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Do mental health professionals in England know about and document clients' traumas and adversities, and do they respond therapeutically?

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Abstract

This study aimed to ascertain how often staff in community mental health services in England ask about adverse experiences, how often those experiences are known about and documented by staff, and how staff respond when such experiences are known about and documented. The files of 400 people were reviewed. Only 13% of clinical records contained documentation of any adverse experiences. 1% showed clear evidence that clients had been asked about adversities. People with psychosis diagnoses were less likely to have adverse experiences documented in their file. Rates of responses to adversities that staff did became aware of were high, with 90% of records indicating some appropriate support following disclosure. Future research endeavours are recommended. Recommendations are made in relation to policy change, staff training and guidelines to improve routine enquiry about adversities. Ultimately, a move to 'trauma-informed' services, already underway in some areas, is required for all mental health services.

Introduction

The circumstances of people's lives play a major role in the development and maintenance of psychological, emotional and behavioural problems across the lifespan (Johnstone et al., 2018). Users of mental health services have experienced particularly high numbers of early adverse life events (Bentall et al., 2014; Varese et al., 2012; World Health Organization, 2013).

There is a dose-dependent relationship between the range, severity and frequency of adverse experiences and subsequent impact on mental health (Bentall et al., 2014; Varese et al., 2012). The impact of childhood adversities is both cumulative and synergistic (Bebbington et al., 2011). One study found that persons who have experienced one type of abuse are 87% more likely to experience other types of abuse and adversity (Felitti et al., 1998) and the more types of abuse and adversity a person experiences, the higher the risk of harmful health and social outcomes later in life (Anda et al., 2010; Felitti et al., 1998). Being subjected toviolence in adulthood,

including physical or sexual abuse, also increases the risk of mental health problems (Boyda, McFeeters & Shevlin, 2015; Oram et al., 2016).

Adverse childhood experiences have been linked to many psychiatric diagnostic categories, including: anxiety and mood disorders, eating disorders, personality disorders, conduct disorders and psychosis (Bebbington et al., 2011; Bellis et al., 2014; Celic & Odaci, 2020; Couper & Mackie, 2016; Johnstone et al., 2018; McLaughlin et al., 2010; Varese et al., 2012). Individuals who suffer adversity in childhood are more likely to: be admitted to a psychiatric hospital; have earlier, longer and more frequent admissions; self-harm; die by suicide; and have greater severity of symptoms (Guha et al., 2019; Hepworth & McGowan, 2012; Karatzias et al., 2019; Lipschitz et al., 1996; Read, 1998). They are also, as adults, far more likely to be prescribed antipsychotic, antidepressant and anxiolytic drugs (Anda et al., 2007; Guha et al., 2019). Adverse outcomes are not restricted to psychological distress, but also include: low educational achievement, relationship difficulties, medical problems - including cancer and heart disease, sexual and reproductive health issues and premature death (Anda et al., 2010; Felitti et al., 1998).

It has long been NHS policy that mental health services should address the links between adversity and mental health and that staff are obliged to ask about such experiences, and to receive training in how to do so (DoH, 2008). Researchers have suggested that experiences of adversity should be systematically and routinely inquired about, because many service users are reluctant to spontaneously report such experiences (Read & Fraser, 1998a; Read et al., 2006; Wurr & Partridge, 1996), especially abuse by a caregiver (Read et al., 2006). Service users have also called for routine enquiry of adverse experiences (Scott et al., 2015). However, service providers often fail to systematically screen for adverse events (Lee, Coles, Lee, & Kulkarni, 2012; Nixon & Quinlan, 2021; Read et al., 2006; Sellick, Rose, & Harms, 2020), with a recent study suggesting this may be particularly so for less severe cases of abuse (Nagar, Nakash, & Westen, 2019). A recent review found that most people who use mental health services are still never asked about adverse experiences, including childhood abuse or neglect (Read, Harper, Tucker & Kennedy, 2018a), with men and people diagnosed with psychotic disorders less likely to be asked than other people. For example, even the most encouraging finding in relation to sexual abuse showed that mental health services in the UK were, in 2016, still missing half of the cases identified by researchers (Cunningham et al. 2016).

Another review found that disclosures of adversities are often not responded to therapeutically (Read, Harper, Tucker & Kennedy, 2018b). In this way, people presenting to mental health services have their mental health problems disconnected from the context of their lives (Sweeney, Clement, Filson & Kennedy, 2016).

Aims of the study

The current study was designed to better understand the frequency of asking about, knowing about, documenting, and responding to disclosures of, lifetime adverse experiences, in clinical practice within adult Community Mental Health Services (CMHSs) in England, and to see if practice is improving over time in this crucial area. Previous research of a similar nature has generally focused on experiences of childhood sexual and physical abuse. This study included a broader range of childhood adversities, and also included adult adversities.

Conflicts of interest

Neither author has any conflicts of interest relating to this paper.

Methods

Approval for the study was obtained from the University of East London Research Ethics committee, on 28/2/2018. Individual participants were not asked for informed consent because the study took the form of an audit of anonymised NHS medical records. Permission to access the anonymised database was granted by the Research and Development department at the NHS Trust hosting the research.

Sample selection and characteristics

All 400 records were of adults accessing CMHSs provided by a large NHS Trust operating across a number of outer London boroughs. 100 consecutive clinical records, from June to September 2018, at four CMHSs were accessed from an electronic database. Files that reported no face-to-face contact with clinicians, were active in the system for less than five days, or reported that a service user had not had an initial assessment with CMHS staff, were excluded.

The sample consisted of 235 men (58.8%) and 165 women (41.3%). The mean age of participants was 50.9 years (SD: 11.56). The service users were, according to the categories used in the medical records, mostly 'White British' (54.5%), followed by 'Black' or 'Black British' (18.8%), 'Asian' or 'Asian British' (15.3%), and other (11.5%) (see Table 1). A majority of participants were categorised as having a psychotic disorder (83.8%). The most frequent diagnosis, by far, was paranoid schizophrenia (67%), followed by schizoaffective disorder (9.3%) and bipolar affective disorder (8.5%).

Data collection

Data were collected by way of a retrospective audit of 400 clinical records. This design has been utilised successfully in previous research (Agar et al., 2002; Jones, 2018; Read et al., 1998; Sampson et al., 2017). The 'core assessment' forms on each participant's clinical record were reviewed (by CN) for data concerning adverse experiences. These forms are required to be updated for all service users after each assessment and whenever new 'key' information becomes known about. The forms cover: mental health history, presenting situation, social history, accommodation and support, and mental state exam.

A data sheet, informed by similar studies (Agar & Read, 2002; Read et al., 2016), was developed to collect clinical and demographic information. The data sheet was used as a guide to prompt the researcher to record a range of experiences of adversity as well as the responses from mental health professionals following disclosures. This included whether the following types of childhood adversity were recorded anywhere in the record: child physical neglect, child emotional neglect , child physical abuse, child emotional abuse, child sexual abuse, parental loss, child poverty, fostering and/or adoption. This study extended previous research to include adverse experiences occurring in adult life. This was reflected on the data sheet by including adverse experiences conceptualised by the Social Care Institute for Excellence (SCIE, 2015). These included: adult neglect, domestic violence, adult physical abuse, adult psychological or emotional abuse, adult sexual assault, financial abuse, modern slavery, and discriminatory abuse.

Staff responses to identified adversity histories were recorded as follows:

- the service user was given any advice/counselling/support relevant to the adversity
- adversity formed part of a formulation
- adversity formed part of a treatment plan
- there was a discussion about whether any previous disclosures had been made and how these were responded to
- there was a discussion about, or actual, referral to specialist provision related to the adversity
- there was a discussion about causal beliefs - whether the client feels there is any connection between the adverse experience and their mental health difficulties
- there was a discussion about reporting the adversity to authorities
- the adversity was reported to authorities.

Consistent with earlier research (Agar, Read & Bush, 2002; Sampson & Read, 2017; Read & Fraser, 1998a), the operational definition of adverse experiences was based on what the mental health professional considered adverse and documented in the clinical record. For example, a clinical record included for documentation for domestic violence stated '…talked about the domestic violence she has experienced in the past' and elsewhere in the notes '…blames her mental illness on this experience.' An example of a record included for multiple adverse experiences was '…bullied and sexually abused by brother,' 'physical abuse' and 'death of father' in childhood. Another example of a clinical record included for documentation of child physical abuse is: '…he reported that his mother frequently hit him as a child.'

In eight cases where a clinical record included notes indicating that adverse events may have occurred but the clinician had not clearly stated this to be the case, and/or the primary researcher assessed the note to be inconclusive, the two researchers independently judged whether it was 'highly probable' that an adversity had been experienced. This approach was used in previous studies, in which the criterion for 'highly probable' was a blinded, independent individual subjective estimation of '95% certainty' that the adversity had occurred (Agar & Read, 2002; Sampson & Read, 2017; Read & Fraser, 1998a). In five of the eight cases both researchers independently judged an event to be 'highly probable' and these were included for analysis. The other three cases were excluded from the analysis.

Data analysis

Descriptive statistics were computed for participant demographics, the total number of adverse experiences documented in clinical records and the total number of clinician responses to disclosures. Mann-Whitney tests were used to analyse differences involving non-parametric continuous variables. Differences between proportions were tested with the Chi-Square test for independence, using the Yates Continuity Correction, in order to prevent overestimation of statistical significance. Pearson's correlations were used to analyse relationships involving continuous variables, including age.

Results

Documentation

At least one adversity was documented in 52 'core assessment' forms (13%). The clinical records of these 52 people were read in their entirety. Table 1 shows demographic and clinical information about this subset.

Adverse experiences in childhood. Forty-two clinical records (10.5%) had one or more childhood adversities recorded (Table 2). The most prevalent was child sexual abuse, with 29 service users (7.2%) having this recorded in their file. Eighteen (4.5%) had child physical abuse, and nine (2.3%) had childhood emotional abuse documented. Twenty-one (5.3%) service users had one type of adverse experience recorded, 11 (2.8%) had two types, four (1%) had three types, five (1.3%) had four types, and one (0.3%) had five different types of adversity documented in their file.

Adverse experiences in adulthood. Twenty-six service users (6.5%) had one or more adulthood adversities recorded (see Table 2). The most prevalent was domestic violence, with thirteen (3.3%) of the 400 records documenting this, ten (2.5%) had sexual assault recorded, and eight (2%) had physical abuse recorded. Fifteen (3.8%) service users had one type of adverse experience recorded, nine (2.3%) had two types, one (0.3%) had three types, and one (0.3%) had six different types of adulthood adversity documented in their clinical record.

[Insert Table 1 here]

[Insert Table 2 here]

Gender. . Females (n = 165) had a significantly greater proportion (19.4%) of adverse experiences documented than males (8.5%) (U = 17138, Z = -3.41, p = .001, r = –.17. In particular, females had higher rates of child sexual abuse and domestic violence.

Twenty-nine clinical records (7.2%) contained documentation about child sexual abuse. Of these, 19 (65.5%) were female service users and ten were male (34.5%): χ^2 (1, n = 400) = 6.56, p = .01. All 13 of the clinical records containing documentation about domestic violence belonged to female service users: χ^2 (1, n = 400) = 16.71, p <.001.

Eighteen of the clinical records had documented experiences of child physical abuse. Eleven (61.1%) of these were female service users and seven (38.9%) were males. There was no significant association between gender and documentation of CPA. Similarly, there were 11 documented experiences of bullying. Seven (63.6%) of these records belonged to male service users, and four (36.4%) belonged to female service users. Again, there was no significant association.

Age. The mean age of the 52 was 47.8 years (SD 10.42). Age was unrelated to inquiry about, and documentation of, adversities.

Diagnoses. Twenty-five (48.1%) of the 52 service users who had adult or childhood adverse experience recorded in their file had a diagnosis of Paranoid Schizophrenia, and a majority (36; 69.2%) were categorised under a psychotic care-cluster. Only one person out of 400 had a diagnosis of PTSD documented as the primary diagnosis in their clinical record.

The 335 individuals with a psychosis diagnosis were significantly less likely to have adverse experiences documented in their file (10.7%) than the 65 categorised in a non-psychotic care cluster (24.6%); $U = 9546$, $Z = -2.71$, $p = .007$, $r = -.14$). People categorised as psychotic were significantly more likely to have child sexual abuse ($\chi^2 = 6.26$, $df = 1$, $p = .01$) and domestic violence ($\chi^2 = 6.70$, $df = 1$, $p = .01$) documented in their file than any other adverse experiences. There was no significant relationship between care cluster and rates of documentation for child physical abuse or bullying.

Variation in inquiry across services. There was a significant difference in documentation between the four CMHSs. The 23 adverse experiences recorded at CMHS 1 (23%) was significantly higher than the seven (7%) recorded at CMHS 3, $U = 4257$, $Z = -2.97$, $p = .003$, $r = -.21$, and the nine (9%) at CMHS 4 , $U = 377.500$, $Z = -2.42$, $p = .016$, $r = -.17$.

Inquiring

Inquiry about adverse experiences. The rates of inquiry were recorded for each of the individuals for whom adverse experiences were known about and documented. Only four (7.7%) of the records contained clear evidence that the individual had been asked by a mental health professional whether they had experienced adversities. Two service users had been asked whether they had experienced adversity and confirmed that they had, and two had been asked and replied they had not. For the latter two, disclosures of adversity were evidenced later on in their clinical record. Seventeen (32.7%) had documentation suggesting they had made a spontaneous, unsolicited disclosure relating to adverse experiences. For the majority (31; 59.6%) it was unclear how the adverse experience had come to be known.

Responding

Responding to disclosures of adverse experiences. There were 52 files in which adverse experiences were documented. Table 3 shows what was recorded in clinical records about how clinicians responded when adverse experiences were known about and documented. The mean number of responses to adversities was 4.3. Five (9.6%) service users received no response at all, one (1.9%) received two responses, two (3.8%) received three responses, eight (15.4%) got four responses, 15 (28.8%) five, and 16 (30.7%) six or more.

Forty-seven of the 52 files (90.4%) showed that the service user was offered some type of relevant advice or support following disclosure. This ranged from being given information about domestic violence and financial abuse, to being referred for sheltered accommodation or being accompanied to a police station to report abuse. Forty-two of the 52 participants (80.8%) with documented adverse experience were referred to specialist provision related to the adversity.

Formulations and treatment plans: Summary formulations which referred to adverse experiences were present in 39 of the 52 records (75%). Thirty-eight of the 52 files (73.1%) included treatment plans which related to the adversity experienced by the service user.

Documentation of previous disclosures: Only five of the files (9.6%) in which adverse experiences were recorded included documentation concerning whether any previous disclosures had been made and how these had previously been responded to.

Causal beliefs: Discussion about causal beliefs, particularly whether the service user perceived there to be any connection between the adverse experience and the mental health difficulties, was found in 26 of the 52 files (50%).

Reporting to legal authorities: Sixteen of the 52 files (30.8%) contained documentation that a discussion with the individual about reporting the adversity to authorities had occurred. Thirteen of the 52 files (25%) included documentation that the adversity was actually reported to legal authorities. Reporting of adverse experiences to authorities was not always a direct consequence of the discussion. There were eight instances where discussions about reporting the adverse experience to legal authorities were recorded, with the client indicating that this had already been done, and the mental health professional documenting this in the record. Only five of the clinical

records contained documentation confirming that the adversity had been reported to authorities after contact with the CMHS.

Gender. There was no significant overall difference in the number of appropriate responses provided by a clinician once adverse experiences became known about and documented, according to the gender of the service user , $U = 233.00$, $Z = –1.67$, $p = .096$, r = –.22.

Diagnostic cluster. The number of appropriate responses provided by clinicians was not significantly different according to whether service users were in a psychotic care cluster or a non-psychotic cluster, $U = 201.00$, $Z = –1.76$, $p = .079$, $r = –.24$.

CMHS site. There was no significant difference in the total number of responses documented between the four CMHSs.

[Insert Table 3 here]

Discussion

This study sought to determine whether mental health professionals routinely ask service users about adverse experiences, and how professionals respond when such experiences become known. It attempted to address gaps in the literature by including a wider range of adverse experiences, occurring both in adult and childhood. The findings are consistent with previous research (Read et al., 2018b; Sampson & Read, 2017), with the majority (87%) of the core assessments in 400 clinical records containing no documentation about adverse experiences. This is consistent with the recent review of the literature which found that in nine studies, less than one-third (28%) of abuse and neglect identified by researchers had been documented in clinical records, let alone responded to therapeutically (Read et al., 2018b). The figures for emotional neglect (17%) and physical neglect (10%) were particularly low (Read et al., 2018b).

It should be noted that mental health services are not alone in failing to identify abuse and neglect. A recent analysis of identified child maltreatment and domestic abuse, in a database of nearly 12 million General Practitioners' patients, concluded that 'Despite recent improvements in recording, there is still a substantial under-recording of maltreatment and abuse within UK primary care records (Chandan et al., 2020).

Adverse experiences in childhood

Comparison with similar studies, in Ireland (Rossiter et al., 2015) and New Zealand (Sampson & Read, 2017), allows for a more detailed examination of the findings concerning adverse experiences in childhood. As shown in Table 4, the number of adversities documented in clinical records is poorer in this study than in previous research. Overall, 42 (10.5%) clinical records had one or more childhood adversities recorded. This is significantly smaller than the range of 38–56% reported in the Irish and New Zealand studies (Rossiter et al., 2015; Sampson & Read, 2017).

Only 7.2% of clinical notes contained documentation of child sexual abuse, in comparison to rates of 8% (Rossiter et al., 2015) and 32%. (Sampson & Read, 2017). For child physical abuse, 4.5% of individuals had this recorded in their files, compared to 20% and 36%. For emotional abuse, the rate of documentation was 2.3%, compared with previous rates of 25%–35% in the other studies. The identification and documentation of emotional and physical neglect in childhood has been extremely low in previous research, with rates of between 5%–7% for physical neglect and 13%–21% for emotional neglect. This is despite neglect being the most common form of child maltreatment in Britain (Davies et al., 2017). In the current study only three (0.8%) of 400 files documented emotional neglect, and none documented physical neglect.

[Insert Table 4 here]

Adverse experiences in adulthood

Only 26 (6.5%) of the 400 service users had one or more adulthood adversities recorded in their file. This is lower than in similar studies. Read and colleagues (2016) found that one or more forms of adulthood abuse or neglect were recorded in 35% of clinical records within community mental health services. An earlier study (Agar & Read, 2002) reported a rate of 27%. Documentation of physical and emotional abuse, emotional neglect and sexual assault were all significantly lower in this study in comparison with these studies (see Table 5).

[Insert Table 5 here]

Psychosis

Support is provided for the hypothesis that psychiatric services are less likely to know, or ask about, adversities experienced by certain groups of people. Consistent with previous research (Cavanagh, Read, & New, 2004; Read et al., 2018a; Sampson & Read, 2017; Sellick et al., 2020), people with a diagnosis indicative of psychosis were less likely than individuals in a non-psychotic care cluster to have such experiences documented, despite these individuals being more likely to have experienced adversities in their lifetime (Bentall & Varese, 2012; Read et al., 2003).

It is important to note that abuse disclosures by people diagnosed with schizophrenia are no less, or more, reliable than the rest of the population, with good test-retest reliability (Darves-Bornoz et al., 1995) and no evidence that inaccurate reporting is related to severity of psychosis (Fisher et al., 2011).

Diagnoses

Only one person out of 400 had a diagnosis of PTSD documented as the primary diagnosis in their clinical record. Exposure to adverse and traumatic events is associated with a range of mental health difficulties, not just PTSD. Nevertheless, the prevalence of PTSD in the *general* adult population is 3% (Greenberg et al., 2015), so in a sample of 400 mental health service users, one might expect to see far more than the 12 to be found in 400 adults in the general population. It seems probable that a trauma-informed service would identify more than one case of the only diagnosis that, by definition, is trauma-based.

Gender

The clinical records of female clients contained a higher total number of adverse experiences than male clients. Specifically, females had higher rates of child sexual abuse and domestic violence documented. This is consistent with previous findings that female users of adult mental health services had higher rates of child sexual abuse and adult sexual abuse identified in their records than men (Sampson & Read, 2017). This reflects the reality that women are more likely than men to experience adversities, particularly sexual assault (Finkelhor, Shattuck, Turner, & Hamby, 2014).

Age

Previous research reported that older service users were less likely to have been asked about adverse experiences (Read et al., 2006). This was not supported by the current study.

Identification and documentation of adversities

Prevalence rates of documentation in which inquiry had definitely occurred (versus spontaneous disclosure) were lower in this study than in previous studies. Only four of the clinical records (1%) showed clear evidence that the service user had been asked by a clinician if they had experienced adversities. (Two individuals had been asked and confirmed that they had, and two were asked and replied that they had not.) Previous research in Australia found that of 100 files, 24 included documentation of child sexual abuse and a further 29 had evidence that clients had actually been asked about this (Mansfield et al., 2016). In a New Zealand sample, 164 files (64%) had some form of adult or childhood abuse or neglect recorded. In 153 (61.2%) of the files, clinicians had recorded information in the abuse/neglect section of an assessment form, indicating that inquiry had occurred (Sampson & Read, 2017).

This study expanded the research base to include a wider range of adverse experiences. There is no existing literature on whether childhood experiences such as bullying, loss of a parent, or growing up in institutional care or poverty are asked about within mental health services, despite our knowledge of how these adversities relate to poor mental health (Felitti et al., 1998; Kessler et al., 2010). Even without comparison to other research, the low number of adversities documented in clinical records is concerning, and suggests that these other adversities should be included in future research endeavours.

Responding to adverse experiences

Positives can be drawn from the findings concerned with how clinicians respond once adverse experiences were known about. Overall, clinicians in this study were more likely to offer an appropriate response, such as adding the information to a formulation or treatment plan, in comparison to previous research (Eilenberg et al., 1996; Read et al., 2016). Table 6 shows that the majority of cases of recorded adversity led to some kind of positive response, and that rates of specific responses were higher than in previous studies. Adverse experiences were mentioned in formulations in 75% of the 52 files where adversities were recorded, and mentioned in treatment plans in 73.1% of those files. These rates are higher than those found by Agar & Read (2002), Read and colleagues (2016) and Eilenberg and colleagues (1996). The one exception to higher rates in comparison with previous studies was documentation of discussions about previous disclosures, which only 9.6% of the 52 records contained.

One possible explanation for this finding relates to the low number of adverse experiences documented in the clinical records in comparison to previous studies (Read et al., 2018a). It could be that within this study only

the most extreme experiences of adversity are documented within the core assessment forms. If this were the case, these experiences of adversity, including child sexual abuse or multiple traumas, would necessitate a more proactive and appropriate response from professionals. As a result, the number of responses to disclosures of adversity might be disproportionately higher in this study than in previous research. This explanation is merely conjecture and cannot be supported by the data; yet it makes sense when considering the overall findings.

[Insert Table 6 here]

Limitations and recommendations for future research

Documentation of adverse experiences in clinical records consistently and significantly underestimates the true prevalence rates within mental health service user populations (Briere & Zaidi, 1989; Cunningham et al., 2016; Goodwin et al., 1988; Jacobson et al., 1987; Lipschitz et al., 1996; Read & Fraser, 1998b; Wurr & Partridge, 1996). Clinicians may not have recorded details of adversity if they perceived them to be too sensitive, not relevant to the referral reason, at the request of the client, or if the client denied having experienced adversity. It is possible that inquiry took place, but no note was made in the record; and when disclosures of adversity were made, there may have been more support offered than was documented. Actual prevalence rates could only be verified by using a validated instrument such as the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998).

Records were only read in their entirety when one or more types of adversity were documented in the 'core assessment' area of the file. This may have precluded further examination of clinical records containing documentation of adversities, potentially leading to an underestimation of the overall amount of adversities documented by the end of treatment'. This may also be an explanation for lower rates compared to earlier studies. As a result, the proportion of clients with adverse experiences receiving an adequate response from clinicians will have been overestimated by the present study, as is the case with previous research (Read et al., 2016). In order to investigate the extent to which this precluded clinical records, future research might benefit from reading all service users' clinical records in their entirety.

The emotive nature of many of the clinical records in addition to the inherent biases and assumptions of the researcher, may have influenced the inclusion and exclusion of clinical records. However, this will have been mitigated against to some extent as the files were read in detail for an average of one and a half hours each, and records which required clarification were screened by the secondary researcher.

The findings are limited in their generalisability to other adult mental health services. However, data were not restricted to one CMHS only. Clinician inquiry and response behaviour was assessed across four different services in separate boroughs, slightly increasing the generalizability of the findings.

More could be gained by continuing to conduct research in this area in order to fully understand clinician inquiry and response to adverse experiences within UK mental health services. Replications in other regions of the UK would be valuable, Qualitative research might be necessary to determine why mental health staff are not using the PTSD diagnosis. There is a clear need for research into staff training in how to ask and respond to experiences of adversity amongst mental health service users. However, it is unclear whether meaningful change could occur without there being a paradigm shift towards more trauma-informed approaches (Read, Dillon & Lampshire, 2014; Sweeney, Clement, Filson & Kennedy, 2016).

Conclusion

This study highlights the failure of mental health services to pay due attention to the impact of adverse experiences on the lives of service users. It is problematic that services that hold such power over the lives of service users, and which are supposed to offer support to ease distress, continue to pay insufficient attention to the impact of adversity. There is a clear need for greater acknowledgement of the social determinants of distress. Without such a change in approach, adversities in people's lives will continue to be ignored, and the subsequent distress stripped of meaning and significance by services which do not attend to the role these adversities play in the onset and maintenance of human distress.

Relevance for clinical practice

Mental health staff, should ensure clients are asked about the full range of past and current adversities explored in this study, and whether these are related to their current problems (Read, Hammersley & Rudegeair., 2007). They should also be asked what they need, if anything, and be offered a range of approaches to treatment (Read et al., 2018b). This requires staff training.

Training programmes need to address both asking and responding, as well as the need for careful and consistent documentation. For example, although training should stress that ideally service users should be asked about adversities on admission to services, so as to formulate accurately and create an appropriate treatment/support plan, this should obviously be delayed if the person is in extreme distress, is acutely psychotic or is suicidal (Read et al., 2007). Several training programmes have been evaluated as effective in improving

clinical practice (Cavanagh et al., 2004; Coyle at al., 2016; Currier & Briere, 2000; Day et al., 2003; Lotzin et al., 2018; Read et al., 2007; Walters et al., 2015). A one day training programme has been delivered in the National Health Service in England (Department of Health, 2008, 2015; McNeish & Scott, 2008). It's goals included: 'To equip staff to routinely and consistently explore violence and abuse in assessments and respond appropriately to disclosures' (McNeish & Scott, 2008, p.7).

These changes to practice, and the training programmes on which they depend, are more sustainable within a trauma-informed service (Read et al., 2014; Sellick et al., 2020; Sweeney et al. 2016). Trauma-informed services are being developed internationally (Bateman et al., 2013: Brooker et al.,2016; Muskett, 2014; Prytherch et al., 2021; S.A.M.H.S.A., 2014; Sweeney et al., 2016; Toner et al., 2013;). The central theme is to develop a culture within which all health and mental health professionals treat patients in ways that facilitate recovery from any trauma or adversity that has led to their problems, while avoiding re-traumatisation by use of force, or by denial of the existence, or effects, of abuse or neglect.

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TABLE 1: *Summary of subset participant demographics*

Demographic	**Total Sample - 400**	**Adversity sub-sample - 52 (13%)**
Gender**	Male (235)	20 (8.5%)
	Female (165)	32 (19.4%)
Age	22-80 years	47.81 years (SD: 10.42)
Clinical Service**	CMHS Location One (100)	23 (23%)
	CMHS Location Two (100)	13 (13%)
	CMHS Location Three (100)	7 (7%)
	CMHS Location Four (100)	9 (9%)
Ethnicity	White British (218)	32 (14.7%)
	Black or Black British (75)	7 (9.3%)
	Asian or Asian British (61)	7 (11.5%)
	Any Other Background (46)	6 (13%)
Psychiatric Diagnosis	Paranoid Schizophrenia (268)	25 (9.3%)
	Schizoaffective Disorder (37)	3 (8.11%)
	Bipolar Affective Disorder (34)	5 (14.7%)
	Emotionally Unstable Personality Disorder (17)	8 (47.1%)
	Recurrent Depressive Disorder (13)	5 (38.5%)
	Mental and behavioural disorders due to use of cannabinoids (4)	1 (25%)
	Generalised Anxiety Disorder (3)	1 (33.33%)
	Borderline Personality Disorder (3)	1 (33.3%)
	Post-Traumatic Stress Disorder (1)	1 (100%)
	Other (17)	2 (11.8%)
Care Cluster**	Psychotic (335)	36 (10.7%)
	Non-Psychotic (65)	16 (24.6%)

** significant at $p < 0.01$.

TABLE 2: *Adverse experiences documented in the clinical records of service users*

Adverse Experience	**Number of adverse experience types documented in file**

Any adversity	**N = 52 (13%)**
Child Physical Neglect	0 (0%)
Child Emotional Neglect	3 (0.8%)
Child Physical Abuse	18 (4.5%)
Child Emotional Abuse	9 (2.3%)
Child Sexual Abuse	29 (7.2%)
Bullying	11 (2.8%)
Parental Loss	2 (0.5%)
Child Poverty	1 (0.3%)
Fostering/Adoption	7 (1.8%)
Adult Neglect	1 (0.3%)
Domestic Violence	13 (3.3%)
Adult Physical Abuse	8 (2%)
Adult Psychological/ Emotional Abuse	5 (1.3%)
Adult Sexual Assault	10 (2.5%)
Adult Financial Abuse	3 (0.8%)
Adult Modern Slavery	0 (0%)
Adult Discriminatory Abuse	2 (0.5%)

n: Number of participants

TABLE 3: *Responses from mental health professionals*

Response Categories	n (% of the 52 participants with adverse experiences documented in their clinical record)
Any type of response	47 (90.4%)
Adversity formed part of a formulation	39 (75%)
Adversity formed part of a treatment plan	38 (73.1%)
Discussion about whether any previous disclosures had been made and how these were responded to	5 (9.6%)
Discussion about, or actual, referral to specialist provision related to the adversity	42 (80.8%)
Discussion about causal beliefs in relation to mental health difficulties	26 (50%)
Discussion about reporting the adversity to authorities	16 (30.8%)
Adversity was reported to authorities	13 (25%)
No response	5 (9.6%)

TABLE 4: *Documentation of childhood adversities compared to previous studies*

Documentation	Rossiter et al., (Ireland – 2015)	Sampson & Read (New Zealand –2017)	Current study (UK – 2019)
Any child adverse experience	38%	56%	10.5%
Sexual abuse	8%	32%	7.2%
Physical abuse	20%	36%	4.5%
Emotional abuse	25%	35%	2.3%
Physical neglect	5%	7%	0%
Emotional neglect	13%	21%	0.8%

TABLE 5: *Documentation of adult adversities in comparison with previous studies*

	Read et al., (New Zealand – 2016)	Agar & Read (New Zealand – 2002)	Current study (UK – 2019)
Any adult adverse experience	35%	27%	6.5%
Physical abuse	24%	19.5%	2%
Emotional abuse/neglect	22%	N/A	EA: 1.3% Neglect: 0.3%
Sexual assault	14%	7.5%	2.5%

TABLE 6: *Documentation of clinician response in comparison with previous studies*

	Read et al., (New Zealand – 2016)	**Agar & Read (New Zealand – (2002)**	**Current study (UK – 2019)**
Adversity formed part of a formulation	CSA: 56.8% CPA: 47.3% ASA: 30.6% APA: 31.1%	Overall: 17.4%	Overall: 75%
Adversity formed part of a treatment plan	CSA: 44.4% CPA: 24.2% ASA: 36.1% APA: 23.0%	Overall: 16.3%	Overall: 73.1%
Discussion about previous disclosures and how these were responded to	50%	32.6%	9.6%
Discussion about, or actual, referral to specialist provision related to the adversity	CSA: 23.5% CPA: 19.8% ASA: 19.4% APA: 11.5%	Overall: 21.7%	Overall:80.8%
Discussion about causal beliefs in relation to mental health difficulties	22.5%	N/A	50%
Discussion about reporting the adversity to authorities	5%	0%	30.8%
Adversity was reported to authorities	2%	0%	25%