items relating to sexual abuse were selected: Talked to in a sexual way: "… did anyone talk to you in a sexual way that made you feel uncomfortable?"; Touched in a sexual way: "… did anyone touch you, or get you to touch them, in a sexual way without your consent?"; Rape: " … did anyone have sexual intercourse with you without your consent?" These questions are asked both 'since the age of 16' and 'before the age of 16'. A new mutually exclusive category of sexual abuse was created where 'rape' superseded 'touched in a sexual way' which superseded 'talked to in a sexual way' versus 'none'. For those raped, whether they were raped since the age of 16, before the age of 16, or both was also included.

A range of mental health diagnoses were investigated. These, included both derived and aggregate variables which were produced by NATCEN researchers and made available within the dataset. The full list of variables investigated are shown within the univariate tables presented in the results and included (but were not limited to): 'Ever admitted to hospital or ward specialising in mental health problems', 'Receiving any medication, counselling, therapy', 'Spoken with GP in past 12 months about a mental, nervous or emotional complaint', 'How happy would you say you are these days?', 'Any neurotic disorder'. Further questions regarding substance use, including cigarettes, alcohol and drugs were included. Some questions asked about the current situation and some covered lifetime conditions. Demographic confounders selected were: sex, age in 20 year bands, ethnicity, socio-economic group and Index of Multiple Deprivation (IMD – which is a geographic measure of social deprivation based on postcode of residence.[10]

This reduced (selected variables) dataset containing data from 7403 adults was analysed with IBM SPSS v 22. The prevalence of the various mental health and service use measures was determined across the difference sexual abuse categories. For this, the dataset was weighted using the overall survey weight provided by NATCEN, which takes account of non-response, household size, age, sex and geographic region, so that the results are representative of the household population aged 16 years and over.

Multiple logistic regression was applied in a backward stepwise method to determine the independent influences on different sexual abuse categories compared with no sexual abuse.

3. Results

Results of bivariate analysis suggested that individuals who had raped were more likely to be female (66%), under 55 years of age (83%), have 'intermediate' occupations (63%) and have an alcohol problem (28%) compared with people who had no history of sexual abuse (Table 1).

In addition, individuals who had been sexually abused in any way were more likely to show the above characteristics than those who had no history of sexual abuse but less than those raped. Individuals who had been raped were also more likely to be underweight (5%) or overweight (23%), of non-white ethnic origin 12%), live in the most deprived areas (30%), to smoke (28%) and be dependent on drugs (11%) compared to people who had no history of sexual abuse and to those who had been talked to/touched in a sexual way.

There was a distinct correlation with the 'severity' of sexual abuse and the prevalence of existing mental health issues. Individuals were increasingly more likely to be unhappy as the severity of sexual abuse increased; with 8% of those talked to in a sexual way, 11% of those touched in a sexual way and 19% of those raped stating that they were 'not too happy these days' compared with 7% of those with no sexual abuse history (Table 1).

Mental health diagnoses also increased as the severity of sexual abuse increased. For example, with 32% of those talked to in a sexual way, 36% of those touched in a sexual way and 51% of those raped had anxiety, depression or other mental health issue compared with 17% of those with no sexual abuse history. Also, with 23% of those talked to in a sexual way, 28% of those touched in a sexual way and 45% of those raped had some neurotic disorder compared with 13% of those with no sexual abuse history. Overall, 10% of adults with no sexual abuse history had thought about suicided in their lifetime and 3% had attempted suicide. This compared with 21% of those talked to in a sexual way, 30% of those touched in a sexual way and 45% of those raped who had lifetime thoughts of suicide and 6% of those talked to in a sexual way, 9% of those touched in a sexual way and 23% of those raped who had attempted suicide.

Correspondingly, the use of mental health services and taking medication also increased as the severity of sexual abuse increased