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Are mental health services getting better at responding to abuse, assault and neglect?

Read J, Sampson M, Critchley C. Are mental health services getting better at responding to abuse, assault and neglect?

Objective: To determine whether staff responses to abuse disclosures had improved since the introduction of a trauma policy and training programme.
Method: The files of 250 clients attending four New Zealand mental health centres were audited.
Results: There was a significant improvement, compared to an audit prior to the introduction of the policy and training, in the proportion of abuse cases included in formulations, and, to a lesser extent, in treatment plans. There was no significant improvement in the proportion referred for relevant treatment, which remained at less than 25% across abuse categories. The proportion of neglect disclosures responded to was significantly lower than for abuse cases. Fifty percent of the files in which abuse/neglect was recorded noted whether the client had been asked about previous disclosure, and 22% noted whether the client thought there was any connection between the abuse/neglect and their current problems. Less than 1% of cases were reported to legal authorities. People diagnosed with a psychotic disorder were significantly less likely to be responded to appropriately.
Conclusion: Future training may need to focus on responding well to neglect and people diagnosed with psychosis, on making treatment referrals, and on initiating discussions about reporting to authorities.

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Key words: child abuse; neglect; rape; physical assault; therapeutic response

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Significant outcomes

- Following introduction of a trauma policy and training programme, the proportions of child/adult sexual/physical abuse included in formulations and treatment plans increased.
- Actual treatment referrals and reports to legal authorities remained low.
- Clients who had been neglected as a child, and those diagnosed psychotic, received fewer appropriate responses than other clients.

Limitations

- Improvements may have been due to general increased awareness about child abuse.
- Reliance on file notes almost definitely result in some abuse and neglect cases being missed.
- Some staff may have responded in a helpful way but not recorded that in the file.

Introduction

Childhood adversities, such as abuse and neglect, are risk factors for most mental health problems, including: depression, psychosis, anxiety disorders, eating disorders, sexual dysfunction, personality disorder, dissociative disorder and substance misuse (1–5).

Moreover, childhood abuse is related to severity of disturbance whichever way one defines severity. People subjected to childhood physical or sexual abuse are more likely to: be admitted to a

psychiatric hospital; have earlier, longer and more frequent admissions; receive more antidepressant and antipsychotic medication; self-harm and try to kill themselves (3, 6–9). A review of 52 in-patient studies (10) found that more than 50% of the men and over 60% of the women had been either sexually or physically abused as children.

Victims of child abuse are at risk for revictimization in adulthood (11); and being subjected to violence in adulthood further increases the risk of mental health problems (10, 12).

The researchers who produce these findings have frequently recommended that mental health services routinely enquire about abuse and neglect, and that staff be trained in how to ask about abuse and how to respond to disclosures. In 2008, the National Health Service in the UK published guidelines which called for all mental health service users to be asked about abuse and all staff to be trained in how to do that (13). Nevertheless, there is still little research examining whether services *do* ask, and even less evaluating how they *respond* to disclosures of abuse and neglect.

Six studies between 1988 and 1996 found that between 0% and 30% of child abuse was being identified by mental health services in the UK and the USA (14). A 2013 review, having commented on the poor quality and quantity of the literature, confirmed that 'mental health professionals do not routinely enquire about childhood sexual abuse' (7, p.473). The reviewers suggested, again, 'that mental health service providers introduce mandatory enquiry' and called for staff training. The following year a review of studies relating to domestic violence arrived at similar conclusions and recommendations (15).

Response of mental health services to disclosures of abuse

The very few studies that have examined how mental health services respond when people do disclose abuse are difficult to compare because of the diverse types of abuse and categories of staff responses measured, and the range of methods deployed. All, however, report extremely inadequate responses.

The earliest study, in 1991, found that when people in a US intensive psychiatric care facility tried to discuss their abuse histories with clinicians none of the responses were appropriate to the clients' abuse-related needs (16). A US out-patient study found that only 10% of the charts containing trauma histories had summary formulations or treatment plans that incorporated the trauma history (17). A follow-up study at the same clinic, ten years later, found that 14% of the trauma was included in a formulation and 9% in a treatment plan (18). A study of a US community mental health centre [CMHC] found that none of the files which documented trauma exposure and a PTSD diagnosis had a treatment plan that addressed the trauma (19).

A review of 100 charts at a New Zealand in-patient unit (20), focusing on sexual and physical abuse in childhood or adulthood, found that 91% of the files of the abused patients made no mention of any staff action in the form of information sharing, support, counselling or discussion about abuse, during the admission. A referral for postdischarge abuse-focused therapy was made for 9% of the abused patients (and in all of these cases the referral was for continuation of interrupted therapy rather than an initiation of new therapy). Thus, for 91% of those who disclosed abuse, there was no documentation that the abuse was addressed in any way either during or after hospitalization. Furthermore, none of the alleged crimes, some of which were recent or ongoing, were reported to the authorities, and in only one case was there any discussion of the possibility of making such a report.

A subsequent study (21) of 200 files at a New Zealand CMHC in 1997 (with which the findings of the current study will be compared) found that of 92 cases in which lifetime sexual or physical abuse was documented in the file, the abuse was included in a case formulation in 16 cases (17%), and in a treatment plan in 15 cases (16%). Documentation regarding previous disclosure of abuse (i.e. prior to the current CMHC treatment) was found in 30 of the 92 (33%). Fifteen (16%) were referred for abuse-related therapy. No record was found of any of the recorded abuse being reported to legal authorities, or of any discussion with any of the abused/assaulted clients of the possibility of such a report being made (21).

Two recent qualitative studies in London, focussed specifically on domestic violence, have found that both service users and professionals believe that the medical diagnostic and treatment approach can be a barrier to inquiry (22) and that service users experience mixed responses from staff following disclosure (23).

Context of current study

Two of the studies summarized above, both in New Zealand – one in-patient and one out-patient – have examined whether adequacy of responses are related to abuse type, diagnosis or client demographics (20, 21). The three consistent findings across both studies were that men, victims of

physical assault in adulthood and people with a diagnosis indicative of psychosis (e.g. 'schizophrenia') were even less likely to receive an adequate response than other service users.

In 2000 Auckland District Health Board (ADHB), where the CMHC assessed in 1997 (21) and the four CMHCs assessed in the current study are located, had introduced new best practice recommendations on how to enquire into clients' abuse/trauma histories and how to respond therapeutically to disclosures (24), in order 'to ensure that routine mental health assessments include appropriate questions about sexual abuse/trauma and that disclosure is sensitively managed'. Following the introduction of this new policy, the DHB mandated mental health staff to undertake a training course on how to enquire about adverse childhood experiences, and how to respond to disclosures. This evidence- and skill-based one-day programme was piloted, with positive outcomes (24), and then offered to small groups of staff several times a year, for nine years. The morning focussed on research documenting the prevalence and effects of abuse and neglect and about current rates of enquiry and response in mental health services; the pros and cons of asking and not asking; and discussions about helpful and unhelpful ways to respond to disclosures. The afternoon was taken up primarily with role-plays relating to asking and responding. The programme is outlined by Cavanagh et al. (24) and Read et al. (14) and described in detail by Read (25).

The four CMHCs in which the current study was conducted were all typical of New Zealand CMHCs in that they provided both medication and, to a lesser extent, psychological treatments, and had no specialized trauma services.

Aims of the study

The current study was designed as a follow-up study to assess whether practice has improved since the introduction of the policy and training programme. It went beyond the earlier study (21), however, by including staff responses to neglect and emotional abuse and by examining whether clients had been asked whether they thought there was any connection between their adversities and their current difficulties (a recommendation of the training).

Methods

Approval was obtained from the ethics committees of the University of Auckland and the Auckland District Health Board [ADHB].

Sample selection and characteristics

A list of 250 files of adult users (18 or older) of the four CMHCs in ADHB were generated at random. Exclusion criteria were as follows: files that had been active in the system for less than four days; and files opened prior to January 1, 2001 – to avoid including the same events as the earlier study with which comparisons were to be made (21).

The sample consisted of 122 women and 128 men. The mean age was 35.6 years (SD: 12.3). The majority of participants were either New Zealand European (55.6%) or Māori (24.0%), and were commonly single (50.4%) and unemployed (52.4%). The most frequent diagnoses were mood (45.4%) and psychotic (23.5%) disorders.

Data collection

The 250 files were read in their entirety by the two researchers (taking an average of 140 minutes per file). A data form was developed specifically for this study to collect clinical and demographic information. This included whether the following types of adversity were recorded anywhere in the file: 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]. The staff responses to these identified abuse histories were recorded as follows:

i) Whether the adversity was mentioned in a formulation.
ii) Whether the adversity was mentioned in a treatment plan.
iii) Whether the client had been referred for treatment which the notes explicitly identified as adversity-related.
iv) Whether the client had been asked whether s/he had ever disclosed the adversity to anyone before the current disclosure.
v) Whether the client had been asked if he/she thought that there was any connection between their adverse experiences and their current mental health difficulties.
vi) Whether there had been any discussion of the possibility of reporting alleged crimes to the police or other authorities; and whether any such report had been made.

Data analysis

Data were analysed using the IBM SPSS Statistics 23.0 package, and a significance level of <0.05. Comparisons involving categorical data were con-

ducted using the chi-square (X^2) test of independence (with df = 1 in all cases), or, where any expected cell counts were less than five, Fisher's exact test. Analyses relating to diagnoses examined differences between the two largest groupings, depression and psychosis. Differences relating to age, which constituted continuous data, were examined using two-tailed independent sample t-tests (tests of kurtosis and skewness revealed normal distribution).

Results

One or more forms of *childhood* abuse or neglect were recorded in 141 of the 250 files (56%), specifically CPA 91 (36%), CEA 88 (35%), CSA 81 (32%), CEN 55 (22.0%) and CPN 22 (9%). One or more forms of *adulthood* abuse or neglect were recorded in 88 files (35%), specifically APA 61 (24%), AEA/N 54 (22%) and ASA 36 (14%). Women had significantly higher rates recorded for all categories except CPA.

Formulations, treatment plans and referrals

Child abuse/neglect. Table 1 shows that the proportion of the recorded childhood abuse or neglect that was included in a formulation ranged from 57%, for CSA, to 23%, for CPN. Similarly, the percentages that were included in treatment plans varied from 44% for CSA to 15% for CPN. In terms of referral for relevant treatment, CSA again elicited the highest response (23%), but the lowest response was for CEN (11%).

Childhood neglect (both types combined) was less likely than childhood abuse (all three types combined) to be included in formulations (31% vs. 50%; $X^2 = 9.4$, $P < 0.01$) or treatment plans (14% vs. 31%; $X^2 = 8.5$, $P < 0.01$). However, of the 11 cases of neglect that did get included in treatment plans there was evidence in the file that nine (82%) received an actual referral. This was the case for 53 of the 81 abuse cases (65%). The worst attrition rate between planning and referral was for CSA, where only 53% of the cases made the transition from treatment plan to actual referral.

Table 1. Proportion of files where documented abuse/neglect was recorded in the formulation and treatment plan, and was referred for related treatment

	N	Recorded in formulation	Recorded in treatment plan	Referred for treatment
Child sexual abuse	81	46 (56.8%)	36 (44.4%)	19 (23.5%)
Child physical abuse	91	43 (47.3%)	22 (24.2%)	18 (19.8%)
Child emotional abuse	88	40 (45.5%)	23 (26.1)	16 (18.2%)
Child physical neglect	22	5 (22.7%)	3 (13.6%)	3 (13.6%)
Child emotional neglect	55	18 (32.7%)	8 (14.5%)	6 (10.9%)
Adult sexual assault	36	11 (30.6%)	13 (36.1%)	7 (19.4%)
Adult physical assault	61	19 (31.1%)	14 (23%)	7 (11.5%)
Adult emotional abuse or neglect	54	16 (29.6%)	10 (18.5%)	6 (11.1%)

Adult abuse/neglect. There was less variation in responses between the three types of adulthood abuse/neglect (see Table 1). When compared to responses to the parallel types of *child* abuse/neglect, the only significant differences were that ASA was less frequently included in formulations than CSA (31% vs. 57%; $X^2 = 6.9$, $P < 0.01$) and APA was less frequently included in formulations than CPA (31% vs. 47%; $X^2 = 3.9$, $P < 0.05$). Treatment planning and referral rates were broadly similar to those for childhood abuse/neglect.

Client demographics. There were no significant relationships between the 24 response rates (the three types of response to the eight types of abuse/neglect) and gender, ethnicity or age.

Diagnoses. For eight of the 24 response rates, those diagnosed with psychosis were responded to significantly less often than those with a diagnosis of depression. This was the case for all three types of response to both CPA and CEA. In addition, within those subjected to CSA people diagnosed with psychosis were significantly less likely than those diagnosed with depression to have that abuse included in the treatment plan; and within those subjected to AEA/N people diagnosed with psychosis were significantly less likely to have that abuse/neglect included in the formulation. In the case of CPA, for example, 20 of the 29 people diagnosed with depression (71%) had the CPA mentioned in a formulation, but this was the case for only six of the 20 diagnosed with psychosis (26%) ($X^2 = 10.3$, $P < 0.001$). Similarly, the CPA was included in the treatment plans of 12 of the people diagnosed with depression (43%) but none of those diagnosed with psychosis ($X^2 = 12.89$, $P < 0.0001$). Eleven of the people diagnosed with depression (39%) but none of those diagnosed with psychosis were actually referred for relevant treatment ($X^2 = 11.52$, $P < 0.001$).

Overall, of the 100 recorded cases of child or adult abuse/neglect identified in the records of people with a primary diagnosis of psychosis, only three were referred for treatment. All three were CSA cases, representing 18% of the 17 CSA–psychosis cases, compared to 10 of the 22 CSA–depression cases (31.3%) (a non-significant difference; Fisher's exact test). For all other seven types of abuse/neglect, nobody with a primary diagnosis of psychosis was referred for relevant treatment.

However, besides CPA (see above), the only other type of abuse/neglect for which the difference with those diagnosed with depression reached statistical significance was CEA (30% vs. 0%; ($P < 0.05$, Fisher's exact test).

Enquiry about previous disclosure

Of the 160 files in which one or more forms of abuse/neglect were recorded, 80 (50%) had a note about the client being asked whether s/he had ever told anyone before. Of these 80, 12 (15%) had never told anyone before. Fifty-nine of the files of the 68 people (87%) who *had* told someone before had a note about the quality of the response to the previous disclosures (68% of which had been positive). There were no gender, ethnicity or diagnostic differences.

Enquiry into clients' views about connection between abuse and current presentation

Thirty-six of the 160 files (22.5%) in which one or more forms of abuse/neglect were recorded included a note about the client being asked whether they thought there was a connection between the abuse/neglect and their current difficulties. There were no significant differences by ethnicity, gender or diagnosis.

Reporting of potentially criminal offences

Only eight of the 160 files (5%) in which one or more forms of abuse/neglect were recorded indicated that there had been some discussion regarding the possibility of reporting to legal authorities. Only three of the 160 files (2%) stated that the alleged crimes had actually been reported to legal authorities. All three of these were women who had suffered ASA (and at least one other type of abuse/neglect). Thus, from a total of 488 separate cases of abuse or neglect (337 abuse and 151 neglect), less than one percentage were reported to the authorities (one in every 162 overall, and one in every 112 alleged abuse cases).

None of the 100 recorded cases of child or adult abuse/neglect identified in the records of the 62 people with a primary diagnosis of psychosis resulted in any discussion about the possibility of reporting being recorded in the notes.

Changes in practice since 1997

Table 2 compares three response rates for the four types of abuse that were assessed at both time points. Overall response (i.e. combining the frequencies of all three types of response to all four types of abuse) has improved significantly ($X^2 = 81.6$, $P < 0.001$). Overall response has improved significantly for each of the four types of abuse (CSA – $X^2 = 32.2$, $P < 0.001$; CPA – $X^2 = 26.6$, $P < 0.001$; ASA – $X^2 = 14.7$, $P < 0.001$; APA – $X^2 = 11.3$, $P < 0.01$).

Table 2. Proportion of files where the recorded abuse was documented in formulation and treatment plans, and treatment referrals made, in 1997 compared to current study

	Formulation		Treatment plan		Treatment referral	
	1997	Current	1997	Current	1997	Current
Child sexual abuse	22.5% 9/40	56.8%*** 46/81	20.0% 8/40	44.4%*** 36/81	17.5% 7/40	23.5% 19/81
Child physical abuse	11.8% 4/34	47.3%*** 43/91	11.8% 4/34	24.2%* 22/91	14.7% 5/34	19.8% 18/91
Adult sexual assault	6.7% 1/15	30.6%*** 11/36	20.0% 3/15	36.1%* 13/36	20.0% 3/15	19.4% 7/36
Adult physical assault	15.4% 6/39	31.1%** 19/61	10.3% 4/39	23.0%* 14.61	10.3% 4/39	11.5% 7/61

*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$ – greater response than in 1997.

Significant improvement was found in formulation across all four abuse types combined ($X^2 = 74.2$, $P < 0.001$, and treatment plans ($X^2 = 29.3$, $P < 0.001$). There was no parallel improvement, however, in treatment referrals. Table 2 confirms that inclusion in formulations and treatment plans were significantly higher than in 1997, for all four specific types of abuse that were assessed at both time points; but that this was not the case for treatment referral for any of the four abuse types.

The proportion of clients whose files recorded that they had been asked about whether they had told anyone before (in keeping with the training recommendation) increased significantly, from 33% to 50% ($X^2 = 5.9$, $P < 0.05$). The proportion of cases where there was any record of discussing the possibility of reporting to authorities, however, has only increased from 0% to 5%; and the proportion actually reported from 0% to 1% (both non-significant findings).

No comparison can be made with 1997 for the finding that 22.5% of the files included a note about the client being asked whether they thought there was a connection between the abuse/neglect and their current difficulties (also in keeping with training suggestions).

Discussion

Before evaluating the results, we must be clear that the target is not 100% for all the variables assessed. Routine assessment of abuse/neglect

histories *is* recommended for *all* users of mental health services; and it also advisable that positive responses to such enquiries lead to an interest in whether this is the first time the abuse/neglect has been disclosed, how previous disclosures were responded to, and whether the client sees any connection between the abuse/neglect and their current problems (13, 14). It is not the case, however, that 100% of disclosures should be included in formulations. Whether this is appropriate will depend partly on the problem being formulated (which will not always be adversity-related, even when adversity is recorded). Similarly, recorded adversities need not always lead to treatment. This should depend largely on the needs and wishes of the client. Furthermore, it is definitely not recommended that all cases should be reported to legal authorities. This is a complex decision (involving potential retraumatization by legal processes) that should be made in almost all instances by the client (with the exception of imminent risk of serious harm to the client or other people) after consideration of advantages and disadvantages (14).

It should be noted that the latest New Zealand rates of inclusion in formulations and treatment plans, apart from being significantly greater than in the 1997 New Zealand audit, also far surpass the response levels identified in the four US studies discussed earlier (16–19). Nevertheless, there are important areas still in need of improvement.

Neglect

The relatively small proportions of childhood neglect, compared to childhood abuse, that was included in formulations and treatment plans is of concern. Nevertheless, where inclusion did occur, it was highly likely to lead to an actual referral. No comparisons can be made with other studies as this, surprisingly, was the first to include neglect.

Psychosis

The finding that a diagnosis indicative of psychosis continues to be a barrier to appropriate care, particularly in relation to childhood abuse, is disappointing. This is consistent with the two previous New Zealand studies discussed earlier (20, 21). It seems that some clinicians remain unaware of, or are reluctant to act on, the recent avalanche of evidence linking childhood adversities to psychosis (4, 5, 10, 26–30). The finding is also consistent with the finding that in the current sample people diagnosed with a psychotic disorder were also less likely to be asked in the first place (31), so that their chances of having any abuse responded to appropriately is synergistically reduced.

Demographics

The training presented the research showing that older people and men (and people diagnosed with psychotic disorders) are less likely to be asked, and less likely to be responded to, following disclosure (20, 21), and encouraged staff to treat all clients equally. Although the men in this sample were less likely to be *asked* about abuse/neglect (31), there were no gender, or age, differences in any of the types of *response* by gender or age.

Polices and training within trauma-informed services

Despite the significant progress in some areas, future training programmes may need to pay particular attention to responding to neglect and to people with a diagnosis indicative of psychosis. Greater focus on when and how to initiate discussions with clients about whether to report the alleged crimes to legal authorities may also be required. (Such discussion should include the reality that taking a case through the legal system can be retraumatizing).

Polices should be designed not only to mandate training about asking and responding, but to create a positive, trauma-focussed culture for the service as a whole (32–38). Improving coordination with trauma-oriented agencies, such as domestic violence services, is also necessary (39).

The barriers to asking about abuse have received a small amount of research attention (22, 40), but the barriers to responding therapeutically following disclosures remain, apart from a misguided belief in some staff that psychosis is unrelated to adverse life events (20, 21), unidentified.

Limitations

The improvements in responding rates cannot be attributed with any degree of certainty to the policy or training programme. The greater awareness, in general, of the role of childhood adversity in mental health problems that has been developing in recent years (26, 27) may have had an impact.

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

The absence of actual rates of abuse/neglect assessed by a validated instrument renders it impossible to calculate exactly how many adverse experiences were missed. Furthermore, clinicians may well have identified some abuse/neglect, and responded to it in some way, without making a note in the files.

Although inter-rater reliability was assessed for the presence of abuse/neglect in the files (31), this was not the case for the occurrences of the various types of responses. Unlike the presence of absence of some abuse/neglect cases, however, the presence or absence of responses was quite clearly evident in the files, which were read very carefully, for an average of more than two hours each.

Declaration of interest

None of the authors have received any financial payments that represent any conflict of interest either in general or in relation to the current study.

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