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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