ARTICLE

Domestic abuse and mental health: the amplified risks created during the pandemic

Idura N. Hisham, Jacqueline Sin, Khadj Rouf, Danny Taggart, Giles Townsend & Angela Sweeney

Idura N. Hisham is currently a junior doctor working as a Foundation Year 1 Trainee at St Helier Hospital, Carshalton, UK. **Jacqueline Sin** is a mental health nurse and Professor of Mental Health Nursing in the Division of Nursing within the School of Health Sciences, City, University of London, UK. Her clinical research interest focuses on providing effective psychosocial treatments for people with mental health problems and for their informal carers. In addition to optimising conventional interventions, she has particular interest in co-designing digital interventions that mobilise both clinicians' and peers' expertise. **Khadj Rouf** is a consultant clinical psychologist with the Complex Post-Traumatic Stress Disorder Service, Northamptonshire Healthcare NHS Foundation Trust, Northampton, UK. **Danny Taggart** is a clinical psychologist in the School of Health and Social Care at the University of Essex, Colchester, UK. He is currently on a career break to work on the Independent Inquiry into Child Sexual Abuse, where is he the Clinical Lead for the Truth Project. He is particularly interested in the impact of trauma on social and psychological functioning across the lifespan. **Giles Townsend** is a consultant psychiatrist with Surrey and Borders Partnership NHS Foundation Trust. He specialises in the care of older adults and people with dementia and is based at Meadows West Park Hospital, Epsom, UK. **Angela Sweeney** is a trauma survivor researcher, Senior Lecturer in User Led Research and Director of the Service User Research Enterprise (SURE), King's College London, UK. She is Co-Chair of the Trauma Informed Community of Action and has particular interest in gender based violence, parenting and trauma-informed approaches. **Correspondence** Idura N. Hisham. Email: idura.hisham@nhs.net

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SUMMARY

No recent pandemic has had such a severe socioeconomic impact as COVID-19. Significant economic uncertainty and social restrictions have led to increased levels of stress for many. There has been increased social isolation, financial stress and alcohol intake, all of which can increase domestic abuse and other forms of household abuse. Increases in abuse in the home found in other public health emergencies and economic recessions can be seen now – reported UK domestic abuse rates have increased since the start of COVID-19. This article focuses on how COVID-19 and its anticipated aftermath exacerbate the risk factors for domestic abuse in the general population and discusses clinical implications for mental health practitioners in the UK. It aims to provide a point of learning based on previous disease outbreaks and recessions, with a focus on specific factors, such as unemployment and alcohol misuse, and how these contribute to increasing incidence and severity of abuse – and more importantly, how mental health professionals can mitigate these for patients, 1 in 3 of whom are estimated to have already experienced abuse before the COVID-19 pandemic.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the three specific risk factors for domestic abuse that the COVID-19 pandemic has introduced or exacerbated: poverty, alcohol use and levels of mental distress
- recognise how the pandemic and the associated restrictions introduced into clinical care can affect the detection and mitigation of domestic abuse in mental health settings
- understand how mental health practitioners might mitigate these changes and help safeguard patients from domestic abuse.

KEYWORDS

COVID-19; domestic abuse; violence; trauma; alcohol use disorders.

The COVID-19 pandemic has brought significant changes in multiple domains of social life that are likely to continue beyond vaccine rollout; of the viral outbreaks in the 21st century, none has had such severe socioeconomic impact as COVID-19. Population stress brought about by the pandemic and the social and economic fallout can have drastic effects, including increased alcohol use and worsening mental health and financial insecurity. These are risk factors that have been associated with domestic abuse and myriad problems in research on past disease outbreaks and recessions. Reports have already emerged on increased rates of domestic abuse resulting from the current pandemic. In this article we discuss domestic abuse during and post-COVID-19, focusing on three specific factors – poverty, alcohol use and mental distress – on how these contribute to increasing incidence and severity of abuse in domestic settings and on how UK mental health practitioners might identify and support individuals who are particularly at risk.

We use the term 'domestic abuse' to cover all broad categories and types of abuse and violence (including but not limited to sexual violence, emotional abuse, coercion and control, and physical aggression) that occur in domestic settings and between familiar or intimate partners.

Understanding risk factors for domestic abuse

The often hidden nature of abuse in domestic settings makes it hard to detect and harder still during the lockdown restrictions of COVID-19. Nevertheless, a report on domestic abuse in England and Wales during the first 9 months of 2020 found an increased demand for domestic abuse services, particularly helplines, that continued even after initial lockdown measures were eased. The increased demand was partly due to an increase in the severity of the abuse that people experienced and a lack of access to normal coping mechanisms, such as leaving home or periods of respite away from the abusive

relationship (Office for National Statistics 2020). It was also found that children are at an increased risk of experiencing or witnessing violence and abuse in the home during the pandemic.

The causes of domestic abuse are multifactorial, complex and overlapping, influenced by individual, relationship, community and societal factors. Societal factors such as norms regarding gender roles and reduced access to support networks to help manage individual stressors can contribute to perpetration and exacerbation of abuse (García-Moreno 2014). In the following sections we focus on three specific risk factors exacerbated by COVID-19: poverty, alcohol use and levels of mental distress.

Poverty

The COVID-19 pandemic saw the UK officially fall into recession in 2020, with further economic downturns predicted for 2021 and 2022, making a protracted recession likely. An association between economic downturns and increased domestic abuse is well established in the literature (Durrance 2013). Women who experience domestic abuse are at increased risk of exposure to more serious and repeated abuse if they live in economically precarious circumstances (Benson 2001). Research commissioned by the Joseph Rowntree Foundation found that domestic abuse and poverty are connected by rigid and unhealthy gender norms regarding resources and caring responsibilities (Box 1). Poverty can exert a dual effect by increasing domestic stressors while simultaneously limiting resources that women can access to respond to these stressors, making it harder to leave abusive relationships (Fahmy 2016). This may have been exacerbated by the COVID-19 pandemic; for instance, it has been argued that lockdown measures have disproportionately disadvantaged working women (compared with working men) through disruptions to childcare and income reduction (Bangham 2020).

Experiencing domestic abuse may reduce individuals' ability to participate in the labour market, or to do so effectively, through its impact on their physical and mental health. Also, perpetrators of abuse have been known to use job-interference methods such as incessant phone calls and frequent workplace visits as part of their abuse tactics (Swanberg 2005). In the context of COVID-19, where working from home is encouraged, the extent of this could be exacerbated, limiting individuals' ability not only to get a job, but also to maintain one.

Although vaccines look promising for limiting the spread of the COVID-19 virus, they will not prevent the enduring impacts of the pandemic. In previous economic downturns, the negative impact on young people's pay and employment continued for several years, creating a scarring effect that damaged their long-term income and career prospects (Dias 2020). For the most deprived, the debts carried forward from unpaid mortgage/rent and bills can be catastrophic if income sources fail to recover in time (Bourquin 2020).

BOX 1 Exploring the links between domestic abuse and poverty

A report for the Joseph Rowntree Foundation, conducted by the University of Bristol, found that there is a link between domestic abuse and poverty, and that this link is due to gendered assumptions about household resources and caring responsibilities which shape women's vulnerability to domestic abuse. These gendered assumptions and expectations were found to extend to:

- access to household incomes and resources
- financial dependency, including whether benefits are received as a dependent
- caring responsibilities that limit employment possibilities and prospects
- the view that benefits are for the whole family, and not the women
- male partners preventing women from working, claiming benefits or leaving the house.

(Fahmy 2016)

Alcohol use

Poverty, precariousness and unemployment are associated with alcohol use in complex ways. Although the 2008 recession saw overall alcohol intake fall across Europe, alcohol use increased among those who lost their jobs and experienced long-term unemployment and/or significant mental distress (Dom 2016). Research commissioned by Alcohol Change indicates that this pattern has repeated during the COVID-19 pandemic, particularly among existing frequent drinkers and parents of children under 18 (Alcohol Change 2020).

Alcohol may be used as a coping mechanism for dealing with the pandemic. For men in particular, each additional stressor experienced – unemployment, emotional distress, isolation – increases the likelihood of heavy drinking (Dawson 2005). Between 2010 and 2011, 39% of domestic abuse reports showed that perpetrators were drinking alcohol at the time of the incident (Institute of Alcohol Studies 2014). Further, when alcohol is involved, the violence and resultant injury are often more severe. Some use alcohol to cope with the trauma of violence and abuse perpetrated against them. For instance, research has found that

abuse victims were twice as likely to drink after an abusive incident (Barnett 1993). However, among women, alcohol use during or after attacks is associated with increased self-blame and more blame attributed to them by the public and perpetrators alike (Institute of Alcohol Studies 2014). In a recent briefing created in collaboration with Alcohol Change UK, Fox & Galvani (2020) provided insight into the relationship between alcohol and domestic abuse among survivors and perpetrators and how the pandemic could affect this (their findings are summarised in Box 2).

Despite the risks of home drinking and domestic abuse, COVID-19 has resulted in fewer people having access to face-to-face appointments and support for alcohol use, particularly where telemedicine is not available (Finlay 2020). Worryingly, alcohol services have been reduced amidst all of this. This combination of increased risk and reduced protective factors is likely to lead to increased levels of alcohol-related domestic abuse.

For children in homes affected by alcohol use, deprivation and domestic abuse, the impacts on mental and physical health and social well-being could be lifelong (Bywaters 2019). Consequently, the UK's Domestic Abuse Act 2021 classifies children in a household where abuse and violence are perpetrated as victims themselves, regardless of whether the abuse was directed at them or not.

BOX 2 How the COVID-19 pandemic affects alcohol use and domestic abuse

- Social isolation increases the risk of multiple types of domestic abuse (physical, sexual, etc.). This risk is amplified in homes where abuse and alcohol were pre-existing problems.
- The inclusion of off-licences as essential businesses while other social outlets are closed normalises home drinking.
- Perpetrators of domestic abuse can use alcohol restriction as a form of control over individuals who are alcohol dependent. Sudden alcohol withdrawal could lead to serious medical consequences, such as delirium tremens, hallucinations, seizures and heart failure, that can have lasting health effects.
- Less support is available owing to COVID-19 measures necessitating closure or reduced provision of alcohol support services and peer support networks. Most domestic abuse services are not equipped to best support survivors of abuse with substance use or alcohol-related disorders.

(Fox 2020)

Mental distress

Molodynski and colleagues (2021) have outlined three main challenges that the COVID-19 pandemic poses to the UK population's mental health and associated support services:

- impacts on the mental health of front-line staff in healthcare services that were already stretched pre-pandemic
- social and physical distancing measures that exacerbate social inequalities, particularly for the Black, Asian and minority ethnic (BAME) population, older people, those subject to domestic abuse and children
- an economic impact that might lead to austerity measures, which often disproportionately disadvantage people on state benefits or who are already economically deprived. Further, austerity would deplete mental health services that are already severely weakened by past austerity measures.

People with mental health diagnoses are more likely to experience interpersonal abuse; simultaneously, people who experience interpersonal abuse are more likely to receive mental health diagnoses (Golding 1999).

The negative effects of social distancing on mental health are well established (Brooks 2020). These effects are believed to be exacerbated for domestic abuse or childhood trauma survivors during the pandemic owing to a triad of interlocking factors: (a) social marginalisation and disadvantage; (b) pre-existing physical health problems; and (c) the exacerbation of pre-existing mental distress caused by pandemic restrictions that mirror features of abuse (e.g. lack of control and entrapment) (Taggart 2021).

Mental health services have historically received less funding than other healthcare services and this contributes to longer waiting times and time-limited support in many cases. Specific services for BAME communities are also more vulnerable to cutbacks (Taggart 2021). In a system where the service provision for abuse survivors were inadequate pre-COVID, in a post-COVID time of a struggling economy and potentially more robust austerity measures, the increased demand could paradoxically be met with further reductions, creating a bigger backlog. Effective support at multiple levels for those experiencing poverty, alcohol use and significant mental distress will be vital in reducing levels of domestic abuse. Social policies should therefore be developed and implemented as soon as possible to provide this support..

It may be that the true scale of domestic abuse and violence will emerge only after restrictive measures

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imposed because of the pandemic are eased, with many disclosures unlikely to be made for years afterwards, if ever. Furthermore, epidemiological research has shown that gender-based violence intensifies not just during catastrophic events but also after they have ended (Emezue 2020). Risk factors such as increased alcohol intake because of a catastrophe have been shown to peak 1–3 years after the event (Grossman 2020). This means that survivors are likely to present to services for many years to come. It is critical that mental health practitioners feel competent and supported to respond.

Key points on understanding risk factors for domestic abuse in the context of the pandemic are summarised in Box 3.

How can mental health practitioners respond?

The UK government has set out various measures to respond to the increase in domestic abuse, including:

- funding for charities to support survivors of domestic and sexual abuse, vulnerable children and their families, and victims of modern slavery
- automatic qualification as having a priority need for accommodation for domestic abuse survivors under council duties to relieve homelessness.

However, there are concerns that the recent Domestic Abuse Act does not address the chronic underprovision of services. This means that mental health practitioners must respond to domestic abuse without necessarily having adequate services available locally.

Statutory health services have had to adapt to the restrictions that COVID-19 has introduced, including the need for social distancing, which has meant that many services are delivered remotely. Although this has proved beneficial in some areas and might continue to have a role in service delivery post-pandemic, the impact of these new methods of working on domestic abuse must be reviewed and evaluated.

Reporting and detecting domestic abuse

Research evidence demonstrates that over one-third of female patients in mental health settings are experiencing current domestic abuse (Scott 2016). The National Institute for Health and Care Excellence (NICE) recommends that routine enquiry – the practice of asking all patients about their experiences of domestic abuse, regardless of the presence or absence of warning signs – should be standard practice in mental health settings (NICE 2014). Despite this, an analysis of data supplied by National Health Service (NHS) mental health trusts in England for 2017–2018 found that of 42 trusts that responded, 15 had no routine enquiry policies. Of those that did, effectiveness varied, with some trusts having enquiry rates as low as 3% (Agenda 2019).

Multiple barriers exist to reporting and detecting domestic abuse, ranging from the normalisation of violence and abuse to clinicians' stigmatised beliefs about what abuse or abuse victims should look like. Research in a socioeconomically deprived area of south London found that patients face multiple barriers in disclosing domestic abuse to mental health services, including shame and fear – fear of not being believed, fear of the consequences, such as further abuse, and fear of possible social services involvement and child protection proceedings (Rose 2011).

For some, disclosures may be more challenging because of negative institutional or service responses when they reported previous experiences of violence and abuse, complicating access to treatment and support. The impact of childhood trauma reverberates through to adulthood for survivors, increasing the risk of various adverse outcomes – including domestic abuse; consequently, in assessing and treating adult survivors, developmental trauma and its associated social, physical and psychological impact has to be considered as an integral part of the care plan (Taggart 2021).

Thus, routine enquiry does not mean that all those who are asked will disclose, nor does it mean that enquiry is risk-free, and practitioners must take care that enquiries do not cause further harm. As Agenda (2019) stressed, front-line staff must have access to training in making sensitive routine enquiries about domestic abuse and ongoing supportive supervision. Alongside understanding how to ask, mental health practitioners must also understand how to respond to disclosures, including translating

BOX 3 Section 1 takeaway messages for mental health practitioners, understanding risk factors for domestic abuse during the pandemic:

- Severe events such as pandemics are associated with an increase in domestic abuse both during and after the event.
- The causes of this increase in the current pandemic extend beyond its direct consequences (infection, restrictions, bereavement) and can partly be attributed to a failure of sufficient services in several domains, including financial, domestic and health services.
- Be aware of how the pandemic and the different risk factors for domestic abuse interact, so that you build a better understanding of the challenges domestic abuse survivors could face.
- People with mental health conditions are at a heightened risk for domestic abuse. This risk is exacerbated with alcohol and/or substance misuse (by either the perpetrator or the victim – see Box 2), so these should be regularly screened and asked about in consultations.
- Survivors of childhood trauma are at increased risk of re-traumatisation during the pandemic, while also being at an increased risk of abuse. Developmental trauma and its associated social, physical and psychological impacts need to be taken into account when dealing with adult survivors.

disclosures into meaningful individualised support. This requires that there are appropriate services to refer survivors to, including services that understand their needs in the context of intersecting identities, such as services for women from BAME communities, men, and people from LGBTQ communities (Scott 2016).

NICE has provided guidelines on how an environment for disclosing domestic abuse can be fostered in clinical settings (Box 4).

Why don't people realise that they are experiencing abuse?

Abuse can be normalised in different ways (Gillett 2018) and this can mean that people do not always recognise that what they are experiencing is abuse. Coercive and controlling behaviours can be particularly hard to identify and communicate to others (Brennan 2018). Moreover, abuse is often thought of in discrete and clear categories of physical, sexual or emotional abuse; however, abuse often does not happen in neatly nameable boxes but is a messy and overlapping experience of multiple forms of abuse. This can mean that the journey towards understanding experiences as abuse can take many years (Survivors Voices, personal communication 2021).

The survival strategy of 'identification with the aggressor' (Howell 2014) is a common phenomenon in which victims of abuse internalise the abuser's victim-blaming position. The abuse of power is central to domestic abuse and perpetrators may coerce those they are abusing into believing that the abuse is their fault. This can make assessment and disclosure difficult, as the victim cannot recognise the abuse they are suffering. In these cases, 'naming' abuse as criminal and harmful may need initially to come from the mental health practitioner, constituting an intervention in and of itself (Taggart 2021).

'Victim blaming' is the misattribution of responsibility for abuse to the person experiencing it and is commonly reported in survivors' accounts of help-seeking (Crowe 2015). Mental health practitioners who observe women returning to abusive relationships and possibly exposing their children to violence may conclude that this is an active decision rather than a lack of feasible options. One study looking at mothers who had frequent contact with child protection services found high levels of childhood trauma in the mothers' case histories and suggested that a trauma-based understanding could help social care professionals understand these patterns (Mason 2020).

Moreover, women may fear that the negative consequences of leaving a relationship are worse than the abuse that they experience within it. Leaving abusive relationships could trigger the loss of physical and emotional safety, social support, financial stability, home, control over parenting and personal freedom (Thomas 2015). The well-documented lack of justice for women survivors, particularly survivors with intersecting minority identities, may also mean that mothers lose custody of their children or are forced to accept shared custody. Therefore, they can no longer protect their children from direct abuse.

Taking these factors into account, these are some measures that mental health professionals can adopt to better support survivors:

- listen without judgement and without the assumption that a decision to remain in an abusive situation is a simple choice born of a personal deficit
- consider the person's trauma history, social support and understanding of abuse and try to scaffold support accordingly
- when making enquiries, be mindful of the potential weight of the word 'abuse' for the person, including the possibility that they might not recognise it as

BOX 4 NICE guidance on creating an environment for disclosing domestic violence/abuse in face-to-face settings

- Ensure that information about support available to those affected by domestic violence and abuse is clearly and accessibly displayed in waiting areas and other appropriate locations, in a range of visual formats and languages, as well as in more discreet ways such as pens or key rings with helpline numbers.
- Enable maximal privacy and sensitivity for patients, such as by arranging reception areas in a way that people will not be overheard.
- Develop a referral pathway to specialist domestic violence and abuse agencies, with options that take into consideration age and difficulties or reluctance to access services.
- Provide frontline staff who may be asking service users about domestic violence and abuse, with ongoing training and education regarding services, policies and procedures of relevant local agencies, as well as regular supervision and feedback to promote and maintain good practice.
- Establish policies and procedures to support staff affected by domestic violence and abuse, whether through personal experiences or contact with patients or service users.

(National Institute for Health and Care Excellence 2014)

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applying to them – acknowledging that experiences are not acceptable is also an important step
- respect the terminology the person uses to describe their experiences and use it in discussion, favouring it over terms such as 'abuse'.

Telemedicine and reporting and detecting abuse

COVID-19 has led to an increase in telemedicine that may well endure post-pandemic. Although telemedicine can increase engagement for some by removing logistical barriers to attendance, for others, accessibility problems can further marginalise those already marginalised, such as those economically deprived (Molodynski 2021).

Domestic abuse by definition happens in people's own homes, typically perpetrated by people who live in the same household. It is vital that clinicians are mindful of this and conduct consultations accordingly. Against Violence and Abuse (AVA), a national charity opposing violence and abuse against women and girls, has provided guidance for mental health practitioners dealing with patients experiencing domestic abuse during COVID-19. They suggest specific ways in which enquiries can be made safely and sensitively (Box 5) and also give details on safety planning and safe referral (Against Violence and Abuse 2020). Patients might not be aware of the specific support services available for victims of domestic abuse or have the capacity to explore this themselves. Potential resources to be considered are listed in Box 6.

It is equally important to have a basic understanding of how to safely deal with disclosures of perpetration of domestic abuse by patients themselves. This is beyond the scope of this article, but some resources are also listed in Box 6.

BOX 5 Against Violence and Abuse's guidance for mental health practitioners on safe communication

- If abuse is suspected, and it is possible to ask safely, ensure the concern is explored. Normalised the conversation through phrases such as 'This is questions we ask everyone, but have you ever felt unsafe at home?'
- When asking about domestic abuse, ensure it is done in a private environment when the patient is alone, and do not use patients family members, friends or carers as interpertrator.
- Some survivors might be self-isolating with perpetrators of abuse. As such, If there are no current face to face patient contact provision for your service, discuss with the patient whether contact via phone, email or messaging apps is a feasible safe alternative.
- During telephone consultations, ascertain whether the individual is alone and safe to speak by asking "yes/no" questions. If there is someone in the background that can overhear the conversation, change the tone of the conversation away from topics of domestic abuse (exampe: "Do you need medication?").
- To be able to identify whether patient is at risk of harm without the knowledge of the perpetrator, ensure that you have created a safe work.
- Validate patients experience of abuse and reinforce that it not their fault that this has happened to them. Use phrases such as 'What you are describing sounds like abuse', and 'The abuse is not your fault'.
- Ensure the conversation is done with sufficient time so that patient will not be rushed.

(Against Violence and Abuse 2020)

Reporting and detecting abuse against older people

Elder abuse can occur in domestic as well as institutional settings such as care homes. According to NHS Digital (2020) data, elderly people constitute the majority of safeguarding referrals in England, with those aged 65 and over accounting for over 60% of referrals between 2009 (the year data collection began) and 2020. In the year 2019–2020, an estimated 1 in 38 adults aged over 85 years were involved in a referral under Section 42 of the Care Act 2014, with neglect and omission of care being the main form of maltreatment. Perpetrators of abuse in this group are often caregivers, both from within and outside the family (Age UK 2020).

A study identified 15 factors in caregivers that increase the risk of maltreatment of elderly people in their care (Reay 2001). Three of them are particularly relevant during the current pandemic:

- being subject to high stress and strain
- living with the elderly person, who is often a partner or spouse
- being isolated and lacking community and personal support.

The responsibility and load of informal, unpaid and long-term caregiving can cause high levels of distress in family carers, and these levels are positively correlated with increasing amount of time spent on caregiving (Sin 2021). Worsening anxiety and depression in carers can impair their caregiving capacity, potentially leading to neglect and abusive behaviours toward those they are caring for (Cooper 2018). In the context of dementia, the carer is often an elderly spouse, and perceived neglect can be a manifestation of their own inability to cope with the added pressure brought on by COVID-19.

While COVID-19 has intensified the risk factors for caregivers, placing the elderly at a higher risk of abuse or neglect, support from external agencies (e.g. social services) and informal resources (e.g. friends, relatives) has simultaneously decreased in both frequency

BOX 6 Third-sector services that could be useful for patients experiencing or perpetrating domestic abuse

Experiencing abuse

- Women's Aid Directory: www.womensaid.org.uk/domestic-abuse-directory/
- National Domestic Abuse Hotline (Refuge): 0808 2000 247 (further details can be found at: https://www.nationaldahelpline.org.uk/en)
- Hestia's Bright Sky app (www.hestia.org/brightsky): this is a free mobile app that includes information on a UK-wide directory of specialist domestic abuse support services, with contact details and nationwide helplines available 24/7.

Perpetrating abuse

- SafeLives guidance: *Staying Safe during COVID-19: Guidance for Practitioners Working with Those Who Harm* (safelives.org.uk/sites/default/files/resources/Guidance%20for%20professionals%20working%20with%20perpetrators.pdf)
- The Respect Phoneline for those worried about their own behaviour: 0808 802 4040 (respectphoneline.org.uk/)

and intensity. A significant proportion of the elderly population are also considered to be at high risk of infection and are encouraged to 'shield', further reducing their contact with the outside world. Ensuring that older adults and their family carers are well supported may help prevent abuse. The Social Care Institute for Excellence, in partnership with the Alzheimer's Society, has published guidance on safeguarding adults with dementia during the COVID-19 pandemic, emphasising the importance of ensuring that carers are well supported and made aware of available support resources (this and further resources are listed in the supplementary material available at https://dx.doi.org/10.1192/bja.2021.69).

Reporting and detecting abuse in BAME communities

Although domestic abuse occurs across cultures and in all countries, rates vary considerably cross-culturally (Do 2013). In multicultural societies, mental health practitioners and others make clinical decisions about people from backgrounds different from their own despite limited training and clinical experience in assessing domestic abuse across cultures. One of the factors influencing decision-making can be clinicians' implicit bias due to unconscious assumptions about the other person based on their ethnicity, gender, sexual orientation, disability and other characteristics (Fitzgerald 2017).

Therefore, it is imperative that mental health practitioners adopt a 'not knowing' position and understand the need to learn from patients, rather than risk the stereotyping that can result from focusing on supposed group characteristics. Challenging our assumptions about a person's identity, beliefs and behaviours could be a key element in improving identification and prevention of domestic abuse. Key recommendations on engaging trauma survivors in culturally sensitive ways are outlined in Box 7.

On an individual level, mental health practitioners need to actively challenge and identify their own internal biases. Yet implicit bias training alone is not enough. Systemic and organisational change are necessary to develop policies and design services that are actively anti-racist and anti-discriminatory. COVID-19 has highlighted and exacerbated existing structural inequalities in our society. However, it also offers an opportunity for us to learn from the long-standing problems that the pandemic has made more evident and finally make the necessary changes.

Taking action: developing trauma-informed clinical relationships

The impacts of COVID-19 and the lack of access to usual social supports and coping mechanisms has placed greater importance on the relationships between patients and mental healthcare providers. Research has consistently found that these relationships are central to abuse survivors' experience of services (Elliott 2005). Unfortunately, research evidence indicates that relationships between patients and providers can sometimes be a source of harm. Ellinghaus and colleagues (2020) found that traumatised young people face relational (and systemic) barriers to engaging with mental health services. Relational barriers included a lack of continuity of provider, difficulties disclosing trauma and feeling judged or blamed for what had happened. Young people also described their lack of power and feeling that professionals were pressuring them 'to adopt particular perspectives, engage in therapies and use strategies that were in conflict with their own explanatory models'.

Even if their organisation has not yet completed the process of organisational change that embeds trauma-informed approaches – an understanding of trauma (Sweeney 2018a) – throughout service planning and delivery (Sweeney 2018b), practitioners can develop trauma-informed relationships (see the supplementary material for further resources offering information on trauma-informed approaches).

Engaging in trauma-informed relationships means understanding that the symptoms or behaviours a person displays – which may seem 'difficult', 'challenging', 'damaging' or 'bizarre' – might

BOX 7 Culturally sensitive approaches to trauma survivors

- Understand that abuse is inflicted by groups and institutions, not just individuals, and that it is so commonplace that people may be desensitised to it.
- Recognise that political and social oppression may influence people's priorities and values, and that individuals need to define the meaning of their own experiences. Recognise that trauma responses vary and that different cultures express grief and loss and understand trauma differently.
- Understand that some topics are very difficult to talk about in anything other than the individual's first language and provide translation/language assistance services when necessary.
- Understand that help-seeking and disclosures vary culturally and may depend on how safe people feel with you. Learn from people what their cultural norms and expectations are.

(Blanch 2012)

be learned adaptations to trauma that have helped them survive. This extends to understanding the reasons why a person may 'choose' to remain in a violent and abusive relationship and being able to continue giving them support.

Alongside this shift away from a pathologising model of trauma symptoms, adopting strengths-based approaches can help people in their journeys to healing and recovery (Xie 2013). A strengths-based approach is a counter to the deficit model that focuses on an individual's weaknesses, with an alternative focus on the strengths that they have developed to help them survive and thrive. A strengths-based approach helps people to find more time and space to draw on these coping strategies and personal resources. This approach requires the practitioner not to make assumptions, to listen carefully and to be patient-led, ultimately adopting a position of 'How can I help?'.

Healthcare practitioners who experience domestic abuse

A report by the British Medical Association (BMA) estimated that healthcare professionals, particularly midwives and healthcare assistants, are three times more likely to experience domestic abuse compared with the general population (BMA 2019). Despite this, it is harder for them to get support for domestic abuse – additional barriers to disclosure and detection include societal expectations of the role and clinicians' own beliefs. These barriers are expanded on in Box 8. Additionally, certain norms of the medical profession – such as the focus on resilience, empathy and sympathy, and frequently dealing with challenging behaviour from both colleagues and patients alike – can extend to their personal lives and normalise 'abusive' behaviours within their own interpersonal relationships (Donovan 2021).

The effects of domestic abuse at home extend to the workplace, contributing to slower career progression and reduced attendance, with those still in training worst affected. A lack of support by employers and the emphasis on 'resilience' despite poor mental and physical health further compounds this effect (BMA 2019; Donovan 2021). Among trainees, a lack of control and consideration regarding rotas and deployment, and unsympathetic educational supervisors have been cited as factors contributing to increased distress and social isolation (Donovan 2021). Despite the many negative effects of domestic abuse that reflect in the workplace, there continues to be a lack of awareness among employers and healthcare practitioners themselves; the BMA found that 32% of National Health Service (NHS) trusts do not currently have a domestic abuse policy for staff. Domestic abuse is a workplace issue that requires its own specific solutions, with consideration of the unique challenges and barriers healthcare professionals face.

Taking action: small steps, big impact

Given that the effects of the pandemic-related increased rates and severity of domestic abuse are likely to be felt for years to come, we propose a range of recommendations for services and practitioners to consider and act on towards establishing a trauma-informed culture for all those affected by domestic abuse.

For commissioners and mental health services

Commissioners and local mental health services:

- could increase the availability and range of support offered, including that provided by individuals with lived experience of abuse
- should review current trust policies and practices, particularly on the following key areas:
  - routine enquiry – is there a current routine enquiry policy in place? If there is one, how well is it being adopted? Look into local and national campaigns and initiatives on domestic abuse, such as Agenda's Ask and Take Action (weareagenda.org/askandtakeaction)
  - is the clinical environment currently conducive to disclosure of abuse as per NICE guidelines (Box 4)?
  - does the trust have a policy for supporting staff members who are experiencing domestic abuse? If there is one, does it address the key challenges they might be facing, including acknowledgement and appropriate support if the abuse is

BOX 8 Unique barriers to accessing support for doctors experiencing domestic abuse

Ongoing research involving doctors who have personal experience of domestic abuse reveals the following themes.

- **Self-stigmatisation** – Doctors who experienced domestic abuse reported guilt, shame and difficulty reconciling their status as victims with their identity as doctors.
- **Stereotypes** – They described having internalised stereotypes of domestic abuse victims that contributed to their fear of not being believed if they spoke up, as they do not fit these images. This was a particular problem in 'medical marriages', where both the victim and perpetrator of abuse are doctors.
- **Accessing support services** – Some doctors are worried about being recognised or encountering their own patients when using these services.
- **Professional isolation** – Doctors on less than full-time contracts struggle to establish supportive workplace networks owing to limited contact with their full-time colleagues. The resultant sense of isolation makes it harder to discuss sensitive matters with colleagues.
- **Financial concerns** – Support services often assume that doctors are affluent without considering that financial control within domestic abuse makes it harder for doctors subject to such behaviour to access emergency financial support.
- **Fear of professional consequences** – Doctors were concerned that disclosure could bring their professional capability into question, that perpetrators might make false allegations to the GMC or social services, and that patients' trust might be undermined if their situation were made public.

(British Medical Association 2019)

BOX 9 Responding to the increase in domestic abuse: key takeaway messages for mental health practitioners

- Reflect on how your own internalised beliefs and unconscious bias could affect your ability to detect and support patients experiencing domestic abuse.
- Review your current practice to identify any areas of improvement and gaps in knowledge. How can routine enquiry and safe enquiry practices be incorporated in your own clinical work?
- Be aware of barriers surrounding disclosure of abuse that patients might face, and also the unique barriers that certain groups, such as the elderly and minority populations, might face.
- Consider how to deal with disclosure and find out about potential routes of referral.
- Find out what trauma-informed care is and how its values can be adopted to best support patients.

affecting their job performance and interfering with meeting training requirements?
- should provide training for staff to better deal with patient disclosure of being a victim or perpetrator of abuse, ensuring adequate knowledge in detection and management of disclosure
- should ensure 'joined-up' communication and engagement with other agencies working with survivors, e.g. police, social care, housing, charities.

To better support colleagues who are experiencing abuse themselves, trusts need to ensure that a domestic abuse policy for staff members is in place. In drawing up such a policy, particular attention needs to be paid to the following areas:

- recognising how domestic abuse could affect job performance through lower productivity, increasing absenteeism and so on, and putting in place support/adjustments to help them navigate this – with particular consideration for those still in training and/or working less than full-time
- lone working – staff members experiencing domestic abuse in a public-facing role working alone in the community may be more vulnerable to their perpetrators. Measures such as lone worker alarms or moving staff who are currently experiencing abuse out of community roles might be needed.

For mental health practitioners

Mental health practitioners should:

- identify gaps in their knowledge, beliefs and current clinical practice regarding domestic abuse that could impede detection and support offered to patients. This could be done through:
  - reflection on current beliefs and biases (both conscious and unconscious) – practitioners should familiarise themselves with individuals' experiences of domestic abuse by, for example, reading survivor testimonies
  - withholding judgement on why adults may choose to live with domestic abuse – people who are abused should not be abused for their abuse
- review their current clinical practice to identify areas of improvement, in particular auditing their practice against current guidelines and recommendations, which include:
  - routine enquiry about domestic abuse during clinical encounters
  - safe enquiry practices as per recommendations outlined in Box 5
  - awareness of routes for escalation and referral if a patient were to disclose domestic abuse.

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Key points on how mental health practitioners should respond to the increase in domestic abuse are summarised in Box 9.

Conclusions

The health and social impacts of the COVID-19 pandemic are only beginning to be understood. They are likely to become clearer once the immediate public health crisis abates as a result of mass vaccinations, at least in the UK. Domestic abuse is one area of social life that we already know has been exacerbated by the crisis and has major health implications for individuals, families and communities. What makes domestic abuse and its impacts particularly insidious is that it often occurs in secret and its hidden nature has increased with the imposed social isolation during the pandemic.

The restricted and remote provision of healthcare, particularly mental healthcare, whose patients were at higher risk of domestic abuse even pre-COVID, makes assessment, detection and treatment of domestic abuse more challenging. These factors combined can present a daunting picture for survivors of domestic abuse, their children and the healthcare professionals serving them. There are additional complexities in working with victims of domestic abuse from different cultural contexts and generations. An underpinning trauma-informed approach, coupled with sensitive investigation and non-stigmatising, non-victim-blaming responses will go some way to mitigating some of the additional barriers caused by the pandemic.

For any lasting change to happen, current practices needs to be audited. On a trust level, this could mean organising regular audits or quality improvement projects; getting specific feedback from patients and staff on current barriers to detection and disclosure; and providing remedies for identified issues either through increased training or policy changes. On an individual level, reviewing current practices and reflecting on one's beliefs are essential so any gaps in knowledge and unhelpful beliefs can be identified, challenged and remedied.

Supplementary material

Supplementary material is available online at https://doi.org/10.1192/bja.2021.69.

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I.N.H wrote the first draft of the paper. A.S., J.S., D.T. and K.R. wrote sections of the paper. All other authors gave extensive comments on drafts.

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Declaration of interest

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ICMJE forms are in the supplementary material, available online at https://doi.org/10.1192/bja.2021.67.

MCQ answers
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References

Against Violence and Abuse (2020) *Domestic Abuse during COVID-19: Guidance for Mental Health Practitioners*. AVA (https://avaproject.org.uk/wp-content/uploads/2020/04/FINAL-AVA-Briefing-for-MH-professionals-1.pdf).

Age UK (2020) *Safeguarding Older People from Abuse and Neglect*. Age UK.

Agenda (2019) *Ask and Take Action: Why Public Services Must ask about Domestic Abuse*. Agenda (https://weareagenda.org/wp-content/uploads/2020/12/Ask-and-Take-Action-report_upd.pdf).

Alcohol Change (2020) Research: drinking in the UK during lockdown and beyond. *Alcohol Change*, 3 July (https://alcoholchange.org.uk/blog/2020/drinking-in-the-uk-during-lockdown-and-beyond) Accessed 27 Dec 2020.

Bangham G (2020) *Time with the Kids: How Parents' Time Use has Changed during the Pandemic*. Resolution Foundation.

Barbosa C, Cowell AJ, Dowd WN (2021) Alcohol consumption in response to the Covid-19 pandemic in the United States. *Journal of Addiction Medicine*, **15**: 341–4.

Barnett OW, Fagan RW (1993) Alcohol use in male spouse abusers and their female partners. *Journal of Family Violence*, **8**: 1–25.

Benson ML, Fox GL (2001) *Economic Distress, Community Context and Intimate Violence: An Application and Extension of Social Disorganization Theory, Final Report*. National Institute of Justice.

Blanch A, Filson B, Penney D, et al (2012) *Engaging Women in Trauma-Informed Peer Support: A Guidebook*. National Centre for Trauma-Informed Care.

Bourquin P, Delestre I, Joyce R, et al (2020) *The Effects of Coronavirus on Household Finances and Financial Distress*. Institute for Fiscal Studies.

Brennan IR, Burton V, Gormally S, et al (2018) Service provider difficulties in operationalizing coercive control. *Violence Against Women*, **25**: 635–53.

British Medical Association (2019) *Support for Doctors Affected by Domestic Abuse*. BMA (https://www.bma.org.uk/media/3476/bma-domestic-abuse-briefing-nov-19.pdf).

Brooks SK, Webster RK, Smith LE, et al (2020) The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet*, **395**: 912–20.

Bywaters P, Featherstone B, Morris K (2019) Child protection and social inequality: Editorial. *Social Sciences*, **8**: 42.

Cooper C, Blanchard M, Selwood A, et al (2018) Family carers' distress and abusive behaviour: longitudinal study. *British Journal of Psychiatry*, **196**: 480–5.

Crowe A, Murray CE (2015) Stigma from professional helpers to survivors of intimate partner violence. *Partner Abuse*, **6**: 157–179.

Dawson DA, Grant BF, Ruan WJ (2005) The association between stress and drinking: modifying effects of gender and vulnerability. *Alcohol and Alcoholism*, **40**: 453–60.

Dias MC, Joyce R, Keiller AN (2020) *COVID-19 and the Career Prospects of Young People*. Institute for Fiscal Studies.

Do KN, Weiss B, Pollack A (2013) Cultural beliefs, intimate partner violence, and mental health functioning among Vietnamese women. *International Perspectives in Psychology*, **2**: 149–63.

Dom G, Samochowiec J, Evans-Lacko S, et al (2016) The impact of the 2008 economic crisis on substance use patterns in the Countries of the European Union. *International Journal of Environmental Research and Public Health*, **13**(1): 122.

Donovan E, Santer M, Daker-White G, et al (2021) Domestic abuse amongst female doctors: thematic analysis of qualitative interviews. *British Journal of General Practice*, **71**: e193–200.

Durrance CP, Perreira KM, Golden SD (2013) Troubled times, troubled relationships: how economic resources, gender beliefs, and neighborhood disadvantage influence intimate partner violence. *Journal of Interpersonal Violence*, **28**: 2134–55.

Ellinghaus C, Truss K, Liao Siling J, et al (2020) I'm tired of being pulled from pillar to post': a qualitative analysis of barriers to mental health care for trauma-exposed young people. *Early Intervention in Psychiatry*, **15**: 113–22.

Elliott DE, Bjelajac P, Fallot RD, et al (2005) Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, **33**: 461–77.

Emezue C (2020) Digital or digitally delivered responses to domestic and intimate partner violence during COVID-19. *JMIR Public Health and Surveillance*, **6**(3): e19831.

Fahmy E, Williamson E, Pantazis C (2016) *Evidence and Policy Review: Domestic Violence and Poverty*. Joseph Rowntree Foundation.

Finlay I, Gilmore I (2020) Covid-19 and alcohol – a dangerous cocktail. *BMJ*, **369**: m1987.

FitzGerald C, Hurst S (2017) Implicit bias in healthcare professionals: a systematic review. *BMC Medical Ethics*, **18**(1): 19.

Fox S, Galvani S (2020) *Briefing: Alcohol and Domestic Abuse in the Context of Covid-19 Restrictions*. Manchester Metropolitan University (https://www.mmu.ac.uk/media/mmuacuk/content/documents/rcass/Briefing-on-alcohol-and-domestic-abuse-in-context-of-Covid-19-1st-April-2020.pdf).

García-Moreno C, Zimmerman C, Morris-Gehring A, et al (2014) Addressing violence against women: a call to action. *Lancet*, **385**: 1685–95.

Gillett R (2018) Intimate intrusions online: studying the normalisation of abuse in dating apps. *Women's Studies International Forum*, **69**: 212–219.

Golding J (1999) Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *Journal of Family Violence*, **14**: 99–132.

Grossman ER, Benjamin-Neelon SE, Sonnenschein S (2020) Alcohol consumption during the COVID-19 Pandemic: a cross-sectional survey of US adults. *International Journal of Environmental Research and Public Health*, **17**(24): 9189.

Howell EF (2014) Ferenczi's concept of identification with the aggressor: understanding dissociative structure with interacting victim and abuser self-states. *American Journal of Psychoanalysis*, **74**: 48–59.

Institute of Alcohol Studies (2014) *Alcohol, Domestic Abuse and Sexual Assault*. Institute of Alcohol Studies.

Mason C, Taggart D, Broadhurst K (2020) Parental non-engagement within child protection services—how can understandings of complex trauma and epistemic trust help? *Societies (Basel, Switzerland)*, **10**(4): 93.

Molodynski A, McLellan A, Craig T, et al (2021) What does COVID mean for UK mental health care? *International Journal of Social Psychiatry*, **67**: 823–5.

National Institute for Health and Care Excellence (2014) *Domestic Violence and Abuse: Multi-Agency Working*. NICE.

NHS Digital (2020) *Safeguarding Adults England, 2019–20*. NHS Digital (https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2019-20). Accessed 28 Dec 2020.

Office for National Statistics (2020) *Domestic Abuse During the Coronavirus (COVID-19) Pandemic, England and Wales: November 2020*. ONS.

Reay AMC, Browne KD (2001) Risk factor characteristics in carers who physically abuse or neglect their elderly dependants. *Aging & Mental Health*, **5**: 56–62.

Rose D, Trevillion K, Woodall A, et al (2011) Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *British Journal of Psychiatry*, **198**: 189–94.

Scott S, McManus S (2016) *Hidden Hurt: Violence, Abuse and Disadvantage in the Lives of Women (DMSS Research for Agenda)*. Agenda.

Sin J, Elkes J, Batchelor R, et al (2021) Mental health and caregiving experiences of family carers supporting people with psychosis. *Epidemiology and Psychiatric Sciences*, **30**: E3.

Swanberg J, Logan T (2005) Domestic violence and employment: a qualitative study. *Journal of Occupational Health Psychology*, **10**: 3–17.

Sweeney A, Filson B, Kennedy A, et al (2018a) A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Advances*, **24**: 319–333.

Sweeney A, Taggart D (2018b) (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health*, **27**: 383–7.

Taggart D, Rouf K, Hisham IBI, et al (2021) Trauma, mental health and the COVID-19 crisis: are we really all in it together? *Journal of Mental Health*, **30**: 401–4.

Thomas KA, Goodman L, Putnins S (2015) 'I have lost everything': trade-offs of seeking safety from intimate partner violence. *American Journal of Orthopsychiatry*, **85**: 170–80.

Xie H (2013) Strengths-based approach for mental health recovery. *Iranian Journal of Psychiatry and Behavioral Sciences*, **7**(2): 5–10.

MCQs

Select the single best option for each question stem

1 As regards the effect of COVID-19 on domestic abuse:

a. the rate of abuse has increased during the pandemic, but severity of abuse has not
b. there has been no change – reporting has simply increased owing to increased awareness of the issue
c. COVID-19 directly causes domestic abuse
d. the pandemic has increased stressors and reduced protective factors against domestic abuse
e. physical abuse is the main form of domestic abuse to have risen as a result of COVID-19 measures.

2 The most common form of abuse perpetrated against older people identified through safeguarding referrals is:

a. physical abuse by people known to them
b. financial abuse by strangers
c. neglect by people known to them
d. emotional abuse by people known to them
e. all of the above.

3 Barriers to detecting domestic abuse include:

a. normalisation to the clinician's stigmatised beliefs on what abuse or abuse victims should look like
b. displaying in public areas such as waiting rooms information regarding domestic abuse and support available
c. routine sensitive enquiry about domestic abuse
d. increasing employer and employee awareness of domestic abuse in the workplace
e. regular review and audit of current trust policies on domestic abuse, including its current level of use and understanding by trust employees.

4 As regards the work-related impacts of being in a relationship governed by domestic abuse:

a. the victim's ability to get a job or maintain one can be reduced by the perpetrator's job-interference tactics
b. the COVID-19 pandemic has not changed the provision of paid childcare, so women can maintain the quality of their work while working from home
c. men are more likely than women to experience domestic abuse when experiencing poverty related to unemployment
d. disruptions in childcare and pay cuts related to the pandemic lockdown have equally affected working men and working women
e. domestic abuse and poverty are unrelated to gender norms regarding resources and caring responsibilities.

5 Among healthcare professionals who have experienced domestic abuse, which of the following factors is specific to those who are still trainees?

a. a lack of support by employers and an emphasis on 'resilience' despite poor mental and physical health
b. a lack of control and consideration regarding rotas and deployment
c. concerns that disclosure could raise questions about their professional capability
d. concerns about being recognised or meeting patients if they attend domestic abuse support services
e. feeling guilt, shame and difficulty reconciling their status as victims with their identity as doctors.