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Research Paper

The Care Programme Approach, sexual violence and clinical practice in mental health

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ABSTRACT

Introduction: Research in Sexual Assault Referral Centres has shown that 40% of those attending are known to mental health services. The question we posed in this study was to what extent do mental health services know about this group? This was a pertinent question to ask as in 2008 the Department of Health (DH) amended the Care Programme Approach (CPA) to include a question on sexual abuse/violence as part of the overall assessment.
Aims: To assess the extent to which Mental health Trusts were implementing DH guidance on the CPA in relation to assessment of sexual violence and abuse.
Method: 1. Freedom of Information (FOI) requests were sent to all Mental Health Trusts. 2. The Information base at the Health and Social Care Information Centre (HSCIC) was interrogated as Trusts can make returns on this CPA question, however it is not mandatory.
Results: 1. The FOI requests revealed that: only 66% of staff were trained to 'ask the question' (range 35–100%) and only five out of 53 Trusts audited whether the question was asked. 2. The HSCIC data revealed that in 2014/15 there were 335,727 people in the CPA in England and there was a record in only 17% of cases of the question being asked. Over half (57%) of the 69 providers who did not submit any information on the indicator in 2014/15 as well as, for those 30 providers who did submit information, the data field was only 41% complete.
Conclusions: The impetus for 'asking the question' first established in 2008 with the establishment of eight pilot training programmes, has been lost. It is clear that Trusts are not training adequate number of staff nor are they returning useable data to HSCIC. If 40% of people attending SARCs are known to mental health services we suspect that few staff in mental health trusts known much about such a referral. Research shows convincingly that sexual violence and abuse plays a clear role in the aetiology of mental health disorders. A history of such violence/abuse should be always established (or otherwise).

1. Introduction

1.1. The link between sexual violence and mental health

Previous research has established that 40% of those seen in SARCs were already known to mental health services.[1] Data from the national adult psychiatric morbidity survey has also been re-analysed in order to illustrate mental health 'risks' of which SARCs staff should be aware.[2] If so many people, reporting to a SARCs are known to mental health services to what extent are mental health staff aware of this group that had been raped or seriously sexually assaulted ?

In 2013, a joint report, by the Ministry of Justice, the Home office and the Office of National Statistics, was published on sexual violence.[3] 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

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perpetrator prior to the offence. It is also known that approximately 40% of those that pursue the prosecution of an offender for rape through Sexual Assault Referral centres (SARCs) in England are already known to mental health services.[1] This figure is echoed by similar findings in Holland[4] and the US.[5]

The links between mental health and sexual violence seem unambiguous. The 2007 Adult Psychiatric Morbidity Study (APMS, 2007) included questions on the respondent's experience of rape, both before, and after, the age of 16. The APMS surveyed over 7000 respondents and was a nationally representative study. Key papers have been published subsequently which have examined the risk of the development of mental health disorders following rape and the use of mental health services.[6] In a recent briefing paper,[7] The 'Responding Effectively to Violence and Abuse' group (REVA) classified sexual violence into six main categories (see Fig. 1 below) and used this overall system of classification to examine relationships between mental health disorders and service use.

The research shows that the more serious sexual abuse and violence becomes the greater the likelihood that people attempt suicide (see Fig. 2); are admitted to a mental health ward; experience a common mental health disorder and experience three or more mental health disorders.

REVA have subsequently published a series of briefing papers for mental health services which consider the routine use of questions about every service user's experience of sexual violence and abuse when they are being assessed under the CPA.[8–11]

Another recent study has also shown,[2] in a further secondary analysis of the APMS data set, that those who have been subjected to sexual violence: were 7.7 times more likely to be female, 2.7 times more likely to be aged 16–34, 1.8 times to have been ever admitted to a psychiatric hospital, 1.8 times more likely to be alcohol dependent, 2.7 times more likely to be drug dependent, 3.7 times more likely to have thought about suicide in their lifetime, 2 times more likely to have attempted suicide and 2.6 times more likely to have had a diagnosis of a neurotic disorder compared with individuals with no history of sexual abuse.

It should therefore be expected that a reasonably high proportion of mental health service users will have experienced sexual violence and/or and abuse of some kind. To what extent therefore is this reflected in policy?

2. Policy, sexual violence and the Care Programme Approach (CPA)

The inclusion of a question on sexual violence and/or abuse in the Care Programme Approach documentation in 2008 was the fulmination of a four year programme of research and development led by the Department of Health, the National Institute for Mental Health and the Home Office. The four year programme led to the formation of the Victims of Violence and Abuse Programme' (VVAPP) who launched a guide in 2006 entitled ' Tackling the health and mental health effects of domestic and sexual violence and abuse' – a guide supported by health and Home Office ministers. As part of the VVAPP initiative, a pilot was established in a number of eight mental health trusts in order to introduce routine enquiry about violence and abuse in assessment and care planning as part of the CPA. The pilot focused on those with a severe mental illness associated with victimisation.[12] A report of the national pilot evaluation was produced in 2008.[13]

The evaluation report stressed in the official guidance that it was only when staff 'had been satisfactorily trained' that clinical staff could focus on raising issues of violence and abuse routinely in assessment and care planning. The outcomes sought from the eight pilot training programmes were listed as follows:

- Sexual abuse is embedded as a core mental health issue.
- There is routine exploration of physical, emotional and sexual abuse by all mental health professionals conducting assessments.
- Adult service users with a history of abuse receive the support, care and therapy that they need.
- Every trust has an adequate number of staff with the confidence and skills to provide appropriate support to service users with a history of abuse.
- Joint working with service users/survivors is embedded as a core principle.

The evaluation report noted that by December 2007 all of the eight sexual abuse teams (SATs) had been delivering the training locally (see Table 2 for details of the team locations). By June 2008, all SATs had delivered the training to target clinicians working in adult mental health services. A series of interviews were then

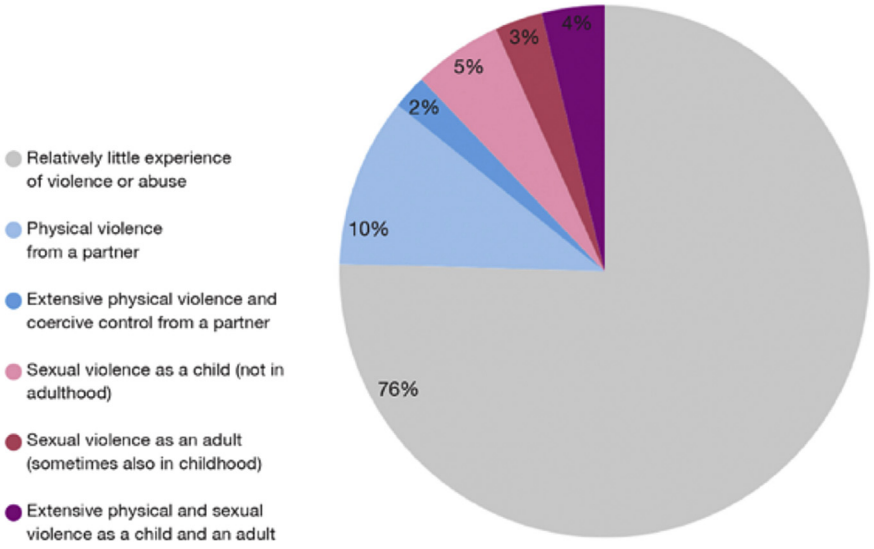

Fig. 1. REVA Categories for violence and abuse (based on APMS, 2007).