when using Read code lists we would hope to use externally validated lists. We have done this for depression and self-harm[2,3] but at the time of extracting data for this study we did not have access to a validated list for conduct disorder.

Children with special educational needs were identified using a variable in the educational data-set. They have been included in the analysis. Although we adjusted for intellectual disability we did not for special educational needs. We made this decision based on the broad nature of special educational needs status, which includes those with hearing impairment and dyslexia. The majority of children with special educational needs status follow the national curriculum.

We disagree with the letter authors in that one of the advantages of linked primary care data in Wales is the whole population coverage rather than a sampled one, such as that currently available in England. We are, therefore, able to anonymously link across general practices and individuals in Wales so we can identify house moves and continue to follow any pupil registered with a general practitioner or attending any hospital in Wales. This also applies to deprived populations. Therefore, we do not believe we have underestimated the association for the reason suggested.

In Wales the ethnic minority group is only approximately 2.1% of the population in 2001. We do not feel ethnicity will greatly affect the results in this analysis. Adverse childhood experiences, bullying, absence, exclusion from school and other events are important factors. However, we would argue that rather than confounders these are on the pathway to explaining the link between educational achievement and poor mental health and self-harm. As such it would be a mistake to adjust for them.

We strongly refute that there is 'no analysis in support of this interpretation' regarding no evidence among those who self-harm of decline in attainment in primary school. We demonstrated that the children who self-harm were doing as well as those who do not self-harm at age 11 (the end of primary school). They cannot be identified from primary school using key stage attainment results. We used the cut-off that schools use for 'achieved' key milestones or did 'not achieve' key milestones. These are the cut-offs that schools report and act upon. As such they are the most useful in feeding findings back to schools to enable them to translate these findings into practice. Self-harm and attainment were associated in secondary school in our study.

References

1 Brophy S, Kennedy J, Fernandez-Gutierrez F, John A, Potter R, Linehan C, et al. Characteristics of children prescribed antipsychotics: analysis of routinely collected data. *J Child Adolesc Psychopharmacol* 2018; **28**: 180–91.

2 Cornish RP, John A, Boyd A, Tilling K, Macleod J. Defining adolescent common mental disorders using electronic primary care data: a comparison with outcomes measured using the CIS-R. *BMJ Open* 2016; **6**: e013167.

3 John A, McGregor J, Fone D, Dunstan F, Cornish R, Lyons RA, et al. Case-finding for common mental disorders of anxiety and depression in primary care: an external validation of routinely collected data. *BMC Med Inform Decis Mak* 2016; **16**: 35.

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The importance of routine enquiry about a possible history of sexual abuse or sexual violence

Thanks to Dr Ingrassia for her recent editorial on the Independent Inquiry into Child Sexual Abuse in the UK, particular her focus on the role of mental health services.[1] She cites the mental health trust's collaboration project commenced in 2006 but omitted to mention that since 2008 it has been a policy requirement that all those on the care programme approach are routinely assessed about their possible history of sexual abuse or sexual violence – so-called 'routine enquiry'. However, training figures for routine enquiry obtained from National Health Service (NHS) mental health trusts indicate that in 2015 (and again in 2017) routine enquiry is becoming less likely in clinical practice and we argued that the policy needed re-invigoration.[2]

Sexual assault referral centres (SARCs) provide a one-stop health shop for those that report a sexual assault. The NHS England specification for the SARC service[3] implies that a thorough mental health assessment should take place in a SARC not least because decisions should be made about the best mental health service to access if required: if risk is a concern the crisis team; if the client is known to mental health services maybe the community mental health team or child and adolescent mental health services; or possibly an Improving Access to Psychological Therapies service if trauma is not complex.

In our experience such pathways are seldom formally negotiated, in the main, mental health services rebuff many SARC referrals. This often leaves specialist voluntary sector counselling services overwhelmed as they take on not just individuals with 'acute' cases (those recently sexually assaulted) but those with historic abuse too. The new national strategy for sexual abuse and assault services proposes that integrated commissioning is required involving NHS England, Clinical Commissioning Groups, Police and Crime Commissioners, local authorities, the Ministry of Justice and the Home office with the creation locally of a new Sexual Assault and Abuse Services Partnership Board.[4]

The articulation of formal pathways for those experiencing trauma following a sexual assault is clearly an important task for these new commissioning boards. In a recent audit of a SARC service we found the following.[5] In a sample of 105 people who consented to undertake a full assessment: 76% of the sample had seen a health professional for their mental health in the preceding 12 months with half being treated by their general practitioner but an important subgroup of people (31%) were being seen by a mental health professional most often a psychiatrist; nearly one-fifth of the sample (19%) had been previously admitted to a psychiatric unit where, on average, they had been admitted three times in total. The remainder of the sample without any previous history of mental health treatment was now, following the sexual assault, at risk of developing a mental health problem.

To conclude, as Dr Ingrassia stated, 'the responsibility rests with the sensitive and well-informed clinician's ability to see past the presenting problem' – maybe a willingness to assess in this manner is a prerequisite to better pathways between SARCs and mental health services in the future.

References

1 Ingrassia A. The Independent Inquiry into Child Sexual Abuse in the UK: reflecting on the mental health needs of victims and survivors. *Br J Psychiatry* 2018; **213**: 571–3.

2 Brooker C, Tocque K, Brown M, Kennedy A. Sexual violence and abuse and the care programme approach. *Br J Psychiatry* 2016; **209**: 359–60.

3 NHS England. *Public Health Functions to be Exercised by NHS England – Service Specification: Sexual Assault Referral Centres*. NHS England, 2018 (https://www.england.nhs.uk/publication/public-health-functions-to-be-exercised-by-nhs-england-service-specification-sexual-assault-referral-centres/).

4 NHS England. *A Strategic Direction for Sexual Abuse and Assault Services: Lifelong Care for Victims and Survivors*. NHS England, 2018 (https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf).

https://doi.org/10.1192/bjp.2018.277 Published online by Cambridge University Press

5 Brooker C, Tocque K, Paul S. Assessment of the mental health status of a one year cohort attending a two Sexual Assault Referral Centres in England. *J Forensic Leg Med* 2018; **54**: 44–9.

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Author's reply

I thank Brooker & Mitchell for their comments on my editorial[1] highlighting the potentially neglected, yet complex, interface between mental health services and sexual assault referral centres and the need to articulate formal pathways for adults experiencing trauma following sexual assault. These issues are similarly problematic for adolescents. A recent *Lancet* study looking at a cohort of young people attending the sexual assault referral centres serving Greater London over 2 years found that 80% of those undertaking a diagnostic assessment had a psychiatric diagnosis.[2] The presence of a psychiatric disorder was associated with psychosocial vulnerability including previous contact with children services, with mental health services and a history of sexual abuse, still raising serious concerns about the ability of institutions to protect those young people who are most at risk.

Brooker & Mitchell also raise the need to strengthen policies that support a 'business as usual' approach to enquiries about a history of sexual abuse within mental health services, for example through the care programme approach. There are perhaps many reasons why this task remains difficult without ongoing training and support for professionals. Since writing my editorial the Inquiry has published a report of its interim findings,[3] one of the emerging themes is the need to focus on the cultural challenge of openly acknowledging, understanding and discussing childhood sexual abuse. This challenge is highlighted by some of the Inquiry's findings, that those charged with protecting them 'did not see children as victims or felt that it raised issues that were simply too difficult or uncomfortable to confront'.[3]

I am pleased with Brooker & Mitchell's agreement with my commentary on the responsibility of the individual well-informed clinician as I have previously advocated the importance of taking a reflexive, self-reflective approach to the practice of medicine.[4]

The reports of victims and survivors, heard by the Inquiry, that NHS mental health provisions lack flexibility and are not tailored to their specific needs are disheartening but need to be placed into the challenging context of providing public services within current funding constraints. I am encouraged by the Inquiry's choice to focus, as a matter of urgency, on the financial implications of providing treatment and support to victims and survivors and its recommendation to better understand current levels and effectiveness of public expenditure in this area. It is my hope that this may lead to much needed wider investment and better coordination of mental health services for the benefit of children and adult victims and survivors.

References

1 Ingrassia A. The Independent Inquiry into child sexual abuse in the UK: reflecting on the mental health needs of victims and survivors. *Br J Psychiatry* 2018; **213**: 571–3.

2 Khadr S, Clarke SV, Wellings K, Villalta L, Goddard A, Welch J, et al. Mental and sexual health outcomes following sexual assault in adolescents: a prospective cohort study. *The Lancet Child Adolesc Health* 2018; **2**: 664–5.

3 Independent Inquiry Child Sexual Abuse. *Interim Report of the Independent Inquiry into Child Sexual Abuse*. HMSO, 2018 (https://www.iicsa.org.uk/key-documents/5368/download/full-interim-report-independent-inquiry-into-child-sexual-abuse.pdf).

4 Ingrassia A. Reflexivity in the medical encounter: contributions from post-modern systemic practice. *J Fam Ther* 2011; **35**: 139–58.

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Environmental preference might mediate the benefits of nature-based therapies

The benefits of psychotherapies are highly variable between patients, perhaps most notably because of personality types, cultural background and one's conception of mental ill health, among others.[1] Case in point, many patients consider group psychotherapy unacceptable and others do not consider psychotherapy credible at all. Similar variations are surely also implicated in nature-based therapies (NBTs).

For example, in the first instance, evidence over recent years has increasingly pointed to a benefit to mental health outcomes from exposure to and use of natural environments, commonly conceived in the literature as 'urban green spaces'. The causal mechanisms are complex, but usually distilled to: improved exercise and socialisation opportunities, reduced exposure to air and noise pollution, and importantly for NBTs, psychological stress-reduction and attention restoration.[2] As well as being evidenced, it is easy to anecdotally see how these non-psychotherapeutic components of NBT – the simple exposure and interaction with one's natural environment – are mediated culturally, and also by personality and personal environmental preferences inter alia. Between cultures, for example, there is dramatic variation in perceptions of natural environments and understandings of appropriate uses of these spaces.[3] These variations are likely to modulate the causal mechanisms of the green space–mental health benefit.

Second, it is reasonable to suggest that these variations in the perceptions of natural environments affect the acceptability, credibility and therefore adherence and completion rates for NBTs. Until now the evidence for green space benefit to mental health outcomes has come largely from observational studies, which demonstrated varied effect sizes, and suggested differences as a result of the quality of environments, perceived safety concerns, among other individual personality and community factors.[4]

Stigsdotter and colleagues' most recent report therefore, which demonstrates non-inferiority of one particular brand of NBT for stress-related mental illnesses compared with a more mainstream cognitive–behavioural therapy, is to be welcomed.[5] Although, of course, randomisation of patients is an essential facet in the production of reliable and valid science, this may have masked a subpopulation with complementary personalities and cultural characteristics (etc) for NBTs. And as the authors allude, given equal study withdrawal rates after randomisation, there may well be an equal subpopulation with preference for office-based cognitive–behavioural therapy (perhaps for perceived credibility reasons). The non-inferiority demonstrated in this trial therefore gives us the option that those patients who may be open and keen on the idea of NBTs may be more adherent, more likely to complete the intervention and independently receive greater benefit through the causal mechanisms described above. NBTs therefore might now be considered another option (rather than any kind of replacement) in the tool kit of primary care or mental health services aimed at addressing the high burden of stress morbidity, especially for those expressing a preference for it.

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