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Are mental health staff getting better at asking about abuse and neglect?

ABSTRACT

This study ascertained the extent to which abuse and neglect are identified and recorded by mental health services. A comprehensive audit of 250 randomly selected files from four community mental health centres in Auckland, New Zealand was conducted, using similar methodology to that of a 1997 audit in the same city so as to permit comparisons. Significant increases, compared to the 1997 audit, were found in the rates of child sexual and physical abuse, and adulthood sexual assault (but not adulthood physical assault) identified in the files. Identification of physical and emotional neglect, however, was poor. Male service users were asked less often than females; and male staff enquired less often than female staff. People with a diagnosis indicative of psychosis, such as 'schizophrenia', tended to be asked less often and had significantly lower rates of abuse/neglect identified. Despite the overall improvement, mental health services are still missing significant amounts of childhood and adulthood adversities, especially neglect. All services need clear policies that all service users be asked about both abuse and neglect, whatever their gender or diagnosis, and that staff receive training that address the barriers to asking and to responding therapeutically to disclosures.

Keywords: Abuse, Assault, Assessment, Maltreatment, Neglect, Trauma,

INTRODUCTION

Child abuse and neglect are associated with many mental health problems, in childhood and adulthood, including , anxiety disorders, attention-deficit/hyperactivity disorder, bipolar disorder, eating disorders, dissociation, personality disorders, psychosis, sexual dysfunction, post traumatic stress disorder (PTSD), and substance misuse (Ashcroft *et al.* 2012; Boyda *et al*. 2015; Cater *et al.* 2014; Cutajar *et al.* 2010; Fuller-Thomson & Lewis 2015; Kendler *et al.* 2000; Read *et al.* 2005; Varese *et al.* 2012; Watson *et al.* 2014). 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). Survivors of child abuse are at risk for revictimization in adulthood (Del Gaizo *et al.* 2011). Subsequently, violence in adulthood further increases risk of mental health problems (Boyda *et al*. 2015; Read *et al.* 2008; Trevillion *et al.* 2014). Adults abused as children are more likely to try to kill themselves and to be admitted to psychiatric hospital (Hepworth & McGowan 2013; Mullen *et al.* 1993; Read 1998, 2013). A review of 52 inpatient studies found that over 50% of the men and over 60% of the women had been either sexually or physically abused as children (Read *et al.* 2008).

Such findings have led to numerous researchers and clinicians recommending routine enquiry about childhood and adulthood abuse and neglect in mental health services. In 2008, the National Health Service of the United Kingdom (UK) published guidelines calling for all mental health service users to be asked about abuse and all staff to be trained in how to do that (National Health Service, 2008). There is little research examining whether such recommendations are being heeded.

Are Mental Health Services Asking about Abuse and Neglect?

Following decades of disinterest in this topic a few studies were published, towards the end of the last century, in the United Kingdom and the United States of America. All found that when researchers asked users of mental health services about childhood abuse, the proportion of that abuse that had been identified by the services was low: 30% (Wurr & Partridge 1996); 28% (Lipschitz *et al.* 1996); 20% (Goodwin *et al.* 1988), 12% (Jacobson *et al.* 1987); and 12% (Briere & Zaidi 1989). Of 30 'heavy users of acute inpatient and emergency services' who disclosed child abuse to researchers, none had ever previously been asked about abuse (Rose *et al.* 1991).

A 2002 New Zealand survey of clients' experiences of initial assessments by mental health services, spanning two decades, found that the majority (65%) reported abuse to the researcher but only 20% had been asked about abuse by services (Lothian & Read 2002). The finding that recency of assessment was positively related to being asked, and the fact that the two later studies found higher rates of asking (Lipschitz *et al.* 1996; Wurr & Partridge 1996), suggests that an improvement in clinical practice may have been taking place during this period.

A New Zealand inpatient study had found that even if admission forms included abuse questions, only 32% of people were asked the questions (Read and Fraser 1998a). Over half (59%) of those who *were* asked on admission disclosed child abuse, but only 6% of those not asked on admission disclosed child abuse during their admission. Similarly 35% of those who were asked about being assaulted as an adult disclosed assaults, compared to 3% of those not asked. Combining the two sets of data showed that 82% of inpatients disclosed either childhood or adulthood sexual/physical abuse if they were asked at admission, compared to just 8% if not asked.

Another New Zealand study found an improvement on the inpatient study. The questions in the abuse section of the admission form of a community mental health centre

[CMHC] were asked in 70% of cases rather than 32% (Agar *et al.* 2002). A later survey of New Zealand women in therapy for sexual abuse found, however, that only 22% of those who had used psychiatric services had been asked about abuse by those services (Read *et al.* 2006).

A 2013 review concluded that 'mental health professionals do not routinely enquire about childhood sexual abuse in acute mental health settings', and noted that the literature is 'limited in quantity and is of moderate to poor quality' (Hepworth & McGowan 2013, p.473). Like many before them, they recommended 'that mental health service providers introduce mandatory enquiry' and called for staff training. The following year a review of how mental health services deal with 'domestic violence' arrived at similar conclusions and recommendations (Trevillion *et al.* 2014).

A 2006 USA study found that the average number of life time traumas experienced by CMHC attenders was 2.6 (most commonly witnessing murder), with 87% experiencing at least one trauma. Only 28% of the files had any mention of these traumas (Cusack et al. 2006). A recent study, the first in nearly a decade to compare rates identified by researchers and services, reported on 129 attenders of inpatient and outpatient services in Ireland (Rossiter *et al.* 2015). Seventy seven percent had experienced one or more of the five types of childhood adversity assessed by the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink 1998), but according to the clinical records this was the case for only 38%. Emotional abuse, sexual abuse, physical neglect and emotional neglect were all significantly more common ($p < .001$) when assessed by the CTQ than in the clinical records (the difference was not quite significant for physical abuse; $p = .06$). The greatest discrepancies were for emotional neglect (62.0% vs 13.2%) and physical neglect (48.1% vs 5.4%). The overall finding that almost half (49%) of all actual cases of child abuse and neglect had been

identified and recorded (compared to the 0% to 39% in the pre-2000 studies) adds weight to the notion that clinical practice may be improving.

Aims of the Current Study

The CMHC assessed in 1997 by Agar and Read (2002), and the four CMHCs assessed in the current study, are located within Auckland District Health Board [ADHB]. In 2000 ADHB introduced recommendations on how to ask about abuse histories (Cavanagh *et al*. 2004). ADHB added a section in their mental health procedures manual entitled "Recommended best practice: Trauma and sexual abuse". This document's purpose was "To ensure that routine mental health assessments include appropriate questions about sexual abuse/trauma, and that disclosure is sensitively managed". Since introducing this policy, ADHB has required mental health staff to attend a training programme on how to ask about childhood adversities. After a positive initial evaluation (Cavanagh *et al*. 2004) this evidence- and skill-based one-day programme (outlined in Cavanagh *et al.* (2004) and in Read *et al.* (2007); and described in detail in Read (2006) was delivered to groups of staff several times a year, for nine years. The training programme summarised the research linking abuse and neglect to a range of mental health problems and studies showing how rarely mental health services ask about, or respond well to, childhood and adulthood adversities. The programme also provided opportunities for role playing the processes of asking about abuse and responding to disclosures .

The current study was designed to replicate the 1997 audit (Agar et al., 2002) of one of the four CMHCs that were audited in the current study. The purpose of this replication was to address the following research question: Has there been an increase in rates of sexual and physical abuse, in childhood and adulthood, identified and recorded by CMHC staff since the introduction of the policy and training. As a further comparison with two previous New

Zealand studies described earlier above (Read & Fraser 1998a; Agar *et al.* 2002), the current study also recorded how often specific abuse/neglect questions in admission forms were completed.

The current study went beyond the previous studies by including childhood physical neglect [CPN], childhood emotional abuse [CEA], childhood emotional neglect [CEN], and adult emotional abuse/neglect [AEA/N].

METHOD

Ethical approval was obtained from the University of Auckland and the Auckland District Health Board.

Sample Selection and Characteristics

A list of 250 files of adult users of four community mental health centres was generated at random from 850 potential files, using exclusion criteria of: files that had been active for three days or less; and files opened prior to January 1st 2001 - to avoid sampling the same events as the comparison study (Agar *et al.* 2002). The 250 files were thoroughly read by one of the two researchers (taking an average of 140 minutes per file). A data form was developed specifically for this study to collect a range of clinical and demographic information that had been recorded in the files prior to, during or following Initial Assessments. Initial Assessments were the first formal assessment conducted and were recorded in the computerised records under that title; 217 (86.8%) were completed within three days of admission to the service.

The sample consisted of 122 women and 128 men, with an average age of 35.6 years (SD: 12.3). The majority were New Zealand European (55.6%) or Māori (24.0%). About

half (50.4%) were single and about half were unemployed (52.4%). The most common diagnoses were for mood disorders (45.4%), e.g. major depressive disorder, and psychotic disorders (23.5%), e.g. schizophrenia.

The professions of the clinicians conducting the Initial Assessments were: psychiatrist - 74.8%; nurse - 20.0%; psychologist - 2.8%; other 2.4%. The majority (62.0%) of these clinicians were female.

Abuse and Neglect

Abuse and neglect were categorised as follows: childhood sexual abuse [CSA], childhood physical abuse [CPA], childhood physical neglect [CPN], childhood emotional abuse [CEA], childhood emotional neglect [CEN], adult sexual abuse [ASA], adult physical assault [APA], and adult emotional abuse/neglect [AEA/N]. Consistent with the earlier studies with which comparisons were being made, which were also chart reviews, the operational definitions of abuse or neglect were based on what the clinician recorded as abuse or neglect. For example files that included 'sexually abused as a child' or 'client reported frequently being physically assaulted by ex-husband' were scored as abuse.

As was the case in the previous chart reviews, there were numerous cases where there was some evidence that abuse or neglect might have taken place but no statement was recorded as to whether the clinician had reached such a conclusion. In the current study there were 32 such files. All these 'uncertain' files were independently rated by the two researchers for the probability of abuse or neglect having occurred, using the rating system used by the previous audit (Agar et al., 2002). For an instance of possible abuse or neglect to be included in the analysis both researchers had to rate it as '95% or more probable' to have taken place. If either rated the case as less than 95% probable, it was coded as 'no abuse or neglect noted' on the data sheet. The raters agreed in 29 of the 32 cases (Inter–Rater Reliability = 91%, κ =

0.81). Fourteen (44%) were rated as 95% or more likely by both raters and therefore coded as 'abuse or neglect noted'; 15 (47%) cases were rated as less than 95% likely by both researchers and coded as "no abuse or neglect". The three cases where the raters diasagreed were coded as 'no abuse or neglect'. An example that was rated as less than 95% likely to have occurred by both raters, was "violent and abusive father". This was deemed too vague because it was not clear whether the father had been violent *to the client*.

Data Analysis

Descriptive data is provided for the five types of child abuse/neglect and three types of adult abuse/neglect, as well as for demographics. Comparisons involving categorical data were conducted using the chi-square test of independence (X^2). Differences between variables with continuous data were examined using two-tailed independent sample t-tests.

RESULTS

Recorded Abuse and Neglect

Some form of adult or childhood abuse or neglect was recorded somewhere in the files of 164 people (64.0%). At least one form of *childhood* abuse or neglect were recorded in 141 files (56.4%), specifically: CPA 90 (36.0%); CEA 88 (35.2%), CSA 81 (32.4%), CEN 53 (21.2%) and CPN 18 (7.2%). One or more forms of *adulthood* abuse or neglect were recorded in 88 files (35.2%), specifically: APA 61 (24.4%), ASA 36 (14.4%) and AEA/N 54 (21.6%). Women had significantly higher rates recorded for all categories except CPA. There were no significant differences between the four CMHCs.

One hundred and fifteen files (46.0%) indicated that a recorded disclosure of abuse/neglect (spontaneous or following enquiry) had taken place during the IA; 116 (46.4%) after the IA; and 77 (30.8%) prior to the IA. Thus many clients were asked (or spontaneously

disclosed) more than once; with 46 (18.4%) having abuse/neglect in their files at all three time periods. For 135 clients (54.0%), however, there was no evidence of being asked during their IA. Furthermore, for 87 clients (34.8%) there was no evidence of any enquiry at any time.

Demographics

Female clinicians (52.3%) were more likely than male clinicians (35.9%) to record one or more forms of abuse or neglect during the Initial Assessment ($\chi 2 = 6.44$, p=.04). Recording occurred in 63.1% of situations if both clinician and client involved in the Initial Assessment were female, compared to 26.4% of cases when both were male.

There were no significant differences in the probability of one or more forms of abuse/neglect being recorded according to the age or ethnicity of the client, the profession of the clinician or which of the four CMHCs the client attended.

Diagnosis

The rates of recorded abuse/neglect at the Initial Assessment varied with the clients' primary diagnosis, as follows: PTSD - 88.9%, 'other' - 58.8%, major depression - 54.6%, generalised anxiety disorder - 53.8%, bipolar disorder - 51.8%, 'no diagnosis' - 44.4%, drug/alcohol abuse – 42.8%, and psychotic disorders - 23.4%. Clients diagnosed with a psychotic disorder were significantly less likely to have abuse/neglect identified than each of the other diagnostic groupings (e.g. compared to drug/alcohol abuse ($\chi 2 = 6.08$, p<.001).

Completion of the Abuse/Neglect Section in Assessment Forms

The computerised forms for Initial Assessments at the four CMHCs included a specific section on current and historical abuse and neglect. In 153 (61.2%) of the 250 files the form

was used to record the information from the Initial Assessment (with the other 97 summarising the assessment elsewhere in the file). Tables 1 and 2 show that using the form (regardless of whether the abuse/neglect section was completed) was related to slightly higher rates of recorded abuse compared to files where the form was not used, but these differences were only statistically significant for CPA, APA and AE/N.

TABLES 1 AND 2 ABOUT HERE

Of the 153 files that had used the computerised form the abuse/neglect session was completed in only 69 (45.1%) files, and left blank in 84 (54.9%). Tables 1 and 2 show that the recorded rates for Initial Assessments were higher when the specific abuse/neglect section was filled in, for all categories of abuse/neglect, and that these differences were significant for all but CPN. For example, when the abuse/neglect section of the form was completed (and it can therefore be reasonably assumed that enquiry took place) CPA was recorded 3.8 times more often than if the form had not been used (50.7% vs. 13.4%), and 5.4 times more likely than if the form had been used but the abuse/neglect section had been ignored (50.7% vs. 9.5%).

The abuse/neglect section of the male clients' records was left blank somewhat more often (63.0%) than for females (46.3%) ($X^2 = 4.32$, $p < .05$). Furthermore, male staff members left the section blank considerably more often than female staff (69.1% vs 46.3%) ($X^2 = 7.29$, $p < .01$).

Three diagnoses had high rates of the section being left blank: psychosis (63.6%), bipolar disorder (72.2%) and drug/alcohol abuse (71.4%), (compared to 52.0% for depression and 17.7% for PTSD), but the differences between these three and the rest of the sample were not statistically significant.

Comparisons with 1997 Audit

Prevalence Rates

The 1997 file audit at one of the four CMHCs had not included emotional abuse, physical neglect or emotional neglect. Comparisons can therefore only be made in relation to sexual and physical abuse. Tables 3 and 4 show that rates of recorded sexual and physical abuse have increased for both childhood and adult abuse since 1997. These increases are statistically significant for CSA ($\chi 2 = 7.69$, p<.01), CPA ($\chi 2 = 22.14$, p<.001), and ASA ($\chi 2 = 6.35$, p<.05), but not for APA. Analysis by gender showed that both men and women are more likely than in 1997 to have childhood abuse recorded, but the parallel increase in relation to adulthood abuse applies only to women.

TABLES 3 AND 4 ABOUT HERE

Demographics. Psychiatrists (74.8% vs 54.4%) and females (62.0% vs 44.5%) made up a greater proportion of mental health workers responsible for Initial Assessments in the current study than in the earlier study. The present sample also had a significantly higher proportion of Māori clients (24.0% vs 10.5%).

DISCUSSION

Comparison with the 1997 Study

Overall there was a marked increase in the rate of identification of abuse. This is consistent with the increase in abuse identification over time indicated in the Introduction section of this paper.

It is impossible to know whether this improvement was partly due to the training programme introduced in the interim period, to a general increase in awareness of abuse/neglect (in mental health services and in the public) or to other factors, such as a more supportive service culture or, perhaps, the greater proportion of female clinicians in the follow up study.

Encouraging as this improvement is, it was not consistent across gender or abuse type. While rates more than doubled for CPA (both genders) and for ASA (for women), there was no significant increase in the overall identification of APA. The rates of APA and ASA for men actually fell slightly.

It is concerning that for 35% of clients there was no evidence of inquiry at all during their involvement with the CMHC. It is also unsatisfactory that the specific abuse/neglect section of the admission form was ignored in 55% of cases, compared to just 23% in the 1997 audit. The fact that the current study nevertheless found higher rates of abuse/neglect is because even though the abuse/neglect section was ignored more often, the assessment form was used more often than in 1997– meaning that, overall, the abuse/neglect section was completed more often in the current study. Both of these New Zealand studies confirm the importance of having, and *using*, assessment forms with specific abuse/neglect questions.

Neglect

Neglect and emotional abuse were not assessed in the 2002 study. Approximate comparisons can be made, however, with the recent Irish study that compared actual rates of abuse and neglect measured by researchers using the Childhood Trauma Questionnaire with rates recorded in clinical files of adults using a mental health service (Rossiter *et al.* 2015). Table 5 suggests that while the New Zealand clinicians identified more child abuse than their Irish counterparts (particularly sexual abuse), the identification of emotional and physical neglect

remains inadequate in both countries, despite their being the two most common of the five types of childhood adversity. A parallel failure to identify neglect, relative to abuse, has been documented among British journalists, despite neglect being the most common form of child maltreatment in Britain (Davies *et al.* 2015).

TABLE 5 ABOUT HERE

Patient Characteristics

Gender

Women having significantly higher rates of CSA and ASA identified in their records partly reflects the higher rates of sexual abuse actually experienced by women. However, the findings that all other types of abuse and neglect (except CPA) were also significantly more likely to be identified and recorded if the client was female suggest that training needs to focus on asking men as well as women. Previous studies have also found that men are particularly unlikely to be asked about child abuse (Lab *et al.* 2000; Mills 1993; Muenzenmaier *et al.* 2010; Read & Fraser 1998a). In a survey of New Zealand psychiatrists and clinical psychologists, 25% self-reported that they were less likely to ask about sexual abuse if the client were male (Cavanagh *et al.* 2004). The Irish study, however, found no gender discrepancies in the clinical notes for any of the five types of child abuse/neglect studied (Rossiter *et al.* 2015).

It is of particular concern that in the current study the abuse/neglect section of the admission form was avoided more often for male clients. This, and the finding that recording of some form of abuse/neglect occurred in 63% of assessments if both clinician and client were female, compared to 26% of cases when both were male, could be highlighted in training courses.

Diagnosis

The finding that people with a diagnosis indicative of psychosis were significantly less likely to have abuse/neglect identified is important. Child abuse/neglect is at least as common in adults experiencing psychosis as in adults with other mental health problems; and child adversity is a strong risk factor for psychosis (Varese *et al.* 2012; Read *et al.* 2005; Read *et al.* 2014). Therefore, the current finding cannot be explained in terms of lower actual rates of abuse/neglect in this group, but can reasonably be interpreted as bias against asking about childhood adversities with this group of people. This bias has been identified before (Agar *et al.* 2002; Cavanagh *et al.* 2004; Cunningham *et al.* 2016; Young *et al.* 2001). A New Zealand survey found that 41% of psychologists and psychiatrists stated they were more likely to ask about sexual abuse with people diagnosed with personality disorder, depression and PTSD (Cavanagh *et al.* 2004). The hypothesis that the bias is partly because of traditional assumptions about 'schizophrenia' being a biological phenomenon was supported by a survey of New Zealand psychiatrists in which degree of belief in biological causation was related to being more likely to ask someone with a diagnosis of 'major depressive disorder' about child abuse than someone diagnosed with 'schizophrenia' (Young *et al.* 2001).

Clinician Characteristics

Profession was unrelated to level of identification of abuse/neglect in either the current study or the 1997 audit. There were also no significant differences between professions in frequency of ignoring the admission form's abuse/neglect section.

In the 1997 audit the gender of the clinician was also unrelated. In the current study, however, women clinicians were significantly more likely to identify abuse/neglect, and were significantly *less* likely to skip the abuse/neglect section of the admission form. A United

States study has also found that female mental health clinicians were more likely to identify sexual assaults (Currier & Briere 2000). Thus the overall improvement may be partly the result of increased asking by female staff in particular, including (given the high proportion of psychiatrists conducting the Initial Assessments) female psychiatrists.

Policies and Training

It seems necessary to recommend, yet again, that mental health services have a clear policy that all clients be asked about adverse events (in childhood and adulthood) during the process of admitting someone to the service. Acceptable reasons for delay include current suicidality and *acute* psychosis (but not just a *diagnosis* thereof) (Young *et al.* 2001; Cavanagh *et al*. 2004; Read *et al.* 2007)

These policies, however, must help create a trauma-focussed culture (Toner *et al.* 2013), and must mandate and provide training for staff in how to ask and how to respond to disclosures. Neither just including abuse questions in an admission form (Read and Fraser, 1998a), nor instructing staff to ask about abuse (Dill *et al.* 1991) are, without training, effective. Previous training is a predictor of both self-reported probability of (Young *et al.* 2001), and *actual,* trauma enquiry (Currier *et al.* 1996). While the New Zealand programme is a full day (Cavanagh *et al.* 2004), USA mental health staff who attended a one-hour lecture, on prevalence, impacts and assessment, identified significantly more sexual and physical violence than those not attending (Currier & Briere, 2000).

Training programmes should address the barriers to asking. Reviews (Cavanagh *et al*. 2004; Lab *et al*. 2000; Read 2006; Read *et al.* 2007; Young *et al.* 2001) have identified the following barriers: staff feeling there are more immediate concerns; worry that enquiry could be suggestive (and thereby lead to 'false memories'); belief that it is inappropriate to ask patients with problems that the clinician *believes* are irrelevant to sexual abuse - for example

psychosis; belief that disclosures by patients may be imagined/delusion; not knowing how to respond to disclosures; lack of resources to deal with the consequences of disclosure; the client being male; the staff member being male; the client and clinician being different genders; belief that clients would prefer to be asked by a clinician of the same gender; the client being over 60; staff having strong bio-genetic causal beliefs; fear that clients may find being asked very distressing and may make their problems worse (the 'can of worms' reason for not asking), fear of vicarious traumatisation, and lack of training in how to ask and how to respond. A British study of service users and staff suggests that 'the medical diagnostic and treatment model with its emphasis on symptoms could act as a barrier to enquiry' about domestic violence (Rose *et al.* 2011, p.189)

Training should stress the fact that, for a range of reasons, service users (particularly men) rarely disclose abuse spontaneously (Eilenberg *et al*. 1996; Read *et al.* 2006; Young *et al*. 2001), and that it is, therefore, incumbent on staff to ask all clients, regardless of gender, age or diagnosis. As Middleton and colleagues argue, "We have to avoid passively opting for silence if we are to be part of the solution rather than an extension of the problem,' (Middleton *et al*. 2014a, p.581). The research demonstrating that abuse disclosures by mental health service users, including those diagnosed with 'schizophrenia', are reliable (Fisher *et al.* 2011) should be covered.

Training must include not only when and how to *ask,* but how to *respond* to disclosures (Agar & Read 2002; Read 2006; Read *et al.* 2007; Read *et al.* 2016; Walters *et al.* 2016). Taking a psycho-social history, including abuse/neglect and other adversities, is only the first step towards creating a shared formulation of the causes of the current problems and providing a comprehensive support/treatment package which addresses, if necessary, historic and ongoing adversities. A small research literature suggests that even when abuse *is* disclosed within mental health services, responses are typically inadequate (Agar & Read

2002; Ashmore *et al.* 2015; Eilenberg *et al.* 1996; Read & Fraser 1998b). As is the case for enquiry, however, there are signs of recent improvement in this area (Posner *et al.* 2008; Read 2013; Read *et al.* 2016).

Other Signs of Progress

In 2007 the developers of the Auckland training programme (Cavanagh *et al.* 2004; Read 2006) were invited to present it, and its research base, in the professional journal of the UK's Royal College of Psychiatrists (Read *et al.* 2007). In 2008 the National Health Service introduced guidelines similar to those introduced eight years earlier by ADHB in New Zealand. The NHS document states that "Violence and abuse is a core mental health issue", adding that "All service users should be asked about abuse in assessments, after appropriate staff training, and that survivors of abuse receive appropriate care". (NHS 2008).

Besides the evidence of gradual improvement in enquiry about abuse (but not neglect), and in immediate response to abuse, by staff, there are also signs of greater acknowledgement of childhood trauma by mental health professionals and researchers (Middleton *et al.* 2014b; Read & Bentall 2012) and an emerging international awareness of the need for trauma-informed services (Ashmore *et al.* 2015; Bateman et al. 2013; Haliburn 2014; Kezelman & Stavropoulos 2012; Muskett 2014; SAMHSA 2014; Walters *et al.* 2016). Implementation, however, can be painfully slow (Rose *et al*. 2012).

Limitations

The findings cannot be generalised with great certainty to other countries, or even other parts of New Zealand, particularly as the training programme offered by ADHB was extremely rare, possibly unique, at that point in time.

The comparison between data from four CMHCs in the current study and data from just one of those four in the 1997 audit (Agar & Read 2002) is less than ideal. However, in the current study there were no differences in rates of abuse identified between the four CMHS, all of which were in the same District Health Board and offered similar services.

The absence of actual rates of abuse/neglect assessed by a validated instrument such as the CTQ renders it impossible to calculate exactly how many adverse experiences were missed. The rates identified may be underestimates because of the potentially over strict criteria of the inter-rater reliability process. Furthermore clinicians may have identified some abuse/neglect without recording it.

It is possible that the 2001 cut-off date excluded people with longer contact with the services, which may have introduced some unidentified bias into the sample.

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TABLE 1: *Comparisons of recorded rates of childhood abuse and neglect during the Initial Assessment depending on use of computerised assessment form, and abuse/neglect section thereof*

	N	Childhood sexual abuse	Childhood physical abuse	Childhood emotional abuse	Childhood emotional neglect	Childhood physical neglect
Form						
Used	153	38 (24.8%)	43 (28.1%) ***	35 (22.9%)	24(15.7%)	10 (6.5%)
Not used	97	19 (19.6%)	13 (13.4%)	16 (16.5%)	9 (9.3%)	4 (4.1%)
Abuse section						
Used	69	29 (41.0%) ***	35 (50.7%) ***	32 (46.4%) ***	21 (30.4%) ***	7 (10.1%)
Not used	84	9 (10.7%)	8 (9.5%)	3 (3.6%)	3 (3.6%)	3 (3.6%)

*** = p<.001.

TABLE 2: *Comparisons of recorded rates of adult abuse and neglect during the Initial Assessment depending on use of computerised assessment form, and abuse/neglect section thereof*

	N	Adult sexual abuse	Adult physical abuse	Adult emotional abuse or neglect
Form				
Used	153	13 (8.5%)	24 (15.7%) **	24 (15.7%) *
Not used	97	7 (7.2%)	5 (5.2%)	6 (6.2 %)
Abuse section				
Used	69	12 (17.4%) **	15 (21.7%) **	18 (26.1%) ***
Not used	84	1 (1.2%)	9 (10.7%)	6 (7.1%)

*= p < .05. **= p <. 01. *** = p<.001.

TABLE 3: *Comparing the recorded prevalence rates of childhood sexual and physical abuse between 1997 and current study, with significant differences over time*

	Childhood sexual abuse		Childhood physical abuse	
	1997	Current	1997	Current
All	20.0%	32.4% **	17.0 %	36.0% ***
Female	26.3%	44.8% ***	17.5%	39.2% ***
Male	11.6%	20.0% *	16.3%	33.6% ***

* = p < .05. ** = p <. 01. *** = p<.001.

TABLE 4: *Comparing the recorded prevalence rates of adult sexual and physical abuse between 1997 and current study with significant differences over time*

	Adult sexual assault		Adult physical assault	
	1997	Current	1997	Current
All	7.5%	14.4 *	19.5%	24.4%
Female	8.8%	25.6% ***	25.4%	41.6% **
Male	5.8%	3.2%	11.6%	7.2%

* = p < .05. ** = p <. 01. *** = p<.001

TABLE 5: *Comparison of current study with similar 2015 study in Ireland* *

	Irish Study* Actual	Clinical notes	Current Study Clinical notes
Any child abuse/neglect	77%	38%	56%
Sexual abuse	25%	8%	32%
Physical abuse	28%	20%	36%
Emotional abuse	40%	25%	35%
Physical neglect	48%	5%	7%
Emotional neglect	62%	13%	21%

*Rossiter et al., 2015