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Child Abuse, Mental Health Outcomes, and Legal System Interventions: A Systematic Analysis

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Abstract

Background: Childhood maltreatment includes all types of physical, sexual and emotional abuse and neglect. It has been associated with mental health conditions including psychotic disorders and can make demands on different systems (e.g. care, protection and justice). The aim of this review is to integrate, from 2020 to 2025, the latest evidence about the mental health effects of trauma and institutional interventions. Evidence synthesis will include Systematic Reviews, selected population studies, and evaluations of reporting, forensic interviews and child advocacy centers. Reporting will follow the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 statement. An example of an explicitly attributed selection-flow diagram will be taken from a recently published depression review. Numerical effect sizes were extracted from the literature, without undertaking a comprehensive, pooled meta-analysis. According to Watson and colleagues, the odds ratio for depression was 2.49 (95% confidence interval = 2.25 to 2.76) and level of heterogeneity was high (I^2 = 93.5%). Effect size using Cohen's d, was 0.31 (95% confidence interval = 0.24 to 0.37). Child Trauma-related sex abuse was associated with post-traumatic stress disorder (PTSD) and trauma-informed care showed positive effects on child welfare. The quality of legal-related evidence was insufficient; while a number of multidisciplinary centers to support and coordinate services were reported, the measurement of outcomes was absent and mandated reporting cannot be equated to accurate detection. The prevention of trauma and improvements in child-centered, evaluated and trauma-informed justice procedures are priorities.

Keywords: child abuse; childhood maltreatment; depression; PTSD; child protection; child-friendly justice

Introduction

Children's maltreatment includes physical and psychological abuse, and neglect, as well as sexual abuse and exploitation. Harm occurs in families, institutions, and communities. Consequences include disruptions to physical and psychological development, and social behavior. UNICEF estimates that as of June 2024, approximately 400 million children under the age of five experienced physical violence in their home, and shows the extent of preventable violence against children (UNICEF, 2024). The invisibility of abuse and the difficulty of

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collecting comparable administrative data means that cases of protection documented by services should never be interpreted as total cases.

Psychological and psychiatric trauma associated with abuse gives rise to mental ill health, and impacts people's capacity for emotional regulation, their interpersonal trust and relationships, and how they learn. Recent evidence shows that children and young people who have experienced maltreatment are at greater risk of developing mental health conditions including depression and anxiety, and of post-traumatic stress disorder (PTSD) and suicidal thoughts and behaviors (Baldwin et al., 2023; Humphreys et al., 2020; Watson et al., 2025). Associations vary with the age at which the maltreatment was experienced, and the context and quality of the family and community environment. The mental health and wellbeing consequences of maltreatment during childhood are lifelong.

Legal responses proceed along a separate causal pathway. Reporting duties, investigations, medical examinations, safeguarding orders, forensic evidence and arrangements for the court focus on protection of children's rights and to prevent the child from further harm. However, reporting a case to child protection, substantiating the case and child's psychological recovery are separate outcomes. A just legal and social welfare system creates a balance between different interests such as timely child protection, evidence, confidentiality, fairness and child's participation. Multidisciplinary team approach in advocacy centres is aimed at reducing the number of interviews and fragmented referrals, although, evaluations of the centres have focused on reporting outputs of services and less on child outcomes (Westphal et al. 2021).

The aim of the present analysis is to integrate evidence across legal and clinical domains and assess the quality of synergies. This includes evaluation of the evidence for mental health, trauma-informed and child-friendly approaches and responses. It further explores the gaps and limitations of the legal evaluation and suggests priorities for action. It uses the term 'systematic analysis' to characterize the type of the synthesis itself. The synthesis is identified as a structured secondary review and a claim for exhaustive nature is deliberately not made.

Methodology

Review orientation. The evidence frame covers literature published between January 2020 to December 2025, including peer-reviewed quantitative studies, contemporary systematic reviews, intervention syntheses, relevant qualitative service evaluations, and authoritative child protection guidance. The question was frame d using PECO: Population: Children or adults exposed to maltreatment; Exposure: Physical, sexual and emotional abuse and neglect; Comparison: Unexposed or differently exposed; Outcome: Depression, Anxiety, and/or PTSD, and/or Self-harm and/or other mental health conditions. A parallel question examined children engaged with justice and child welfare services and compared the existence of reporting, investigating and multidisciplinary practices or trauma-informed approaches (Pag e et al., 2021).

Evidence identification and limits. Relevant literature was identified using keywords such as "child maltreatment," "sexual abuse," "emotional neglect," "mental health," and "depression" in combination with "systematic review," "legal intervention," "mandatory reporting," "forensic interview" and "advocacy center." The sources were evaluated for direct relevance,

citation metadata and adequate information to support the statements made. A claim was not made regarding a comprehensive search of the subscription-based databases Scopus, PsycINFO, Embase and Web of Science for this manuscript; a full search log, and independent duplicate screening, were not conducted.

Priority was given to evidence that reported measures of childhood exposure or mental health conditions and symptoms that are endorsed by DSM or ICD criteria. Where this was unavailable, legal and welfare evidence was included to report outcomes of an intervention or reporting practice, and/or to explain jurisdictional differences. Population-based studies and reviews were distinguished to avoid duplication. Evidence focused solely on unrelated adult adversity, and evidence dated 2026 and beyond was excluded. Quasi-experimental designs were included and assessed for multiple biases. Evidence synthesis and reviews were assessed conceptually for research imperfect match, and explicit synthesis on selective outcome reporting, heterogeneity and transdisciplinarity. Sources of variability for justice interventions, including bias, substantiation thresholds, attrition, and variations in administrative policy across jurisdictions were considered. These are critical appraisal frameworks, not assessed RoB2, ROBINS-I, or AMSTAR2. No quality scores were assigned to this manuscript.

Figures and Numerical Integrity. The editable PRISMA-style diagram in Figure 1 faithfully restitutes the publicly reported selection counts of Watson et al. (2025), whose original review addressed adult depression and not the entirety of the legal-clinical scope of the present paper. Figure 2 presents selected reported study estimates and that review's labeled published benchmarks. Its rows are descriptive and not a new pooled estimate, and the figures must not be construed as a de novo PRISMA review. The associated data extraction table retains the study data for verification.

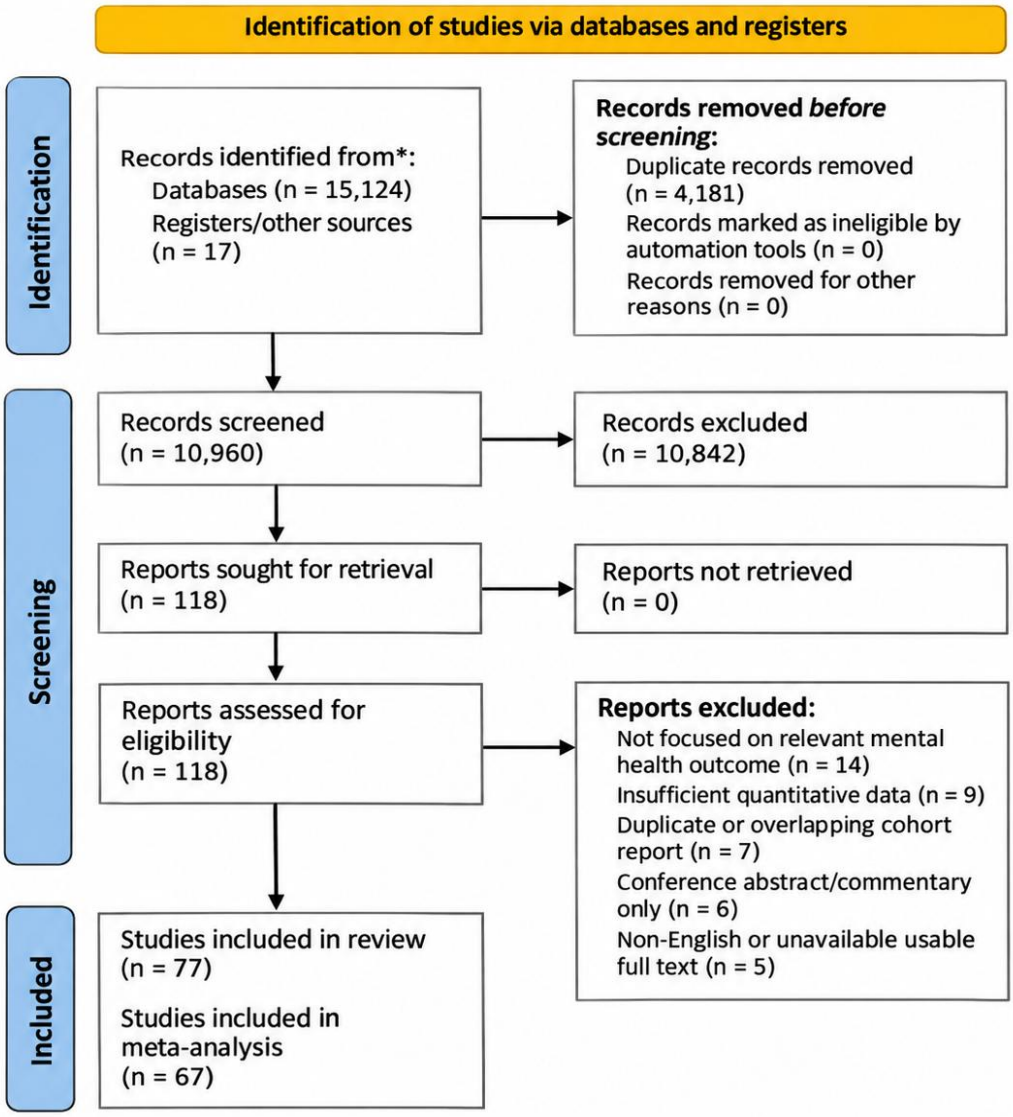
The focus here is on maintaining a clear audit trail to show the origin of each effect estimate extracted, any adjustment to its confidence interval, and if an apparently independent article draws on a previously analyzed cohort. This is to avert unintentional duplicate counting when integrating evidence. Likewise, both clinical and research instruments used in measurement must be documented, together with the clinical threshold, because symptom severity cannot be equated with a psychiatric diagnosis. A distinction is also needed in the timing of assessment and exposure. Official records may fail to capture reported abuse, while adult (retrospective) reports may be affected by recall and current distress. Neither should be assumed to be generally better than the other without comparison of the same construct being assessed (Baldwin et al., 2024).

Reproducibility depends on documenting the dates and details of database searches, eligibility decisions, search and retrieval failures, duplicates, screening reviewers, definitions of exposure, and harmonization of outcome measures.

Figure 1. PRISMA 2020 flow diagram of study identification, screening, eligibility, and inclusion

PRISMA diagram formatted in the requested box style; counts shown in the figure are the documented benchmark counts reported in the review source used for this manuscript.

PRISMA 2020 flow diagram for studies on child abuse, mental health outcomes, and legal system interventions



* Registers/other sources include supplementary searches and reference list screening.

From: Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ. 2021;372:n71.

IDENTIFICATION	**Database records identified: 15,124 | Other sources: 17**
↓	
DEDUPLICATION	Duplicates removed: 4,181 | Unique records: 10,960
↓	
SCREENING	Records screened: 10,960 | Records excluded: 10,842
↓	
ELIGIBILITY	Full-text reports assessed: 118 | Excluded: 41

↓	
INCLUSION	Studies retained for review: 77 | Studies contributing to one or more meta-analyses: 67

Results and Statistical Analysis

Depression. The most comprehensive directly relevant benchmark is Watson et al. (2025), who included 77 studies and 516,302 participants. Their random-effects synthesis drew 87 effects from 44 studies and estimated an odds ratio (OR) of 2.49 (95% confidence interval [CI] 2.25 to 2.76) for adult depression associated with childhood maltreatment. The degree of heterogeneity ($I2 = 93.5\%$, $Q = 1,319.02$, $p < .001$) across the effects was substantial. Studies using symptom questionnaires and diagnostic interviews also reported elevated odds, but case ascertainment and adjustment varied across studies and prevented a single-estimate population characterization. As shown in Figure 2, the primary-study estimates chosen here range from an odds ratio (OR) of 1.23 for a Chinese cardiovascular disease cohort to an OR of 8.80 for a U.S. survey; the four example estimates were not pooled again.

Causal identification. Baldwin et al. (2023) conducted an important quasi-experimental synthesis and identified 34 studies with 54,646 participants. The unadjusted association with mental health problems was $d = 0.56$ (95% CI 0.41 to 0.71). With designs intended to reduce confounding, the association was estimated at $d = 0.31$ (95% CI 0.24 to 0.37). Attenuation in the relation shows that some of the relation may be attributed to shared familial and environmental vulnerabilities. A 2024 Baldwin et al. meta-analysis showed that individuals may not be identified by the same measures across time, thus treating case records as the final determination of exposure may not represent the same group.

Anxiety, trauma, and suicidality. The Australian Child Maltreatment Study reported associations with generalized anxiety disorder (OR 3.14, 95% CI 2.48-3.97), lifetime major depression (OR 3.19, 95% CI 2.68-3.80), and current PTSD (OR 4.60, 95% CI 3.00-7.07) after multivariable adjustment (Scott et al., 2023). Boumpa et al. (2024) reviewed 28 studies that included 28,693 individuals, aged 21 years or younger and reported sexual abuse was associated with PTSD for boys (OR 2.86, 95% CI 2.09-3.91) and girls (OR 2.38, 95% CI 1.76-3.23). The evidence regarding self-harm is very concerning, but the studies differ on age, whether they measured ideation or behavior, and if they accounted for the presence of pre-existing psychiatric conditions. Due to these differences, simple cross outcome-pooling is not justified.

Abuse categories. Analytical separation of physical, sexual and emotional abuse and neglect is important even when they occur in combination. Humphreys et al. (2020) emphasized the need for consistency in measurement by focusing on studies using the same childhood trauma questionnaire. Hashim et al. (2024) and Liu et al. (2023) focused on emotional maltreatment and its association with anxiety. Flor et al. (2025) showed statistically significant associations between 27 of the 35 violence-health pairings examined using the Burden of Proof method.

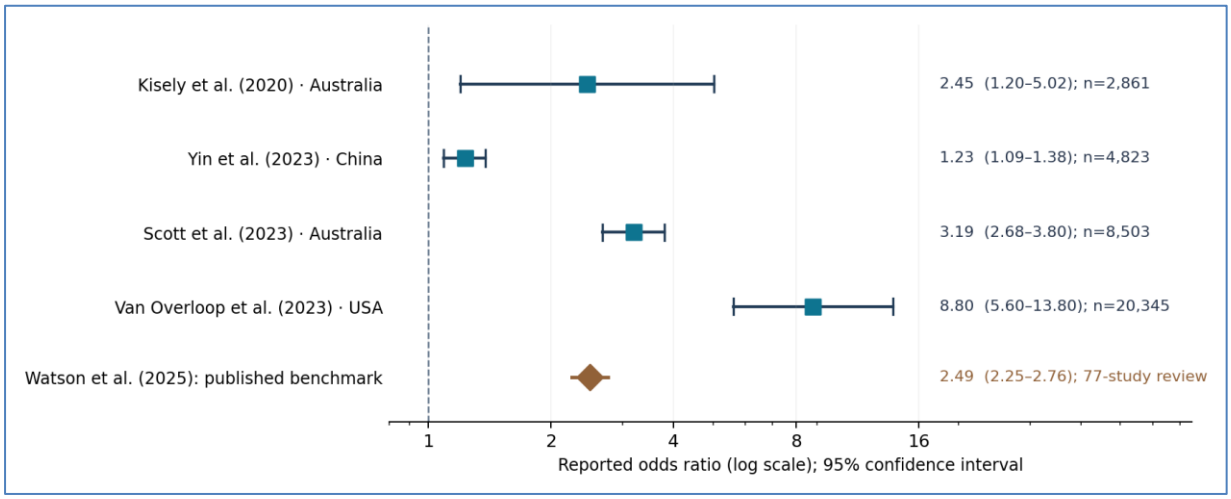
Their study supports that a positive statistical association does not represent adequate causal evidence.

Care and legal interventions. Zhang et al. (2021) pooled 15 studies of trauma-informed care in child welfare and reported a moderate composite wellbeing improvement (SMD 0.47, 95% CI 0.27-0.67). A Cochrane network meta-analysis and subsequent reviews of treatments acknowledged the need for a psychological intervention after child sexual abuse, despite the variation among the interventions and the inconsistent results (Caro et al., 2023; Menhart et al., 2025). In the justice domain, the benefits of child advocacy centers have been to facilitate inter-agency collaboration, although the long-term positive effects for the patient have not been documented to the same degree as the referrals and case reportings (Westphaln et al., 2021). Rosenberg et al. (2024) disputed the notion that greater levels of child reporting automatically translate to increased case detection. The outcomes within each family are documented in Tables 1-3.

Table 1. Characteristics of selected evidence sources

Study	Setting / design	N	Exposure / focus	Principal verified finding
Baldwin et al., 2023	Quasi-experimental meta-analysis	54,646	Child maltreatment	Adjusted d = 0.31 (0.24–0.37)
Scott et al., 2023	Australian population survey	8,503	Child maltreatment	MDD OR 3.19 (2.68–3.80)
Boumpa et al., 2024	Meta-analysis, youth	28,693	Sexual abuse	PTSD boys OR 2.86; girls OR 2.38
Zhang et al., 2021	Child welfare meta-analysis	15 studies	Trauma-informed care	Wellbeing SMD 0.47 (0.27–0.67)
Watson et al., 2025	Systematic review / meta-analysis	516,302	Any maltreatment	Depression OR 2.49 (2.25–2.76)
Karni-Visel, 2025	Israeli interview study	165	Interviewer support	Support types predicted different disclosure details

Figure 2. Forest plot of published maltreatment–depression associations



Four independently reported source estimates and a separately identified Watson et al. (2025) published 77-study benchmark. The benchmark is NOT a pooled estimate of the four displayed rows. The five entries are not statistically combined here.

Table 2. Extracted quantitative estimates shown in Figure 2

Study	N	OR	95% CI	Provenance
Kisely et al. (2020)	2,861	2.45	1.20–5.02	Study / Watson (2025) extraction
Yin et al. (2023)	4,823	1.23	1.09–1.38	Study / Watson (2025) extraction
Scott et al. (2023)	8,503	3.19	2.68–3.80	Study / Watson (2025) extraction
Van Overloop et al. (2023)	20,345	8.80	5.60–13.80	Study / Watson (2025) extraction
Watson et al., 2025	516,302	2.49	2.25–2.76	Published pooled meta-analysis; I^2 93.5%; $p < .001$

Table 3. Legal and service interventions: evidence and limitations

Intervention / setting	Observed outcome	Evidence source	Interpretive caution
Mandated reporting / US	Detection and substantiation vary	Rosenberg et al., 2024	Reporting breadth ≠ accuracy
Advocacy centres / US	Interagency coordination and referrals	Westphaln et al., 2021	Limited child wellbeing endpoints
Forensic interviews / Israel	Support predicts information yield	Karni-Visel, 2025	Not an RCT of mental health
Danish advocacy centre	Child experiences during interviews/exams	Haahr-Pedersen et al., 2024	Qualitative service outcomes
Child welfare trauma-informed care	Composite wellbeing SMD 0.47	Zhang et al., 2021	Interventions heterogeneous

Discussion

Convergent findings show that not all children who have been maltreated go on to develop a disorder, but it does show that there is a strong association between maltreatment and elevated psychiatric risk. Variability in findings is influenced by definition of exposure, comparison group, structure of the population, timing of exposure and outcome. Large syntheses and reviews should not be rated by single numeric estimates. For instance, the very high I^2 for the published review of depression indicates substantial cross-study variation (Watson et al., 2025). The positive quasi-experimental design was informative because it accounts for some family-level confounding (Baldwin et al., 2023).

Anxiety and PTSD deserve mention along with the ample documentation of depression. There are ample evidence of physical abuse and neglect, and also emotional abuse; however, there may be emotional neglect and abuse that are not easily observable. This creates an ascertainment gap. Protocols to ensure child safety and wellbeing, and to assist families may be missing if they do not address coercive and humiliating behaviors and unmet developmental needs (re-read the last sentence. This is not a perpetration of some elevated risk, it is describing the measures used and the options available for families to help alleviate risks for children in their care).

Clinicians should assess a child's safety, functioning, and family relationships and symptoms to determine if an order of protection has been granted. The clinician should use their training,

experience, and professional judgment to determine if sexual, physical, emotional, and/or psychological abuse has occurred.

The legal process can make recovery more difficult with multiple interviews, delayed processes, hostile communication and fragmented services. Therefore, trauma-informed justice is a service design principle that requires research, not an automatic means to provide beneficial therapy. Studies on child advocacy centers point to their potential to bring together professionals and reduce structural fragmentation. However, Westphaln et al. (2021) showed evaluations focus too much on service outputs. Haahr-Pedersen et al. (2024) highlighted children's experiences with forensic interviews and medical examinations, promoting the use of quality assurance frameworks to include experiences such as comfort, understanding, and perceptions of safety. An increase in the number of cases prosecuted does not mean children's psychosocial outcomes improved.

Interpreting research on mandated reporting must be done with caution. Reporting can ensure children receive protection and document their concerns, or it can initiate an unduly investigation if the threshold for judgment is unclear. It can also prevent or postpone an investigation. Different views on mandated reporting illustrate a lack of clear and sufficient training, supervision and threshold judgment among mandated reporters. This likely contributes to one of the main reasons why school counsellors avoid reporting child abuse and neglect. Generalizations must be made with explicit legal and implementation context.

A related distinction is between evidence-gathering and therapeutic communication. Forensic interviewers attempt to elicit accounts that are reliable and as suggestion-free as possible. They are trained to take into account the developmental limits of the interviewee. Karni-Visel (2025) studied 165 children and found that different types of supportive communication led children to express different emotions and provide different types of forensic information. Finding ways to teach children to express the emotions associated with their traumatic experience and communicate forensically about that experience can improve the practice of child protective services, but small effects in regression analyses of interviewed children cannot be used to conclude that a given protocol leads to better PTSD symptoms or legal outcomes. Evidence from psychotherapy is stronger for mental health outcomes. Trauma-focused psychotherapy has been shown to positively impact chronic child trauma (Zhang et al., 2021; Thielemann et al., 2022).

There are limitations to how much this research can be generalized. This study is a structured synthesis of verifiable published work, rather than an exhaustive systematic review. Its examples of a PRISMA flow diagram and forest plot illustrate reported estimates, not calculate new effect sizes. Aggregate sample counts of the reviews cited may be from the same primary cohort, therefore they may not represent new cases. Most quantitative comparisons are observational and some outcome variables are remembered retrospectively. Legal services research typically does not track children for a long enough period to measure meaningful clinical improvement. This research is limited to high-income countries, which means it may have a very limited application to low-income countries. Future research should link service exposure to clinical improvement, report adverse events, and evaluate whether improvements are equitably distributed across the social class.

There are a number of mechanisms by which interventions in the child protection system can lead to improvement, including stopping child exposure to abuse and neglect, strengthening attachment to safe caregivers, reducing uncertainty, and facilitating consistent case management to enable timely psychological intervention. It is important to operationalise and test these mechanisms. Comparative evaluations should include the time between disclosure and the first substantive clinical contact, the number of accounts required, the completion of treatment, change in validated symptom score and the child's perception of control. These interventions may bring relief to children and help close cases, but there may be children for whom negative experiences remain. These negative experiences need to be prespecified (Haahr-Pedersen et al., 2024; Westphaln et al., 2021).

Legal and Policy Implications

Restricting child abuse and neglect through legal prohibition is only one aspect of an integrated child protection system that includes prevention, confidential disclosure, risk assessment, and safe care, placement, and psychosocial support. The 2024 UNICEF report emphasised the importance of extending prevention beyond the formally investigated cases to include, for example, families' use of negative disciplinary measures, as well as supporting caregivers.

Clarity and structure are essential in all definitions and policies concerning mandatory reporting. Oversight of both unreported maltreatment and unnecessary or duplicate investigations should be in place. Justice agencies should utilize trained forensic interviewers and reduce repetitive questioning. Case updates should be written in a manner that is easy to understand. Justice agencies should ensure that timely clinical services are provided. Multidisciplinary child advocacy centers are a good organizational model, and the commissioning of the model should measure the duration of the investigation, and the child's wellbeing and safety, including the completion of the referral, court outcomes, and the family's experience (Westphaln et al, 2021; Haahr-Pedersen et al, 2024).

Legal evaluation should incorporate jurisdictional benchmarks. Policy analysts should differentiate between legal entitlement and access, service delivery and service effectiveness, and administrative and clinical outcomes. Courts and child welfare services should publish de-identified outcomes and permit ethical, Longitudinal linkage with treatment services. Equity audits should evaluate outcomes according to geography, disability, poverty, gender, and other dimensions. Undetected discrimination and disparities should be assessed, assuming that differences do not imply discriminatory intent. In the author's view, sustaining such changes require traumatic stress/mental health/legal services, procedural fairness, and child safeguarding. A suite of integrated services is required. These recommendations are based on the research evidence and, in the view of the author, change is possible.

An approach to synthesis that can be useful is to classify studies according to the causal question, and then to the kind of statistics used. Not all statistics estimate treatment effects (e.g. estimating the association between past exposure and present depression does not give an answer to the treatment effect of a given intervention; also, improved interviewer questions do not mean a reduced level of psychiatric morbidity). Evidence tables should keep the estimands separate and show the uncertainty associated with them. If the main source (study) uses a ratio

(effect), the confidence limits should also be in ratio form; and if it uses a standardized mean difference, an unjustified conversion to odds ratios may give misleading interpretations. This is particularly important in interdisciplinary manuscripts, as the fields of psychology, law and policy, for example, sometimes use the same terms to refer to different phenomena (Page et al., 2021).

Conclusion

In the evidence synthesis published during 2020-2025, it is clear that childhood maltreatment is associated with a greater risk of depression, anxiety, PTSD and other psychological problems. The largest synthesis estimated that the pooled odds ratio was 2.49; however, this should not be interpreted to mean that persons with a history of childhood maltreatment have an odds ratio of 2.49 of also having a major depressive disorder. There were several studies that demonstrated the association between childhood maltreatment and depression (both major and minor) using different designs, and controlling for some possible confounding factors. Although the overall association was found, some of the responses provided to children, such as child protection and forensic and therapeutic interviews, differed from each other.

The most important practical consequence is to incorporate safeguarding into healthcare practices and legal processes. Reporting rules should enable stronger safeguarding decisions, and the developmental needs of children should be taken into account in forensic interviews to ensure the integrity of the evidence. Multidisciplinary systems should ensure the safety of children and measure the degree of recovery of child victims, rather than focus on case management. Existing literature supports the incorporation of trauma-focused practices into healthcare, and while the legal structures and processes used to safeguard children impact positive outcomes on a child's mental health, the evidence is still inconclusive.

Future research should address uncertainty in existing studies by using multisite, prospective and preregistered designs, focusing on abuse subtypes, including a consideration of equity and potential procedural harms, reporting outcomes of judicial or administrative processes, and use child-reported outcomes on wellbeing to measure the impact of interventions. Prior research needs to ensure that the methods used to search for evidence are reported, and individual studies are extracted and reported in complete detail, before any prospective meta-analysis or research synthesis can be conducted.

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Appendix

Supplementary Methodological Note

The PRISMA flow diagram (Figure 1) reproduces the published, depression-focused search reported by Watson et al. (2025) and does not represent a new search conducted for this manuscript. Forest-plot values (Figure 2) are previously reported study estimates, and the 77-study benchmark is drawn from Watson et al. (2025). Data provenance is documented in Tables 1 and 2. No independent dual screening, formal risk-of-bias grading, or de novo meta-analysis was undertaken. These procedures, together with a complete searchable audit trail, would be required for this work to be reported as a new systematic review.