How do mental health services respond when child abuse or neglect become known? A literature review

Abstract

Objective. Child abuse and neglect are strongly associated with many subsequent mental health problems. This review summarizes the research on how adult mental health services respond when child abuse or neglect become known.

Methods. Medline, PsycINFO and Scopus were searched for studies with rates of responding in various ways to child abuse and neglect by mental health professionals.

Results. Thirteen studies were identified: seven case note reviews, three surveys of staff, and three sets of interviews with service users. Rates of inclusion of abuse or neglect in treatment plans ranged from 12% to 44%. Rates of referral to abuse-related therapy ranged from 8% to 23%. Rates were lower for neglect than for abuse, and were also lower for men and people with a diagnosis of psychosis. Two percent or less of all cases were referred to legal authorities.

Conclusions. The studies varied in focus and methodology, but all indicated inadequate clinical practice. The rates of abused or neglected people referred for therapy are actually lower than indicated by this review because most users of adult mental health services are not asked about abuse or neglect in the first place. The barriers to good practice, and the need for trauma-informed services, are discussed.

Formulations

Introduction

Child abuse and neglect are strongly associated with many subsequent mental health problems. These include anxiety, attention-deficit/hyperactivity problems, extreme mood swings, disordered eating, dissociation, persistent changes in emotional, behavioural and relational patterns, trauma-induced flashbacks and emotional avoidance, psychosis and other disturbances in perceived reality, sexual dysfunction, and substance abuse (Boyda et al., 2015; Felitti et al., 1998; Fuller-Thomson & Lewis D, 2015; Kendler et al., 2000; Read et al., 2005; Read & Bentall, 2012; Varese et al., 1012).

A review of 52 inpatient studies found that over 50% of the men and over 60% of the women had experienced either childhood sexual abuse [CSA] or childhood physical abuse [CPA] (Read et al., 2008). Adults scoring high on the Adverse Childhood Experiences scale are ten times more likely to be prescribed antipsychotics and 17 times more likely to be prescribed antidepressants (Anda et al., 2007). They are also significantly more likely to develop adult diseases, including ischemic heart disease, cancer, lung disease, and liver disease (Felitti et al., 1998). Mental health service users who were abused as children have higher global symptom severity, and are more likely to self-harm and kill themselves (Felitti et al., 1998; Hepworth & McGowan, 2013; Read, 1998, 2013). In the UK the annual cost of CSA alone, in 2012, was estimated to be £3.2 billion (Saied-Tessier, 2014).

It seems essential, therefore, that mental health staff routinely ask service users about abuse and neglect, are well trained in how to respond therapeutically to disclosures, and address recovery from trauma as a means of addressing the presenting issues. A recent review, by the same reviewers as the current review, identified 21 studies researching how often staff ask about child abuse and neglect (Read et al., 2018). It found that the majority of

people who use mental health services are never asked. Of abuse or neglect cases identified by researchers, only 28% are found in client files; with particularly low rates for neglect. Furthermore, the review found that people diagnosed with psychotic disorders, and men, are asked less than other people. The review concluded:

> At a point in history when child abuse is widely acknowledged, internationally, to be prevalent and damaging, and when church, educational, sporting, and governmental organizations are being investigated for institutional collusion, one wonders whether 'collusion' is too strong a word to, apply to psychiatric services as well. This review makes it clear that historical abuse and neglect are being systematically ignored even by services that are specifically intended to provide support and healing for people in emotional distress. (Read et al., 2018, p. 13).

The review drew attention to the dominant 'biogenetic model that often pays little heed to psychosocial factors' (p. 13) (Bentall, 2003; Bentall & Varese, 2012; Read & Bentall, 2012; Read & Dillon, 2013) as a partial explanation for this systematic failure by psychiatric services, and highlighted the need for policies and training to improve clinical practice. It also, however, identified 'not knowing how, or not having resources, to respond well to disclosures' (p. 14) as an important barrier to asking in the first place.

There has only been one review of research about how mental health staff *respond* after child abuse or neglect becomes known to them (van der Zalm et al., 2013). It was restricted to psychiatric nurses and only two studies (both included in the current review) provided data on their actual responses (Lab et al., 2000; Mitchell et al., 1996).

Aims of the review

It was, therefore, decided that a review of studies relating to the responses of all mental health professions, and to all types of child abuse and neglect, is long overdue. This paper first summarises the research on how mental health services and staff respond when childhood abuse or neglect are known about, and then outlines the practical implications of the findings.

Methods

The search and review strategy was based, as far as was possible with a small body of literature utilising very varied methodologies, on Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009).

An electronic database search was completed, by one of the reviewers, using *PsycINFO*, from earliest record to September 2017. The search was restricted to 'academic journals' and 'dissertations' in English. The search terms were. 'abuse' OR 'neglect' OR 'child abuse' OR 'childhood abuse' OR 'childhood trauma' OR 'trauma history' OR 'trauma histories' OR 'child neglect' OR 'childhood neglect' OR 'sexual abuse' OR 'physical abuse' OR 'emotional abuse' OR 'psychological abuse' OR 'physical neglect' OR 'emotional neglect' OR 'child maltreatment' OR 'childhood maltreatment' OR 'Incest' (32,145 articles) AND 'psychiatric services' OR 'psychiatric care' OR 'mental health services' OR 'mental health care' OR "mental health center' OR "mental health centre' OR 'psychiatric nursing' OR 'mental health professionals' OR 'psychiatric hospital' OR 'psychiatric inpatients' OR 'psychiatric outpatients' OR 'treatment plan' OR 'formulation' OR 'referral' OR 'psychotherapy' OR 'trauma therapy' OR 'reporting' OR 'medical records' OR 'patient files' OR 'staff response' (42,164 articles).

This search strategy, when applied to PsycINFO, generated 852 potentially eligible references. Studies whose titles suggested they might have the potential to address the issue of how staff/services respond to adults who disclose childhood abuse or neglect were

extracted and their abstracts read. The primary inclusion criterion was being a study of adult mental health services (inpatient or outpatient), that reports the frequencies of any kind of positive staff responses to disclosures of childhood abuse (physical, sexual or emotional/psychological) or neglect (physical or emotional). Staff responses could include, but were not limited to: provision of any kind of abuse/neglect-related support or information; inclusion of abuse/neglect in formulation, treatment plan or discharge summary; referral for abuse/neglect-related treatment/support; or reporting of abuse to legal/protection authorities, or discussion with patient about that possibility. All methodologies producing relevant data were included. e.g. chart reviews, interviews with staff, service users or managers, etc.. The primary exclusion criterion was specialist mental health services, including child and adolescent, drug/alcohol, forensic, and trauma services. This was to avoid inclusion of services which might have had either disproportionately high numbers of abused service users or a higher probability that staff would respond to trauma appropriately. (The search identified no studies of specialist services for adults.)

On this basis, 45 of the 852 papers were extracted. Reading the abstracts of these 45 papers led to the exclusion of 33. The main reasons for exclusion were focus on: child/adolescent services (nine); *asking* about abuse (seven); training/guidelines (five); and violence against *adults* (four). Thus, 12 studies meeting the inclusion criteria were identified. Searching for papers that were cited in, or have cited, these 12 studies, identified one more study, producing a total of 13 studies for inclusion.

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

Results

Characteristics of the thirteen studies

Of the 13 studies, four were conducted in the USA (Eilenberg et al., 1996; Mitchell et al., 1996; Posner et al., 2008; Rose et al., 1991); four in New Zealand (Agar & Read, 2002; Cavanagh et al., 2004; Read et al., 2016; Read & Fraser, 1998); three in the UK (Goater & Meehan, 1998; Lab et al., 2000; Scott et al., 2015), and one each in Sweden (Örmon et al., 2014) and Australia (Mansfield et al., 2016). The first study was in 1991. Five were published in the 1990s, four between 2000 and 2009, and four since 2009. This represents a steady rate of only about one every two years. Seven were reviews of case notes, three were interviews with service users, and three were surveys of staff.

- - -   TABLE ONE ABOUT HERE   - - -

Case note reviews

Table 1 shows that five of the seven case note reviews involved outpatients, one studied inpatients and one involved both. The number of case notes varied from 100 (Read & Fraser, 1998; Mansfield et al., 2016) to 680 (Goater & Meehan, 1998). The number of child abuse/neglect disclosures within each study ranged from 24 (Mansfield et al., 2016) to 141 (Read et al., 2016). In five of the seven studies the service users' complete clinical records were reviewed. Two studies (Eilenberg et al., 1996; Posner et al., 2008) reviewed only the records of the 'in depth evaluations of new patients', conducted over three separate visits, which 'requires the clinician to record a comprehensive formulation and treatment plan' (Eilenberg, 1996, p. 167).

.   Table 1 shows that two studies focused only on CSA, two on CSA and CPA), and one included CSA, CPA, childhood emotional abuse [CEA], child physical [CPN] and emotional neglect [CEN]. The other two used a more general trauma measure, involving lifetime sexual

and physical abuse and 'catastrophic events'. All samples had more women than men, largely because of the greater preponderance of CSA among females, and one was 100% female by design (Goater & Meehan, 1998). Four of the samples were predominantly white/Caucasian (from 56% to 72%). Two were predominantly Hispanic (Eilenberg et al., 1996; Posner et al., 2998). One did not report ethnicity (Goater & Meehan, 1998).

Recording details of abuse/neglect. Four studies reported how often details of the abuse/neglect were recorded in the notes. A study of 32 CSA cases in the USA found that 22 (69%) had no details about the abuse in the file, and ten (31%) recorded only 'some reference to the identity of the abuser' (Goater & Meehan, 1998). Another USA study reported on the files of 72 outpatients who had disclosed either a 'catastrophic event' (8%) or lifetime sexual or physical abuse (92%) (Eilenberg et al., 2016). More than half (61%) of those who had disclosed abuse had experienced it in childhood. The 'precise nature of the trauma' was recorded in 60% of the files. However, the frequency and severity were both noted in only 15%. A ten year follow up at the same clinic (Posner et al., 2008) found significant improvements in the recording of both severity (56%) and frequency (59%). There was, however, no change with regard to 'adequate description of the nature of the trauma' (61%).

A larger study, of 141 New Zealand outpatients (Read et al., 2016), was the only one of the seven case note reviews to include CEA, CEN and CPN. The frequency with which the age that the abuse/neglect started was noted ranged from 68% (CPN) to 98% (CEN). The identity of the perpetrator was recorded (usually in terms of relationship to the patient rather than by name) in from 73% (CPN) to 100% (CEN and CEA) of the files (see Table 1).

Recording previous disclosure or treatment. Following a disclosure it is considered important to ask whether the person has ever told anyone before, and, if so, how helpful was the

response. It is also useful to know whether they have received any support or treatment related to the abuse or neglect. Only three studies, all in New Zealand have studied this. Table 1 shows that the recording of past disclosures or treatment of CSA ranged from 41% in an inpatient study (Read & Fraser, 1998) to 69% in a recent study of outpatients (Read et al., 2016). The equivalent recording for CPA increased from 8% to 54%. This recent outpatient study is the only study to date that has researched how mental health services respond to CEA, CPN and CEN. The rates of recording previous disclosure or treatment were similar to the rates, in the same study, for CSA and CPA, ranging from 50% for CEA to 60% for CEN (see Table 1).

Inclusion in formulations. Four studies researched how often disclosed abuse or neglect is mentioned in summary formulations of the person's problems. In the 2002 New Zealand outpatient study the rates were 22% for CSA and just 12% for CPA (Agar & Read, 2002), increasing significantly to 57% and 47% respectively in the 2016 study (of the same services) (Read et al., 2016). The 45% rate for CEA in the 2016 study was similar to the two other types of abuse, but the rates for both types of neglect were lower: CEN - 33%; CPN - 22%. An early USA outpatient study found that 72% of lifetime trauma (predominantly CSA and CPA) was mentioned in formulations but only 10% 'incorporated the trauma history appropriately' (Eilenberg et al., 1996). This 10% figure had increased only slightly, to 14%, in the ten year follow up at the same clinic (Posner et al., 2008).

Treatment. Five studies reported on treatment plans. Table 1 shows that the rates of inclusion of CSA ranged, across three studies, from 17% in a recent Australian outpatient study to 44% in the recent New Zealand outpatient study. The rates for CPA, in just two studies, were 12%

and 24%. The only rates ever reported for CEN (15%) and CPN (14%) were lower than the rates for the three types of abuse in the same study, which ranged from 24% to 44%.

The New Zealand inpatient study found that 35% of CSA cases and 25% of CPA cases led to consideration of possible referral (Read & Fraser, 1998). The three New Zealand studies found that the rate of *actual* referral for abuse/neglect-related therapy ranged from 12% to 23% for CSA and from 8% to 20% for CPA (see Table 1). Again, the rates for neglect were lower than those for abuse in the same study: CEN - 11%; CPN - 14% (Read et al., 2016). Only one study has assessed how many abuse disclosures actually led to abuse-related therapy. The 2002 study of disclosures by 74 outpatients at a New Zealand Community Mental Health Centre (CMHC) found that two of the 40 CSA disclosures (5%) led to therapy within the CMHC in which the notes of any of the sessions mentioned CSA. Just one of the 34 CPA disclosures (3%) led to therapy where the CPA was ever mentioned (Agar & Read, 2002).

Reporting to the authorities. Only three studies have researched reporting to legal authorities. None of the 29 cases of child abuse in the New Zealand inpatient study (Read & Fraser, 1998) or the 74 cases in the first of the two New Zealand outpatient studies (Agar & Read, 2002) were reported. Furthermore, there was no record of that possibility even being discussed with any of the patients. Of the 141 people in the 2016 New Zealand outpatient study whose file included a record of child abuse or neglect, three files (2%) recorded that the police had been notified (Read et al., 2016). In a further three cases there was a record of a discussion about the possibility of notifying the police.

Asking about perceived connection between abuse and current problems. The only study

to have researched the issue (Read et al., 2016) found the following frequencies of asking

people if they thought their current difficulties were related to their abuse/neglect: CSA 33%

(27/81); CPA 24% (22/91); CEA 22% (19/88); CEN 29% (16/51); CPN 22% (6/22).

Support or information during hospitalisation. In the New Zealand inpatient study the

files of the 17 people who had disclosed CSA, and of the 12 who had disclosed CPA,

'include no mention of any staff action in relation to the abuse disclosures, in the form of

providing information, support, counselling or the opportunity to discuss relevant issues'

(Read & Fraser, 1998; pp. 208,209).

Changes over time. Two of the seven case notes studies were follow-ups to two earlier

studies. The Agar and Read (2002) New Zealand outpatient study was based on data from an

Auckland CMHC in 1997. In 2000 Auckland District Health Board (DHB) introduced new

best practice recommendations on how to enquire into clients' abuse/trauma histories and

how to respond therapeutically to disclosures (Cavanagh et al., 2004; Read et al., 2005) in

order 'To ensure that routine mental health assessments include appropriate questions about

sexual abuse/trauma, and that disclosure is sensitively manage'. Following the introduction of

this policy, the DHB mandated mental health staff to undertake training on how to enquire

about adverse childhood experiences, and how to respond to disclosures. This one day

programme was piloted, with positive outcomes (Cavanagh et al., 2004), and then offered to

groups of staff several times a year, for nine years. The follow up study (Read et al., 2016)

reported on files from all four Auckland CMHCs including the CMHC that had been the

basis of the Agar and Read (2002) paper. Table 1 shows that there were marked

improvements across three domains. For example, inclusion in treatment plans increased

from 20% to 44% for CSA and from 12% to 24% for CPA. Much smaller changes occurred

for actual referrals for therapy, from 17% to 23% for CSA, and from 15% to 20% for CPA. Reporting to the police, however, only increased, from 0%, to just 2% for both types of abuse.

As noted, the follow up (Posner et al., 2008) of the 1996 study by Eilenberg and colleagues at a USA outpatient clinic, with no new policies or training in the intervening years, found impressive increases in the recording of details, from 15% to 56% for severity and from 15% to 59% for frequency. There was, however, only a tiny increase in inclusion in formulations (10% to 14%) and no increase in inclusion in treatment plans (10% to 9%).

Interviews with service users

Three studies involved interviewing users of adult psychiatric services who had experienced child abuse, one each in the UK, the USA and Sweden. The earliest involved interviews with 50 male and 39 female heavy users of inpatient and emergency services in the USA (Rose et al., 1991). Forty one disclosed CSA or CPA when asked about abuse in the interviews. Of those who had raised their abuse with staff (number unspecified) only three had received any response at all. None of these responses 'were appropriate to their needs for legitimation or ongoing support based on the lasting impact of their history of sexual or physical abuse' (p.501).

In the Swedish study (Örmon et al., 2014) nine women who had been abused (eight CSA, CPA or both) and were attending a psychiatric clinic were asked. 'Can you tell me how you were cared for when you told the staff that you had experienced physical, emotional and/or sexual abuse?'. The women described how 'the staff were divided into two groups, those who believed the women's experiences of abuse and saw the consequences and their effect on their everyday lives, and those who said that the abuse was a secondary issue, misbelieved the women and focused solely on the mental disorder' (p.2310). Examples included.

'The staff said that I could talk to them about it whenever I wanted, and I felt that they were loving and kind towards me, and I needed that. It made me feel better.'

'They just focus on the eating disorder. . . . It would have been good if they'd dug deeper, gone back in time and really worked with what had happened.'

'There's been a focus on the medication and 'I' have just been just passed by.'

'When you've talked about it a number of times without being believed and when people say 'yes, yes, ok' then you lose your self confidence and start thinking, how can I be able to trust someone if people don't believe what I say.' (pp. 2307-2308).

In 2012 the UK's Department of Health funded research on how mental health services respond to the needs of survivors of violence and abuse. Twenty one users of some of the National Health Service Trusts where routine enquiry about abuse had been implemented were interviewed (Scott et al., 2015). Fourteen of the 17 women interviewed had experienced either CSA or CPA. All four of the men had experienced CSA. The findings were reported in generic rather than numerical terms.

'Survivors commented that some staff - particularly, but not exclusively those working in in-patient services - seemed not to view their experiences of abuse as relevant to their mental health'.

'It was not unusual for disclosures to be dismissed or set aside as less important than

the treatment of immediate symptoms. . . . . There were other examples of people

repeatedly asking for help to deal with their experience of abuse and only being

offered medication.'

'Some were assessed as having a need for support but then nothing happened, or

established a relationship with one person or service and were then moved onto

another.'

'The value of individuals (whatever their discipline and skills) listening,

understanding and responding cannot be under-estimated.' (Scott et al., 2015; pp.4-6).

Surveys of mental health staff

Three studies reported on self-report questionnaires assessing staff responses to disclosures.

The earliest involved a questionnaire about nursing staff practice in relation to CSA, sent to

nurse managers at 1,410 psychiatric inpatient units in the USA (Mitchell et al. 1996). Of the

342 that responded and indicated that CSA histories were taken in their unit, 147 (43%)

reported that the patient 'received inpatient therapy specifically related to the issues of sexual

abuse' and 148 (43%) reported that the patient was referred for 'outpatient therapy upon

discharge'. The percentages of all the units whose managers responded to the survey (466)

and where CSA led to inpatient or outpatient therapy were therefore 31% and 32%

respectively. Ten of the 342 (3%) reported that their unit just recorded the abuse and 'gave no

further attention to the issue unless it was raised by the patient' (p.163).

A British study also focused exclusively on responses to disclosures of CSA, but by male

patients only (Lab et al., 2000). A questionnaire was sent to 179 psychiatrists, psychologists

and nurses at a London hospital, and 111 (62%) responded. The two most endorsed (forced

choice) responses to the question about what they do if they 'learn a client has a history of sexual abuse' were: 'Address the issue with the client' and 'Tell another professional' (both 60%), followed by 'Give community options' (42%) and 'Refer to psychologist' (34%). The two least favoured were 'refer to psychiatrist' (7%) and 'refer to a social worker (4%). 'No action' was endorsed by 11%.

A New Zealand study surveyed 85 mental health staff (53% nurses) prior to a training day about asking about abuse (Cavanagh et al., 2004). They estimated the percentage of disclosures in response to which they use each of five responses: 'Record disclosure in client's file' (86%); 'Offer to refer for abuse-related counselling' (79%); Provide information about sexual abuse agencies (78%); Provide information about sexual abuse (58%); and 'Offer to provide abuse-related counselling yourself' (12%). A subset of 25 of these staff were given (prior to been given the check list above) an open ended item asking them to list the most important things they do in response to disclosures. The most common responses were: Offer to refer for, or give information about, counselling (68%); Affirm that it was a good thing to have disclosed (56%); Check whether client is now safe from abuse (56%); and Ask whether the client thinks there is a connection between the abuse and their current difficulties (32%).

Variables related to level of response

Diagnosis. A relationship between poorer response levels and a psychosis diagnosis was found in all three studies that investigated the relationship. The New Zealand inpatient study found that only one of the 20 patients diagnosed with a psychotic disorder (5%) was considered for referral for abuse-related therapy, compared to seven of the 12 (58%) non-psychotic patients ($p < .001$) (Read & Fraser, 1998). The first New Zealand outpatient study (19) found a consistent pattern, across all types of abuse, of clients with schizophrenia-

spectrum diagnoses eliciting lower response frequencies (Agar & Read, 2002). None of them had their abuse or neglect mentioned in either formulations or treatment plans. The only statistically significant difference, however, was that schizophrenia spectrum diagnoses elicited less documentation of previous disclosures or treatment (12% vs 38%; p < .05). The latest New Zealand outpatient study found that clients with a psychosis diagnosis were significantly less likely to have their abuse recorded in formulations or treatment plans or to be referred for abuse-related therapy, compared to all other diagnoses combined (Read et al., 2016). With regard to CPA, for example, none of those with a diagnosis of psychosis were referred, compared to 26% of those with other diagnoses (p < .01). There were, however, no parallel differences in relation to neglect.

Gender of service users. The inpatient study found that all three of the abused people who were referred for abuse-related therapy were women (Read & Fraser, 1998). The 2002 outpatient study found a consistent pattern of insignificant trends towards women receiving better responses than men. Women were slightly more likely to have the CSA or CPA included in formulations (40% - 35%) and treatment plans (39% - 20%); to be referred for therapy (18% - 13%) and to receive therapy (6% - 3%) (Agar & Read, 2002). The difference in documentation of previous disclosure or treatment (42% - 13%) was significant (p < .001). The Australian study found that 17% of the CSA of the women was mentioned in treatment plans (4/24) but this was not the case for any of the four men (Mansfield et al., 2016). The recent New Zealand outpatient study did not, however, replicate any of these differences (Read et al., 2016). The interviews with 21 UK service users (Scott et al., 2015) found that:

'Participants also noted that staff could stereotype them on the basis of gender. Male

survivors reported a lack of awareness and support, with men still not being viewed as

legitimate victims of abuse. Women still experienced services labelling them as 'hysterical' and 'attention seeking'.

Gender of staff. The first New Zealand outpatient study found a consistent pattern of insignificant trends towards female staff providing higher levels of responses than their male counterparts (Agar & Read, 2002). They were, for example, twice as likely to refer for abuse-related therapy (22% - 11%). But, as was the case for the service users, the only statistically significant difference was in relation to documenting previous disclosures or treatment (46% - 22%; $p < .05$). No significant differences were found in the more recent outpatient study (Read et al., 2016).

Age. The only studies to have analyzed their data in relation to age of service users were the three New Zealand studies. Neither outpatient study found any differences. The inpatient study had found that the mean age of those considered for referral to therapy was 32, compared to 39 for those not considered ($p < .05$) (Read & Fraser, 1998).

Ethnicity. The only studies to have analyzed data in relation to ethnicity of service users were the three New Zealand studies. None found any differences between ethnic groups in rates of any responses.

Profession. Only two studies investigated the profession of the staff. The first New Zealand outpatient study (Agar & Read, 2002) found that when the primary clinician was a psychiatrist the response level was lower than all other professions combined for all types of responses measured (inclusion in formulations and treatment plans, documentation of previous disclosures, and referrals for therapy. For example 21% of psychiatrists included the

abuse in the treatment plan compared to 53% of the psychologists, nurses and social workers combined (p < .05). While 8% of psychiatrists referred for therapy, 34% of the other professions did so (p < .01).

The British study that was focused on CSA of men found that 92% of psychologists self-report that they 'address the issue with the client', compared to 48% of psychiatrists and 41% of nurses (Lab et al., 2000). Psychiatrists were also more likely to report taking 'no action' (24%) compared to 10% of psychologists and 5% of nurses.

Type of Abuse/Neglect. Table 1 shows that the New Zealand inpatient study found a consistent pattern of CSA eliciting slightly higher response levels than CPA, but the only significant difference was for documentation of previous disclosures or treatment (41% vs 8%; p < .05). The 2002 New Zealand outpatient study also found a consistent pattern of CSA eliciting higher response frequencies than CPA. For example, CSA was found in 22% of formulations, compared to 12% for CPA. Again, however, the only statistically significant difference was for documentation of previous disclosures or treatments (55% vs. 29%) (p < .01).

The 2016 New Zealand outpatient study was the only study to research responses to five types of abuse and neglect. CSA received the highest rate across all responses. For all types of response except reporting to authorities the three types of abuse elicited higher rates than the two types of neglect (see Table 1).

The two outpatient studies allowed comparisons of amount of change over time for CSA and CPA (see Table 1). The largest change was for inclusion of CPA in formulations, which involved an almost four-fold increase from 12% to 47%. There was little change, however, in referrals for treatment; CPA increased from 15% to 20% while CSA improved from 18% to 24%.

Discussion

Scarcity of studies

The first of the two primary findings of this review is the shortage of studies into what the etiological studies summarized earlier suggest ought to be a primary focus for researchers interested in the quality of mental health services. The total of 13 studies that have ever produced data about how clinicians respond to child maltreatment is even lower than the 21 investigating how often mental health services ask about it (Read et al., 2018). No variable has been the subject of more than five studies (see Table 1). It seems the capacity of our mental health services to ignore child maltreatment is paralleled by our research community.

Summary of findings

The second primary funding is that although the studies are few in number, and variable in their focus and methodology, they consistently suggest poor clinical practice. This is the case in all five countries where research has been undertaken. Furthermore, the frequency of response dwindles as we approach actually doing anything, from a range of 12% - 57% for inclusion in formulations, through 12% - 44% for inclusion in treatment plans, to just 8% - 23% for actually referring for appropriate therapy. Rarely were any of the instances of abuse or neglect reported to authorities. Nor were there even any discussions of the complex pros and cons of reporting. All these figures must be considered, moreover, in the context of the finding that the majority of service users are never asked about child maltreatment (Read et al., 2018). Given that of all the cases of child maltreatment found by researchers in users of mental health services only an average of 28% can be found in their medical notes, the figures above can be divided by about four to estimate the number of maltreated people who are responded to appropriately by psychiatric services. Thus, in reality, approximately 2% to

6% are referred for appropriate treatment. The odds for people diagnosed with psychosis, and for men, are even smaller. This is because both groups are not only less likely to be responded to properly but are less likely to be asked in the first place (Read et al., 2018).

Barriers to good clinical practice

In order to improve practice it is helpful to understand the many and diverse barriers to asking about, or responding humanely and effectively to, child maltreatment. These have been identified, primarily through staff surveys (Cavanagh et al., 2006; Day et al., 2003; Donohoe, 2010; Gallop et al., 1995; Lab et al., 2000; Mansfield et al., 2016; Mitchell et al., 1996; Young et al., 2001), and are listed in Table 2.

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Implications for practice: Training and service culture

One of the most consistently cited barriers is lack of training. Training programmes that address both asking and responding, often based on the New Zealand programme (Cavanagh et al., 2006; Read et al., 2007), have been evaluated as effective in improving clinical practice (Currier & Briere, 2000; Day et al., 2003; 34-37; McNeish et al., 2008; Lotzin et al., 2018; Walters et al., 2015).

The New Zealand, 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). It has been found to produce changes in attitudes and clinical practice (Cavanagh et al., 2004). The training programme has been adapted for use with German substance use healthcare professionals (Lotzin et al., 2018)

A similar one day training programme was delivered in eight Trusts in England

as part of a NHS policy initiative (Department of Health, 2015; McNeish & Scott, 2008). Its 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).

The specific findings of the current review about which types of people may be less likely to receive appropriate responses to disclosures (people diagnosed with psychosis, those neglected as children, and men) and which staff may be less likely to respond well (men and psychiatrists) can usefully inform the design of training programmes. Similarly, training needs to keep in mind the findings that referrals for abuse-related treatment seem not to occur very often and referrals to legal authorities hardly ever. Perhaps the existing training programmes mentioned above can be adjusted to local circumstances after surveying the local mental health work force about their beliefs and current practice. Training programmes should emphasise that there is strong evidence that that most service users are not distressed by being asked about abuse (Lothian & Read, 2002; Department of Health, 2015; Scott et al., 2015).

Policies and training, however, are only like to produce sustainable change if the service, including senior clinicians and managers, develops a culture that acknowledges the role of adversities and trauma in the creation of, and solutions to, human distress. Examples of such 'trauma-informed services' are emerging around the world (Bateman et al., 2013: Brooker et al.,2016a; Brooker et al., 1016b; Muskett, 2014; N.H.S., 2008; Sweeney et al., 2016; Toner et al., 2013; S.A.M.H.S.A., 2014).

What is required is a positive, trauma-focussed culture for the service as a whole, without which any specific gains from policies and trainings may be short lived. The basic idea is that all health and mental health professionals interact with service users in a way that facilitates recovery from any trauma or adversity that has led to their problems, while avoiding re-

traumatisation through use of force, or dismissal of the existence, or effects, of abuse or neglect.

Thus, in order to respond appropriately to the needs of people using mental health services, the evidence of this review leads to the recommendations listed in Table 3.

- - - TABLE THREE ABOUT HERE - - -

Limitations

The most obvious limitation of the review is the scarcity of studies, and their being spread thinly over a long time period. This limits the validity of the review. This scarcity is also, however, an important finding in its own right. Hopefully publishing it will encourage more research. The review excluded staff responses to disclosures of sexual and physical assaults in adulthood (Humphreys et al., 2003; Oram et al., 2017) including by mental health staff (Örmon et al., 2017). It also focused only on positive staff responses to the exclusion of negative responses, such as the finding that people who were maltreated as children are more likely to be restrained and secluded (Frueh et al., 2005; Hammer et al., 2011; S.A.M.H.S.A., 2014), which can be retraumatizing. It was, however, the only review to date to report on the responses of all types of staff to all types of child abuse and neglect.

It should be noted that standards such as reporting abuse to police or other authorities are much more entrenched now than they were in the 1990s when some of the studies were conducted.

The three types of studies reviewed here do not readily lend themselves to ratings of quality of evidence designed more for treatment trials in general, and randomised controlled trials (RCTs) in particular, where effect sizes are estimated (GRADE, 2004). It should be acknowledged, nevertheless, that by these standards all the studies would probably be evaluated as 'low' quality. It is particularly important to note that the findings of the seven

studies that relied on clinical notes may not accurately or fully reflect actual clinical practice. For example, some disclosures may have been responded to well but may not have been documented in the notes. If this was the case to any great degree, however, it would itself constitute a falling short of ideal clinical practice because accurate documentation of these issues is important.

Conclusion

Future training should include a focus on responding to neglect and to people diagnosed with psychosis, on making appropriate referrals, and on how to conduct discussions about reporting to authorities. The failure of both practitioners and researchers to pay due attention to trauma and adversity is alarming, but consistent with the rather simplistic bio-genetic ideology that currently dominates the mental health world. A paradigm shift involving a move to trauma-informed approaches is long overdue, in order to render services humane, effective and evidence-based.

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Table 1.

Summary of main findings from the seven case note reviews regarding staff response to child maltreatment

Study; number of abuse cases recorded	Types of abuse studied	Abuse/ neglect information recorded	Past disclosures or treatment noted	Included in Formulation	Included in Treatment Plan	Referred for abuse-related therapy	Received abuse-related therapy	Reported to Author-ities
Read & Fraser 1998. 29 NZ inpatients	CSA		41%			12%		0%
	CPA		8%			8%		0%
Agar & Read 2002. 74 NZ outpatients	CSA		55%	22%	20%	18%	5%	0%
	CPA		29%	12%	12%	15%	3%	0%
Read et al 2016. 141 NZ outpatients	CSA	80%-93% [1]	69%	57%	44%	24%		2%
	CPA	85%-97% [1]	54%	47%	24%	20%		2%
	CEA	92%-100%[1]	50%	45%	26%	18%		2%
	CEN	98%-100%[1]	60%	33%	15%	11%		2%
	CPN	68%-73% [1]	55%	23%	14%	14%		0%
Mansfield et al 2016. 24 Australian inpatients/ outpatient	CSA				17%			
Goater & Meehan 1998. 32 UK outpatients	CSA	0%-31% [2]						
Eilenberg et al 1996. 72 USA outpatients	Lifetime physical /sexual abuse	15%-60% [3]		10%-72% [4]	10%-44%[6]			
Posner et al 2008. 54 USA outpatients	Lifetime physical /sexual abuse	56%-61% [3]		14% [5]	9% [7]			

CSA - child sexual abuse; CPA - child physical abuse; CEA - child emotional abuse; CEN – child

emotional neglect; CPN - child physical neglect

1. age abuse/neglect started – perpetrator. 2. 'details of abuse' - perpetrator

3. 'severity' - 'nature of abuse'. 4. 'appropriately incorporated' – 'mentioned'

5. 'thorough formulation'.   6. trauma related recommendations - 'mentioned'

7. 'thorough treatment plan'

Table 2.

 Barriers to asking about, or responding humanely and effectively to, child maltreatment.

Lack of training in, and confidence about, asking and responding
Fear that talking about it will distress clients and make their problems worse
Lacking knowledge about prevalence and effects of child maltreatment
Feeling there are more immediate concerns to deal with
Believing that one should not talk about child abuse with clients whose problems one thinks are irrelevant to child abuse (for example psychosis)
Believing that disclosures by 'mental patients' are often false, imagined or delusional
Holding strong bio-genetic causal beliefs

Table 3.

Seven recommendations to improve clinical practice.

That routine enquiry of trauma and adversity is monitored by service providers for gender biases and professional resistance
That disclosures and safeguarding are governed
That disclosures of abuse are understood within a formulation framework that is co-produced with service users
That such understanding of the role of childhood maltreatment in the presenting problem is adequately accounted for in the care plan
That services provide appropriate access to trauma specific therapies
That healthcare providers provide training and supervision that integrates trauma-informed practices into the service culture so that it is not seen as an added extra
That the testimonies of people with lived experience of adversity are given primacy in shaping services