

## Do adult mental health services identify child abuse and neglect?

### A systematic review

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**ABSTRACT:** Child abuse and neglect play a causal role in many mental health problems. Knowing whether users of mental health services were abused or neglected as children could be considered essential for developing comprehensive formulations and effective treatment plans. This paper reports the findings of a systematic review, using independent searches of three data bases, designed to discover how often mental health staff find out whether their clients' were abused or neglected as children. Twenty one relevant studies were identified. The majority of people who use mental health services are never asked about child abuse or neglect. The majority of cases of child abuse or neglect are not identified by mental health services. Of abuse or neglect cases identified by researchers, only 28% is found in the clients' files; with the following specific percentages: emotional abuse - 44%, physical abuse - 33%, sexual abuse - 30%, emotional neglect - 17%, and physical neglect - 10%. Between 0% and 22% of mental health service users report being asked about child abuse. Men, and people diagnosed with psychotic disorders, are asked less than other people. Male staff ask less often than female staff. Some improvement over time was found. Policies compelling routine enquiry, training and trauma-informed services are required.

**KEY WORDS:** child abuse, child neglect, maltreatment, assessment, mental health services, review



## INTRODUCTION

Childhood abuse plays a causal role in many adult mental health problems, including: depression, anxiety disorders, eating disorders, sexual dysfunction, personality disorders, dissociative disorder, substance abuse, PTSD, bipolar disorder and psychosis (Kessler *et al.* 2010; Longden & Read 2016; Read 2013; Read *et al.* 2005; Varese *et al.* 2012; Watson *et al.* 2012). People who were abused as children are high users of adult mental health services; are more likely to be admitted to a psychiatric hospital, and have earlier, longer and more frequent admissions; have higher global symptom severity; and are more likely to self-harm and kill themselves (Hepworth & McGowan 2013; Read 2013). A review of 52 inpatient studies found that over 50% of the men and over 60% of the women had been sexually or physically abused as children (Read *et al.* 2008). Adults scoring high on the Adverse Childhood Experiences scale are 10 times more likely to be prescribed antipsychotics and 17 times more likely to be prescribed antidepressants (Anda *et al.* 2007).

It seems, however, that, until recently very little was known about how well mental health services are acting on this extensive and important body of research. There have been no reviews of studies about the extent to which mental health services enquire about child abuse and neglect in general. The only review in this whole field focused only on sexual abuse (Hepworth & McGowan 2013). It found nine studies directly or indirectly addressing frequency of enquiry about sexual abuse, and two about staff attitudes or knowledge. The reviewers concluded that ‘mental health professionals do not routinely enquire about childhood sexual abuse’ but noted that the literature is ‘limited in quantity and is of moderate to poor quality’.

## AIMS

The current systematic review provides the first ever summary of studies investigating enquiry about five types of childhood adversity: physical neglect, emotional neglect, physical abuse, emotional abuse, and sexual abuse.

## METHOD

### Search Strategy

The search strategy was based on Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. An electronic database search was completed, by one of the reviewers, using PsycINFO, from earliest record to December 2016. The search terms, entered as 'Subject' were: 'child abuse' OR 'child neglect' OR 'sexual abuse' OR 'physical abuse' OR 'emotional abuse' OR 'psychological abuse' OR 'physical neglect' OR 'emotional neglect' OR 'child maltreatment' OR incest (35,692) – AND – 'mental health services' OR 'psychiatric services' OR 'mental health assessment' OR 'psychiatric assessment' OR 'psychological assessment' OR 'psychiatric nursing assessment' OR 'medical records' OR 'patient files' (42,999). This search strategy was limited to research articles and dissertations, but was not limited by language or date. It produced 591 potentially eligible references.

Studies whose titles suggested that they might have the potential to address the issue of how often adult mental staff/services ask about, and/or record, childhood abuse or neglect were extracted. Inclusion criteria comprised a range of types of methodologies, such as studies addressing: (i) How much of the childhood abuse and neglect identified in a clinical sample by researchers, is recorded in the medical files of those people? (ii) How many mental health service users report being asked about childhood abuse or neglect? (iii) How often do mental health staff say they ask? and (iv) If specific abuse/neglect questions are included in clinical assessment protocols, how often are those questions asked?

On this basis, 60 of the 591 papers were extracted. Reading the abstracts of these 60 papers led to the exclusion of 43, for the following reasons: 17 concerned only the relationship between abuse/neglect and mental health problems; eight were not studies (editorials, practice guidelines); eight were about how staff *respond* to abuse disclosures; six focussed on children's services; two on abusers; and two on training.

Thus, 17 studies meeting the inclusion criteria were identified. Searching the references of these 17 papers, and of the only relevant review,<sup>9</sup> identified four more studies, producing a total of 21 eligible for inclusion in the review.<sup>12-32</sup>

The same search strategy, using identical terms, was deployed independently by two of the other reviewers, using *Scopus* and *Medline*. No additional studies were identified.

## RESULTS

### The 21 Studies

The most common research approach, used by nine of the 21 studies (see Table 1) was to compare the amount of abuse or neglect identified by researchers with the amount recorded in the clients' clinical files (Briere & Zaidi 1989; Craine *et al.* 1988; Cunningham *et al.* 2016; Goodwin *et al.* 1988; Jacobson *et al.* 1987; Lipschitz *et al.* 1996; Shannon *et al.* 2011; Rossiter *et al.* 2015; Wurr & Partridge 1996).

The other 12 studies used one or more of five other methodologies (see below) (Agar *et al.* 2002; Cavanagh *et al.* 2004; Cusack *et al.* 2004; Lab *et al.* 2000; Lothian & Read 2002; Mansfield *et al.* 2016; Mitchell *et al.* 1996; Read & Fraser 1998a; Read *et al.* 2006; Rose *et al.* 1991; Sampson & Read 2016; Xiao *et al.* 2016).

Eight of the studies were conducted in the USA, six in New Zealand, two each in Australia, Northern Ireland and England and one in Ireland. Of the 18 with clinical samples (three were with staff) 11 were reasonably gender balanced (from 43% to 57% female), two

were predominantly female - 72% (Lipschitz *et al.* 1996) and 71% (Mansfield *et al.* 2016), and five were 100% female (Briere & Zaidi 1989; Craine *et al.* 1988; Goodwin *et al.* 1988; Read *et al.* 2006; Xiao *et al.* 2016). The earliest study was in 1987 (Jacobson *et al.*). Studies occurred thereafter at a rate of just under one a year on average.

What proportion of adversities identified with direct assessment by researchers is found in files?

Seven studies of clinical samples compared the number of cases of one or more childhood adversities identified by researchers using either structured interviews (Craine *et al.* 1988; Jacobson *et al.* 1987) or questionnaires (Cunningham *et al.* 2016; Lipschitz *et al.* 1996; Rossiter *et al.* 2015; Shannon *et al.* 2011; Wurr & Partridge 1996), with the number found in the same clients' files (see Table 1). For example, Rossiter *et al.* (2015) reported on 129 clients of Irish inpatient and outpatient services. One or more of the five types of childhood adversity assessed by the Childhood Trauma Questionnaire (Bernstein & Fink 1998) were reported by 77% of the clients; but their medical files produced a rate of only 38%. In this study rates of emotional abuse, sexual abuse, physical neglect and emotional neglect were significantly higher ( $p < .001$ ) when investigated by the researchers than in the clinical records (the difference was not significant for physical abuse;  $p = .06$ ). The biggest differences were for emotional neglect and physical neglect, which were 4.7 and 8.9 times, respectively, more likely to be identified by researchers than *by services*.

Two early studies (Briere & Zaidi 1989; Goodwin *et al.* 1988) had generated analogous data, by comparing the number of sexual abuse cases identified when clinicians or researchers specifically asked about sexual abuse, with the number of cases found in the files of a random control group of clients from the same population that had been assessed as per usual practice.

Combining all 23 findings from the nine studies, for all five types of adversity (see Table 1) produces a weighted average of the percentage of identified abuse or neglect that was found in clients' files of 27.9% (211/755). The percentage of identified sexual abuse found in clients' files, in nine studies, ranged from 8.6% to 50%, with a weighted average of 30.2%. The percentage of physical abuse found in files, in five studies, ranged from 12.2% to 69.4%, with a similar weighted average, from four studies, of 33.1%.

Only three studies researched neglect (physical and emotional) and emotional abuse. Their weighted averages were emotional abuse - 44.3% (39/88); physical neglect - 10.3% (10/97); and emotional neglect - 17.4% (20/115). The combined average for the two types of neglect (physical, emotional) was 14.2% (30/212), which was less than half of the 33.3% (181/543) for the three types of active abuse combined (physical, sexual, emotional).

A tenth study found that 87% of 142 service users with 'chronic and severe mental illness' had experienced one or more types of childhood, adulthood or lifetime traumas (including 31% child sexual abuse) but that only 28% had any trauma documented in their files (Cusack *et al.* 2004). The study didn't specify how many of each type of trauma (e.g. child sexual abuse) were documented, and was, therefore, not included in the analysis above.

- - - Table 1 about here - - -

### Asking service users whether they were asked

Three studies directly asked people whether they were asked about child abuse by mental health services. A New Zealand survey of 72 people's experiences of their initial assessments in mental health services (Lothian & Read 2002) found that only 15 (20.8%) had been asked about abuse when assessed, (although 65% reported child abuse when asked by the researcher). A survey of New Zealand women receiving therapy for sexual abuse found

that only 13 of the 60 (21.7%) who had been in contact with mental health services reported that they had ever been asked about abuse by services (Read *et al.* 2006). Interviews with 89 'heavy users' of psychiatric services in New York revealed that 30 had been sexually abused and 34 physically abused as children, but that none had ever been asked about sexual or physical abuse by services (Rose *et al.* 1991).

### Asking mental health staff whether they ask

In a survey of 111 mental health staff in London only 18% said they ask about sexual abuse *in men* half the time or more, and a third reported that they never ask (Lab *et al.* 2000). A sample of 85 New Zealand mental health professionals who chose to attend a training day on asking about child abuse believed, on average, that in 64% of cases they knew whether or not their client had been sexually abused (Cavanagh *et al.* 2004). Recently, only 13 out of 57 Australian mental health staff (23%) agreed with the statement 'I routinely ask patients about childhood trauma including sexual abuse' (Mansfield *et al.* 2016).

### Asking managers whether staff ask

Of 466 nurse managers of psychiatric inpatient units in the USA who responded to a survey on assessment of sexual abuse, 69% believed that assessment at admission *should* always include asking about sexual abuse, but only 43% believed that their facility actually did so (Mitchell *et al.* 1996).

### Completion of abuse sections of assessment forms

Three New Zealand studies measured how often, when abuse questions are included in assessment forms, the questions actually get asked. An inpatient study introduced a new initial assessment form which included questions about sexual, physical and emotional abuse



(Read & Fraser 1998a). The form was used in 53 of 100 subsequent, consecutive admissions. In 36 of those 53 files (67.9%) the questions in the abuse section were not asked. When the study was repeated in a community mental health centre [CMHC], however, the abuse section of the new admission form was ignored in only 6 out of 26 cases (23.1%) (Agar *et al.* 2002). The most recent New Zealand study, of four CMHCs (after the introduction of computerised medical records) found that the abuse sections of 84 out of 153 records (54.9%) were blank (Sampson & Read, 2016). A recent Australian study found that newly introduced child abuse questions were ignored in 17 out of 52 assessments (32.6%) of inpatients and outpatients (Mansfield *et al.* 2016).

### Prevalence of adversities recorded in files when specific questions are asked or not asked at initial assessment

Another, less direct, approach to assessing clinical practice in this area is to use the same three New Zealand studies (Agar *et al.* 2002; Read & Fraser 1998a; Sampson & Read 2016) to examine how much additional abuse is discovered when specific abuse questions in assessment forms *are* asked at initial assessment, compared to when they are *not* asked and disclosures are therefore either spontaneous or result from staff asking at some point after assessment. Table 2 shows that six of the nine comparisons reveal significant differences, confirming that many cases of abuse are unidentified in services unless clients are asked routinely, which is not often the case. The weighted averages for sexual abuse, for the three studies combined, are 37.7% (40/106) if asked at assessment and 13.7% (17/124) if not. For physical abuse the difference between the two averages is even larger 40.6% (42/106) vs 6.3% (8/126).

- - - Table 2 about here - - -

## Documenting affirmative and negative child abuse histories

Two very recent Australian studies have taken yet another route to addressing the issue. A study of 100 files of inpatients and outpatients in Australia found that 24 included documentation of child sexual abuse and a further 29 had a note that the client had been asked and responded that they had not been abused (Mansfield *et al.* 2016). The combined 53% 'CSA history documented' rate may overestimate the rate of enquiry by staff, however, as it may include spontaneous disclosures and abuse known about from previous contact with services. A similar study included a broad range of childhood and adulthood traumas (including child abuse), and found a 49% rate of 'documentation of trauma-history' (41% yes, 8% no) among 100 women inpatients in Australia (Xiao *et al.* 2016). Despite having a different focus, the studies found similar rates of *absence* of any documentation about abuse/trauma: 47% and 51%.

## Is clinical practice improving over time?

In the current review the more recent the study the greater was the amount of previously identified sexual abuse that was found in the medical notes ( $r = .68$ ,  $df = 8$ ,  $p = <.05$ ).

In the New Zealand study of service users' experience of assessments (spanning many years) there was a significant positive correlation between how recently the assessment had occurred and the likelihood of being asked about child abuse (Lothian & Read 2002).

Although not directly assessing how often staff actually enquire, there have been two studies assessing whether identification of abuse increased over time in a given setting. A 2016 audit of 250 files of all four Community Health Centres [CMHCs] in a District Health Board in New Zealand (Sampson & Read 2016) was compared to a 2002 audit of 200 files at one of those four CMHCs (Agar *et al.* 2002). Soon after the first study the District Health

Board had introduced policy guidelines that all clients should be asked about abuse and that staff should be trained on how to do that (Cavanagh *et al.* 2004; Read *et al.* 2007).

Identification of childhood sexual abuse had increased from 20.0% to 32.4% ( $p < .01$ ) and of childhood physical abuse from 17.0% to 36.0% ( $p < .001$ ).

The only other follow-up study found an increase in identification of lifetime physical or sexual abuse, among users of an outpatient clinic in New York City from 40% to 50.5% between 1996 and 2008, without new policies or trainings (but did not analyse the data by specific types of abuse) (Posner *et al.* 2008).

## Demographic and diagnostic differences

### *Gender*

In the early USA inpatient study the proportion of identified sexual abuse that had been recorded in files was, while very low in general, slightly higher for women (18%) than for men (0%), whereas the opposite was the case for physical abuse; women 4%, men 18% (Jacobson *et al.* 1987).

In the New Zealand inpatient study (Read & Fraser 1998a) women were asked the abuse questions in the new admission form more often than men (43% vs 25%) but the difference was not statistically significant (Read & Fraser 1998a). In the second New Zealand CMHC study, however, the difference was significant (women 54%, men 37%) (Sampson & Read 2016). In a recent Australian study the introduction of abuse questions increased the proportion of women for whom there was some file documentation about child sexual abuse (affirmative or negative) to 73% but only to 53% for men (Mansfield *et al.* 2016).

In a survey of New Zealand psychiatrists and psychologists, 25% said they were less likely to ask about sexual abuse if the client was male (Cavanagh *et al.* 2004). The London

survey found that 82% of staff ask men about sexual abuse less than half the time, and a third never ask (Lab *et al.* 2000).

Unfortunately, it seems possible that disclosure about child sexual abuse may be even more dependent on being asked for men than for women. In the New Zealand inpatient study the difference in rates of sexual abuse when asked and not asked was significant for the men (62% vs 4%) but not for the women (33% vs 8%) (Read & Fraser 1998a).

### *Age*

The New Zealand study of women in therapy for sexual abuse found that older women were significantly less likely to have been asked about abuse by mental health services (Read *et al.* 2006). However, in the second New Zealand CMHC study the clients' age was unrelated to whether childhood abuse and neglect were reported (Read & Sampson 2016).

### *Ethnicity*

The only study to have analysed its findings in terms of ethnicity found that whether clients were Maori or European was unrelated to the probability of abuse or neglect being found in their files (Sampson & Read 2016).

### *Income*

The New Zealand study of women in therapy found that higher income was significantly related to probability of being asked about abuse by mental health services (Read *et al.* 2006).

### *Diagnosis*

In the New Zealand inpatient study people diagnosed ‘schizophrenic’ were slightly less likely (23%) to be asked the abuse questions than people with other diagnoses (39%), but the difference was not significant (Read & Fraser 1998a). In the second New Zealand CMHC study (Sampson & Read 2016) people diagnosed with psychotic disorders were significantly less likely than other people to have abuse/neglect recorded in their initial assessments. Three diagnostic groups had high rates of the abuse section of the admission form left blank: psychosis - 64%, bipolar disorder - 72% and drug/alcohol abuse - 71%, compared, for example, to 18% for PTSD.

In the New Zealand survey of psychologists and psychiatrists 41% reported they were more likely to ask about sexual abuse if the diagnosis was depression, borderline personality disorder, or PTSD (Cavanagh *et al.* 2004). If the diagnosis was schizophrenia, however, none were more likely to ask, and a few (4%) were *less* likely to ask. The survey of London professionals found that one of the two most common reasons for not asking about sexual abuse was ‘presenting problem was “irrelevant to sexual abuse” for example simple phobia or psychosis’ (Lab *et al.* 2000).

A trauma initiative that had increased detection of trauma in other psychiatric services, failed to do so for a service for people with ‘serious mental illness’ who were predominantly African-American (Cusack *et al.* 2004).

### *Gender of professional*

In the first New Zealand CMHC study (Agar *et al.* 2002) the new admission form containing abuse questions was used by 26% of female staff but only 3% of male staff. In the subsequent New Zealand CMHC study (Sampson & Read 2016) female clinicians were significantly more likely than their male counterparts to record at least one type of abuse or neglect (52% vs 36%) and male staff were significantly more likely to leave the abuse/neglect section blank

(69% vs 46%). If both clinician and client were female at least one type of abuse or neglect was recorded 63% of the time, compared to 26% if both were male. These findings are consistent with a U.S. finding that female mental health clinicians are more likely to identify sexual assaults in adulthood (Currier & Briere 2000).

### *Profession*

In the survey of 111 London mental health staff 50% of psychologists said they never asked men about sexual abuse histories, compared to 25% of nurses and 16% of psychiatrists (Lab *et al.* 2000). More nurses (29%) than psychiatrists (4%) or psychologists (7%) thought that men should always be asked about sexual abuse.

In the first New Zealand outpatient study, which measured actual behavior rather than self-reports, the new form with abuse questions was used by 1% of psychiatrists and 31% of other professions (Read & Fraser 1998a). In the second New Zealand CMHC study, however, profession was unrelated to whether child abuse and neglect were reported (Sampson & Read 2016).

## DISCUSSION

### Failure to enquire about abuse and neglect

Nine studies reveal that less than a third (28%) of abuse and neglect identified by researchers had been documented in clients' files, let alone responded to therapeutically. This figure falls to particularly alarming levels for emotional neglect - 17%, and physical neglect - 10%.

Three studies confirmed this failure in clinical care with findings that the percentage of mental health service users who report being asked about child abuse ranges from 0% to 21%. The three surveys of professionals, and the one of managers, produce somewhat higher

rates, which may be in part result from social desirability bias. Even ignoring that possibility these studies confirm that routine enquiry is very far from the norm.

At a point in history when child abuse is widely acknowledged, internationally, to be prevalent and damaging, and when church, educational, sporting and governmental organisations are being investigated for institutional collusion, one wonders whether collusion is too strong a word to apply to psychiatric services too. This review makes it clear that historical abuse and neglect are being systematically ignored even by services which are specifically intended to provide support and healing for people in emotional distress.

### Paucity of Studies

Another major finding of this review is the paucity of studies about whether mental health services are responding responsibly to the fact that childhood adversities play a causal role in most mental health problems. Prior to 1987 there were no studies meeting our fairly broad inclusion criteria, and there have been only 21 in the subsequent thirty years. It remains to be seen whether the cluster of five studies in 2015 and 2016 (Cunningham *et al.* 2016; Mansfield *et al.* 2016; Rossiter *et al.* 2015; Sampson & Read 2016; Xiao *et al.* 2016) represents a belated and overdue acceleration of research interest. Enquiry about neglect and emotional abuse is even more under-researched than enquiry about physical and sexual abuse (possibly partly because there is less consensus about definitions of neglect and emotional abuse).

This failure of our research community to show sufficient interest in the self-evidently crucial issue of how abused people are treated by mental health services is troubling, and suggests that the bio-genetic model that often pays little heed to psycho-social factors (Bentall 2003; Read & Dillon 2013) not only dominates services but also seems to pervade our research efforts (Bentall & Varese 2012).

## Barriers to asking

Interventions to improve this state of affairs are likely to be more effective if they can directly address the barriers to asking. Identifying these barriers would therefore be a worthwhile research endeavour. But, again, there is only a very small literature available. Four staff surveys - two in New Zealand (Cavanagh *et al.* 2004; Young *et al.* 2001), and one each in Australia (Mansfield *et al.* 2016) and England (Lab *et al.* 2000) - identify fairly consistent reasons for not asking:

- (i) feeling there are more immediate concerns to deal with;
- (ii) fear that clients may find being asked very distressing and may make their problems worse (the ‘can of worms’ argument);
- (iii) worry that enquiry could be suggestive (and thereby lead to ‘false memories’);
- (iv) belief that it is inappropriate to ask clients with problems that the clinician believes are irrelevant to sexual abuse – e.g. psychosis;
- (v) not knowing how, or not having resources, to respond well to disclosures;
- (vi) belief that disclosures by ‘mental patients’ may be false, imagined or delusional

Furthermore, one study found a negative relationship between bio-genetic causal beliefs and self-reported probability of asking about child abuse (Young *et al.* 2001). Very few participants in these studies identified their own emotional discomfort or potential vicarious traumatization.

## Limitations and future research

The fundamental limitations of this review are the small number of studies and the small sample sizes. That the majority of studies occurred in just two countries is a further limitation. The heterogeneity of the methodologies of the studies significantly limits our ability to estimate precisely how much abuse and neglect is missed by services. The same



heterogeneity, however, can be seen as a strength given that all studies found inadequate clinical practice, regardless of methodology, and, moreover, regardless of location or time.

All aspects of this sparse literature warrant attention from researchers, using larger samples. Priority should be given to identifying the facilitators of sustained systemic change. Evidenced models of Trauma Informed Care should be developed, in co-operation with service users and their families, along with multi-level ways to measure the extent to which each service is implementing effective trauma-informed policies.

## CONCLUSION

On a more positive note, the review found some evidence that clinical practice may have been improving gradually over the three decades spanned by the studies reviewed. However, even the most encouraging finding in relation to sexual abuse showed, in 2016, that mental health services are still missing half of the cases identified by researchers (Cunningham *et al.* 2016). The various pathways to urgently needed further improvement are identified next.

## RELEVANCE TO CLINICAL PRACTICE

### Interventions to improve enquiry rates

Potential mechanisms for improving clinical practice in this domain range from trauma-specific assessment forms, policies and guidelines, and training programmes, to, on a more systemic level, trauma-informed mental health services, and a shift of overall paradigm.

#### *Assessment forms*

Our review found (from just three studies) that when specific abuse questions are asked at assessment the amount of abuse identified is far higher than when relying on subsequent

enquiry or spontaneous disclosure. Introducing assessment forms or procedures that include such questions is therefore to be recommended. We also discovered, however, that forms are not always used (Read & Fraser 1998a), and even when they are used the abuse questions are often ignored (Agar *et al.* 2002; Read & Fraser 1998a; Sampson & Read 2016). It seems, therefore, that forms alone do not change behavior.

### *Policies and guidelines*

Policies or guidelines about the need for routine enquiry, at local or national level, or by professional organisations, are also important. These policies and guidelines should stress that all service users should be asked, about both abuse and neglect, regardless of diagnosis, gender or age. But without training, monitoring, follow up, and commitment from all professions and managers, policies and guidelines will be insufficient.

By 2003 the British government had recognised that ‘awareness about the nature and extent of domestic violence and child sexual abuse and its effects appears to be low generally amongst mental health professionals’ and recommended that ‘staff raise issues of violence and abuse routinely and consistently in assessment and care planning’ (Department of Health, 2003). It soon became apparent that the policy was being ignored, and that a major initiative, including training was required (Department of Health 2015). In 2008 the NHS re-iterated the policy that everyone receiving mental health services should be routinely asked about sexual abuse/assault and that a question on sexual abuse/assault be included in the Care Programme Approach (Department of Health 2008; National Health Service 2008). Seven years later the 53 Mental Health Trusts were asked, via the Freedom of Information (FOI) Act, whether they audited this activity (Brooker *et al.* 2016a; Brooker *et al.* 2016b). Of the 36 who replied only five (14% - or 9% of all trusts) replied that they did audit. The researchers also ascertained that 57% of mental health providers fail to give the Health and Social Care Information

Centre (HSCIC) any data about whether mental health service users are asked about violence and abuse, despite this being expected as part of the Mental Health and Learning Disabilities Data set. Overall the HSCIC could ascertain whether or not abuse was being asked about for only 17% of clients. A Freedom of Information enquiry to the Department of Health asking whether the 2008 policy was still policy referred the enquirers to NHS England. The response from NHS England, however, referred the enquirers back to the Department of Health (Brooker *et al.* 2016a, Brooker *et al.* 2016b). There is a need for greater governance of routine enquiry and clearer leadership from bodies, including governmental and professional organisations, that can influence service providers.

### *Training*

Previous training is a predictor of self-reported probability of abuse enquiry (Young *et al.* 2001) and actual enquiry (Currier *et al.* 1996). Training needs to stress that people, including mental health service users, rarely spontaneously disclose child abuse (Eilenberg *et al.* 1996; Read *et al.* 2006) and that it is, therefore, incumbent on mental health staff to actively ask all clients, regardless of gender, age or diagnosis.

Training programmes should directly address the barriers to asking listed above. For example, it is essential to counter any victim-blaming beliefs about users of mental health services not being believable when they say they were abused, using the research demonstrating that abuse disclosures by service users, including those diagnosed with ‘schizophrenia’, are reliable (Darves-Bornoz *et al.* 1995; Fisher *et al.* 2011).

Besides dealing with when and how to ask, training programmes must teach how to *respond* to disclosures respectfully and therapeutically (Cavanagh *et al.*, Read *et al.*, 2007). Responses to disclosures are often inadequate (Agar & Read 2002; Ashmore *et al.* 2015; Eilenberg *et al.* 1996; Posner *et al.* 2008; Read *et al.* 2007; Read & Fraser 1998b; Read *et al.*

2016). The NHS initiative identified not knowing how to respond as the most important barrier to asking (Department of Health 2015). Training programmes (and policies and guidelines) will need to address the implications of mandatory reporting laws in their locality (Davies et al., 2014; Mathews, 2012).

An example of a programme aiming to address most of the issues and barriers identified above was designed in New Zealand after Auckland District Health Board, introduced a policy in 2000 (similar to the 2008 NHS policy) ‘To ensure that routine mental health assessments include appropriate questions about sexual abuse/trauma, and that discourse is sensitively managed’ (Cavanagh *et al.* 2004). The one-day programme devotes the morning to asking and the afternoon to responding, with both sessions involving both didactic learning and role plays (Cavanagh *et al.* 2004; Read *et al.* 2007). An evaluation produced positive findings in terms of user satisfaction and changes in attitudes and clinical practice (Cavanagh *et al.* 2004). Significant increases in the amount of child abuse recorded in files before and after the training was introduced were reported above; but it is unclear how much of that improvement was due to the training (Sampson & Read 2016). The training programme has been translated and successfully adapted for use with German substance use healthcare professionals (Lotzin et al. in press)

Another one day training programme was delivered in eight Trusts in England as part of the NHS policy initiative (Department of Health 2008, 2015; Donohoe 2010; McNeish & Scott 2008). It’s goals were: ‘To address staff fears in working with survivors/victims of violence and abuse, particularly child sexual abuse’ and ‘To equip staff to routinely and consistently explore violence and abuse in assessments and respond appropriately to disclosures’ (McNeish & Scott 2008, p. 7). An evaluation found that 86% (of the 33% recipients who completed the survey) felt confident to carry out routine enquiry. Half of those conducting assessments in the Trusts said they ‘always’ asked about violence

and abuse, with a further 35% saying ‘mostly’. The only Trust (Devon) to provide evidence from an actual audit, before training had been provided to all staff, reported that abuse had been asked about in 1819 out of 4018 (45% ) of assessments (McNeish & Scott 2008).

The New Zealand and UK training programmes are quite similar, including teaching that *all* clients should be asked and having a strong focus on how to *respond* as well as how to ask. They differ, however, in the recommended wording of the actual questions. The UK programme teaches staff to ask ‘Have you experienced physical, sexual or emotional abuse’ whereas the New Zealand approach is to ask about specific types of events, e.g. ‘Did an adult ever hurt or punish you in a way that left bruises, cuts or scratches?’ and ‘When you were a child, did anyone ever do something sexual that made you feel uncomfortable?’ (Cavanagh *et al.* 2004; Read *et al.* 2007). This is because many abuse survivors have not labelled their abuse as such and because research shows that framing questions in terms of ‘abuse’ reveals only about half of the abuse identified by questions about specific events or behaviours (Dill *et al.* 1991; Read *et al.* 2007).

Training can be tailored to fit specific contexts. For example a programme was recently designed especially for an Early Intervention in Psychosis service in the UK (Walters *et al.* 2015). The most rigorously researched training programme to date was in Germany for staff working in substance use services. Trauma enquiry behavior significantly increased for the staff who were trained, three months and six months after the training, but did not change in the control group (Lotzin *et al.* in press). Even short interventions may be useful. U.S. mental health staff who received just a one-hour lecture, on prevalence, impacts and issues around sensitive assessment, identified significantly more sexual and physical violence than those who did not receive the lecture (Currier & Briere 2000).

Trauma-informed services

Policies should be designed not only to mandate training, but to create a positive, trauma-focussed culture for the service as a whole (Bateman, Henderson, & Kezelman, 2013; Brooker et al. 2016a, 2016b; Department of Health 2008; Muskett 2014; Sweeney *et al.* 2016; Toner *et al.* 2013; Substance Abuse and Mental Health Services Administration 2014). Without such a culture any specific gains from forms, policies and trainings may be short lived. The idea is that all staff engage with people in such a way that facilitates recovery from any trauma or adversity that has led to the problems that they present with, that acknowledges that different traumas and adversities may require different responses, and that, at the very least, avoids re-traumatising through practices that either reproduce the trauma with use of force or that dismiss the occurrence, or impact, of abuse. Whether such changes are a prerequisite for, or dependent on, a fundamental paradigm shift in research and services is debatable (Bentall 2003, Boyle 2013; Read & Dillon 2013; Read *et al.* 2014).

### Service user perspectives

Users of mental health services have written, and spoken, extensively about the role of childhood maltreatment in the development of their difficulties and about the frequent failure of mental health services to respond helpfully, or to even ask (Daya, 2015; Dillon, 2009; Longden, 2013; Romme et al., 2009; Sen, 2017). Family members have also spoken out. For example, the need for Trauma Informed Care is heard in an impassioned plea, over 20 years ago now, called 'On being invisible in the mental health system', from a mother of an abused daughter who eventually killed herself (Jennings 1994).

Training programmes should present the research showing that most service users are not distressed by being asked about violence and abuse (Cunningham et al., 2017; Lothian & Read 2002; Department of Health 2015; Scott *et al.* 2015). Indeed, some are distressed by *not* being asked. In the process of designing the New Zealand training programme, 72 long

term users of mental health services were asked what they thought about asking everyone about child abuse (Lothian & Read 2002). Some of their responses were subsequently used in the training, and remain relevant 15 years later:

“There was an assumption that I had a mental illness and because I wasn’t saying anything about my abuse nobody knew”

“There was so many doctors and nurses and social workers in your life asking you about the same thing, mental, mental, mental, but not asking you why”

“I just wish they would have said ‘What happened to you?’ ‘What happened?’ But they didn’t.”

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Table 1. Nine studies measuring the proportion of previously identified childhood adversities that was found in clients' files.

Study and Diagnoses Reported	Demographics Reported	Sexual Abuse	Physical Abuse	Emotional Abuse	Physical Neglect	Emotional Neglect
<b>Jacobson et al. 1987</b> USA 100 inpatients 32% Affective Disorder 29% Psychosis	50% female modal age: 26-35 81% White 18% Black	10.5% (2/19)	12.2% (6/49)			
<b>Craine et al. 1988</b> USA 105 inpatients 42% Schizophrenia 22% Affective Disorder 22% Personality Disorder	100% female mean age 35 (range 13-81) 79% Caucasian 28% Black	44.4% (24/54)				
<b>Goodwin et al. 1988</b> USA 80 inpatients	100% female	20% (4/20)				
<b>Briere &amp; Zaidi 1989</b> USA 100 psychiatric emergency room attenders 100% 'non-psychotic'	100% female mean age 33 31% Caucasian 31% Hispanic 29% Black	8.6% (3/35)				
<b>Lipschitz et al. 1996</b> USA 120 outpatients 42% Mood Disorder 31% Anxiety Disorder	72% female mean age 40 (18-73) 41% White 38% Hispanic 18% Black	28.3% (15/53)	29.3% (12/41)			
<b>Wurr &amp; Partridge 1996</b> England 120 inpatients 36% Affective Disorder 28% Schizophrenia	52% female mean age 36 (16-65)	30.9% (17/55)				
<b>Shannon et al. 2011</b> Northern Ireland 60 ment. hlth. service users 100% Bipolar Disorder	57% female mean age 49 (25-70)	45.5% (5/11)	21.4% (3/14)	7.7% (1/13)	8.3% (1/12)	9.1% (1/11)
<b>Rossiter et al. 2015</b> Ireland 129 in- & out-patients 46% Depression 22% Schizophrenia	48% female mean age 44 (18-84)	34.4% (11/32)	69.4% (25/36)	61.5% (32/52)	11.3% (7/62)	21.2% (17/80)
<b>Cunningham et al. 2016</b> Northern Ireland 45 ment. hlth. service users 100% Psychosis	51% female mean age 49 (21-70)	50.0% (8/16)	35.0% (7/20)	26.1% (6/23)	8.7% (2/23)	8.3% (2/24)
Weighted Average		30.2% (89/295)	33.1% (53/160)	44.3% (39/88)	10.3% (10/97)	17.4% (20/115)



Table 2. Prevalence of adversities in files when specific questions asked or not asked at initial assessment

Study and Diagnoses Reported	Demographics Reported		If Asked	If Not asked
<b>Read &amp; Fraser 1998a</b> New Zealand 100 inpatients 34% Schizophrenia 19% Depression 17% Bipolar Disorder 16% Substance Abuse	43% female  mean age 38 (20-67)  68% European 15% Maori	Sexual Abuse	47.1% (8/17)	5.5% * (2/36)
		Physical Abuse	29.4% (5/17)	0% * (0/36)
<b>Agar et al. 2002</b> New Zealand 200 outpatients 42% Depression 14% Schizophrenia 10% Substance Abuse	57% female  mean age 36  72% European 11% Maori	Sexual Abuse	15.0% (3/20)	0% (0/6)
		Physical Abuse	15.0% (3/20)	0% (0/6)
<b>Sampson &amp; Read 2016</b> New Zealand 250 outpatients 45% Mood Disorder 23% Psychosis	49% female  mean age 36  56% European 24% Maori	Sexual Abuse	41.0% (29/69)	10.7% * (9/84)
		Physical Abuse	50.7% (35/69)	9.5% * (8/84)
		Emotional Abuse	46.4% (32/69)	3.6% * (3/84)
		Emotional Neglect	30.4% (21/69)	3.6% * (3/84)
		Physical Neglect	10.1% (7/69)	3.6% (3/84)

\* p &lt; .001