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Title:
COVID-19, Domestic Abuse & Mental Health Service Users: Mitigating the increased risk for an already at-risk patient group

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Abstract

COVID-19 has brought seismic changes in many areas of social life. In comparison to other recent pandemics, none has caused as severe of a socio-economic impact as COVID-19 thus far. Significant economic uncertainty and social restrictions have led to increased levels of stress for many. Responses seen include increased social isolation, financial stress, and alcohol intake, all of which can increase domestic abuse and other forms of household abuse. Similar increases in violence in the home have been found in other public health emergencies and economic recessions. The same increase can be seen now – reported UK domestic abuse rates have increased since the start of COVID-19. This paper aims to provide a point of learning based on previous outbreaks and recessions, with a focus on specific factors, such as unemployment and alcohol abuse, and how these contribute to increasing incidence and severity of abuse - and more importantly, how mental health professionals can mitigate it for mental health service users, a group in which 1 in 3 was reported to have already experienced abuse before the COVID-19 pandemic.

Summary

This paper focuses on how COVID-19 and its anticipated aftermath exacerbate the risk factors for domestic abuse among the general population and discuss clinical implications for mental health practitioners in the UK. COVID-19 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 have caused as severe a socio-economic impact as COVID-19. Population stress brought about by the pandemic and the social and economic fallout can have drastic impacts, including increased alcohol use and worsening mental health and financial insecurity. These are risk factors leading to domestic abuse, a myriad of problems which has also been found in research on past disease outbreaks and recessions. Reports have already emerged on the increased rates of domestic abuse as a result of COVID-19. This paper aims to highlight domestic abuse during and post COVID-19 and provide a point of learning, focusing on three specific factors – poverty, alcohol use and mental distress – how these contribute to increasing incidence and severity of abuse in domestic settings, and how UK mental health practitioners might identify and support individuals who are particularly at risk. The learning objectives are to:

a. understand three key risk factors for domestic abuse that COVID-19 has introduced or exacerbated;
b. recognise how COVID-19 and its associated restrictions introduced to clinical care can impact the detection and mitigation of domestic abuse in mental health settings;

c. understand how mental health practitioners might mitigate for these changes and help safeguard service users from domestic abuse.

In this paper, we use the term "domestic abuse" to cover all broad categories and types of abuses and violence (including but not limited to sexual violence, emotional abuse, coercion and controlling patterns, and physical aggression) that occur in domestic settings and among familiar or intimate partner relations.

Section 1: 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 environments of COVID-19. At the same time, disasters such as pandemics are known to increase domestic abuse rates and severity. In a report on domestic abuse and COVID-19 published in November 2020, the UK's Office for National Statistics (ONS) found an increased demand for domestic abuse services, particularly helplines, during and 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 (ONS, 2020). It was also found that children are at an increased risk of experiencing or witnessing violence and abuse within the home during the pandemic.

The causes of domestic abuse are multifactorial, complex, and overlapping with roots in individual, relationship, community and societal factors. Community factors such as societal norms around gender roles, to societal factors such as reduced access to support networks to help manage individual stressors could all contribute to perpetration and exacerbation of abuse. (Garcia-Moreno, 2014) The following sections of this paper focus on three specific risk factors exacerbated by COVID-19: poverty, alcohol use, and increasing levels of mental distress.

Poverty

COVID-19 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 violence 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 and Fox, 2001). Research commissioned by the Joseph Rowntree Foundation found that domestic violence and poverty are connected by rigid and unhealthy gender norms regarding resources and caring responsibilities (see Box I). Poverty can exert a dual effect by increasing domestic stressors whilst simultaneously limiting resources that women can access to respond to these stressors, making it harder to leave abusive relationships (Fahmy et al., 2016). This may have been exacerbated through COVID-19; for instance, it has been argued that lockdown measures have disproportionately disadvantaged working women (compared to working men) through disruptions to childcare and income reduction (Bangham, 2020).

Experiencing domestic abuse may reduce survivors' ability to participate in the labour market, or to do so effectively, through the impacts on their physical and mental health. Also, perpetrators of abuse have been known to employ job-interference methods such as incessant calls, frequent workplace attendance as part of their abuse tactics. (Swanberg & Logan, 2005) In the context of COVID-19, where working from home is encouraged, the extent of this

could be exacerbated, limiting survivors' ability to not only get a job, but also to maintain one.

Whilst vaccines look promising for limiting the spread of the COVID-19 virus, they will not prevent its enduring impacts. 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 et al, 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 et al, 2020).

Box I: Exploring the links between domestic violence and poverty (Fahmy et al, 2016)

A report for the Joseph Rowntree Foundation, conducted by the University of Bristol, found that there is a link between domestic violence and poverty, and that this link is due to gendered assumptions around household resources and caring responsibilities which go on to shape women's vulnerability to domestic violence. 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 women
- male partners preventing women from working, claiming benefits or leaving the house

Alcohol use

Poverty, precarity and unemployment are associated with alcohol use in complex ways. Whilst the 2008 recession saw alcohol intake fall across Europe, alcohol use increased amongst those who lost their jobs and experienced long-term unemployment and/or who experienced significant mental distress (Dom et al, 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 et al, 2005). Between 2010-2011, 39% of domestic violence reports found that perpetrators were drinking alcohol at the time of perpetration (Institute of Alcohol Study, 2014). Further, when alcohol is involved, the violence and resultant injury are often more severe. For survivors, alcohol could be used to cope with the trauma of violence and abuse. For instance, research has found that abuse victims were twice as likely to drink after an abusive event (Barnett and Fagan, 1993). However, amongst women, alcohol use during or after attacks is associated with increased levels of self-blame and more blame attributed to them by the public and perpetrators alike (Institute of Alcohol Study, 2014). In a recent briefing created in collaboration with Alcohol Change UK, Fox and Galvani (2020) provided insight into the existing relationship between alcohol use amongst survivors and perpetrators and how the pandemic could impact this (Box II).

Box II: How COVID-19 impacts on alcohol and domestic abuse (Fox and Galvani, 2020)

- Social isolation increases the risk of multiple types of domestic abuse (e.g., physical, sexual, etc.). This risk is amplified in homes where abuse and alcohol were pre-existing issues.
- The normalisation of home drinking through the inclusion of off-licences as essential businesses whilst other social outlets are closed.
- Alcohol restrictions could be used as a form of control by perpetrators against domestic abuse survivors who are alcohol dependant. Sudden alcohol withdrawal could lead to serious medical consequences such as delirium tremens, hallucinations, seizures and heart failures which could have lasting health effects.
- Less support is available to survivors due to COVID-19 measures necessitating closure or reduced provision of alcohol 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.

Despite the risks of home drinking and domestic violence, 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, available support provisions for alcohol services are 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 wellbeing could be lifelong (Bywater, Featherstone and Morris, 2019). Consequently, the UK government has classified children in a household where abuse and violence are perpetrated as victims themselves, regardless of whether the abuse was directed at them or not (Domestic Abuse Act, 2021).

Mental Distress

Molodynski and colleagues (2020) have outlined three main challenges COVID-19 poses to the UK population's mental health and associated support services:

1. Impacts on the mental health of frontline staff in services that were already stretched pre-COVID.
2. Social and physical distancing measures which exacerbate social inequalities, particularly in the BAME population, older people, domestic abuse survivors, and children.
3. The economic impact leading to potential 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 impacts of social distancing on mental health are well established (Brooks, 2020). These impacts are believed to be exacerbated for domestic abuse or childhood trauma survivors during the pandemic due to a triad of interlocking factors: i) social marginalisation and disadvantage; ii) pre-existing physical health problems; and iii) the exacerbation of pre-existing mental distress caused by pandemic restrictions that mirror features of abuse (e.g. lack of control and entrapment) (Taggart et al., 2021). The impact of childhood trauma reverberates through to adulthood for survivors, increasing the risk of various adverse outcomes – including domestic violence; as such, 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 et al., 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. BAME communities' specific services are also more vulnerable to cutbacks (Taggart et al., 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 to reducing levels of domestic abuse. Social policies should be implemented at multiple levels, given the ecological nature of stressors.

As in past lockdowns, it may be that the true scale of domestic abuse and violence will only emerge once restrictive measures 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 current catastrophic events but also after that (Emezue 2020). Risk factors such as increased alcohol intake because of a catastrophe have been shown to peak one to three years after the event (Grossman, 2021). 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.

Box III: Key takeaway messages for mental health practitioners: section one

- Severe events such as pandemics are associated with an increase in domestic violence both during and after the event.
- The cause of this effect extends beyond the direct consequences of COVID-19 (infection, restrictions, bereavement) but can also partly be attributed to a failure of sufficient services in several domains, including financial, domestic and health services.
- Be aware of how COVID-19 and the different risk factors of domestic abuse interact to build a better understanding of the challenges demestic abuse survivors could face.
- Patients with mental health conditions are at a heightened risk for domestic violence. This risk is exacerbated with alcohol and/or substance misuse. As such, these should be regularly screened and asked about in consultations.
- Survivors of childhood trauma are at increased risk of re-traumatisation through COVID-19, whilst 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.

Section 2: How can mental health practitioners respond?

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

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

However, there are concerns that the recent Domestic Abuse Act (2021) does not address the chronic under-provision 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. Whilst this has proved beneficial in some areas and might continue to have a role in service delivery post-COVID-19, the impact of these new methods of working on domestic abuse must be reviewed and evaluated.

Reporting and detecting domestic violence

Research evidence demonstrates that over one-third of female services users in mental health settings are experiencing current domestic abuse (Scott, 2016), the Ask and Take Action campaign was launched in 2019. NICE recommends that routine enquiry - the practice of asking all service users 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, a recent survey found that of 42 mental health Trusts investigated, 15 had

no routine enquiry policies. Of those who did, effectiveness varied, with some Trusts having enquiry rates of 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 on what abuse or abuse victims should look like. Research in a socioeconomically deprived area of south London found that service users face multiple barriers in disclosing domestic abuse, including shame and fear; fear of not being believed; fear of the consequences, such as further violence; and fear of possible social services involvement and child protection proceedings (Rose et al., 2011).

For some, having repeated past experiences of violence and abuse, could make current disclosures more challenging due to prior negative institutional or service responses, 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 violence; as such, 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 et al., 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) described, frontline staff must have access to training in making sensitive routine inquiries 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 disclosures into meaningful individualised suppport. This requires that there are appropriate services to refer survivors to, including services that understand people's needs in the context of intersecting identities, such as services for women of colour, 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 (see Box IV).

Box IV: Quotations from NICE's *"Domestic violence and abuse: multi-agency working"* section on creating an environment for disclosing domestic violence in face-to-face settings (NICE 2014)

- Clearly display information in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse. This includes contact details of relevant local and national helplines.
- Ensure the information on where to get support is available in a range of formats and locally used languages. The former could include braille and audio versions and the use of large font sizes. There may also be more discreet ways of conveying information, for example, by providing pens or key rings with a helpline number.
- Take steps to ensure people who use the service are given maximum privacy, for example, by arranging the reception area so that people cannot be overheard.
- Establish a referral pathway to specialist domestic violence and abuse agencies (or the equivalent in a health or social care setting). This should include age-appropriate options and options for groups that may have difficulties accessing services, or are reluctant to do so (see recommendation below).
- Ensure frontline staff know about the services, policies and procedures of relevant local agencies in relation to domestic violence and abuse.
- Provide ongoing training and regular supervision for staff who may be asking people about domestic violence and abuse. This should aim to sustain and monitor good practice.
- Establish clear policies and procedures for staff who have been affected by domestic violence and abuse. Ensure staff have the opportunity to address issues relating to their own personal experiences, as well as those that may arise after contact with patients or service users.

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 et al., 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).

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 violence 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 to initially come from the mental health practitioner, constituting an intervention in and of itself (Taggart et al., 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 and Murray, 2015). Mental health practitioners may observe women returning to abusive relationships and possibly exposing their children to violence, and 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 mother's case histories and suggested a trauma-based understanding can help social care professionals understand these patterns (Mason et al, 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 et al, 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 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 borne of a personal deficit.
- Considering trauma history, social support levels and the person's understanding of abuse may help mental health practitioners scaffold support accordingly.
- When making enquiries, be mindful of the potential weight of the word 'abuse' to survivors including the potential for this not to feel recognisable to survivors. Acknowledging that experiences are not acceptable is also an important step.
- The terminology used by survivors to describe their experiences should be respected and used in discussion in favour of terms such as 'abuse'.

Telemedicine and reporting and detecting abuse

COVID-19 has led to an increase in telemedicine which may well endure post-pandemic. Whilst telemedicine can increase engagement for some by removing logistical barriers to attendance; for others, accessibility issues can further marginalise those already marginalised, such as those economically deprived (Molodynski, 2020).

Domestic abuse by definition happens in people's own homes, typically perpetrated by people who live in the same household. It is therefore vital that clinicians are mindful of this and conduct consultations accordingly. AVA, a national violence against women and girls charity, has provided guidance for mental health practitioners dealing with patients experiencing domestic abuse during COVID-19. In it, ways enquiries can be made safely and sensitively are discussed (See Box V). Further details on safety planning and safe referral can also be found in the guidance.

Box V: Quotations from AVA's "Domestic abuse during COVID-19: Guidance for mental health practitioners" section on safe communication

- If you have any suspicion or indication of abuse and it is safe to do so, always ask. For example; "As violence is so common, we are asking all of our service users", "Are there times when you have felt unsafe at home?"
- It is crucial that enquiring about domestic abuse is done sensitively and in a private environment. Speak to individuals alone. Do not use friends, family or carers as interpreters or translators.
- If an outreach service is not currently providing face to face services, discuss with the service user whether contact via phone, text, email or messaging apps is a safe and feasible alternative. Be mindful that some survivors are likely to be self-isolating with perpetrators.
- When providing telephone services, ask 'yes/no' questions to establish if the individual is alone and safe to speak. If you hear someone in the background or if the client confirms that they can be overheard shift the tone of the conversation for example: 'Do you need food/medication etc?'
- Create a safe word with the patient to identify risk of harm without the knowledge of a perpetrator.
- Make sure that you have sufficient time for the conversation so that the survivor will not be rushed.
- If a service user discloses, validate their experience and let them know that the abuse is not their fault. For example; "What you are describing sounds like abuse". "The abuse is not your fault".

Patients might not be aware of what DA specific support services are available or have the capacity to explore this themselves. It is also equally important to have a basic understanding on how to safely deal with disclosures of perpetration of DA by patients. Potential resources to be considered are listed in Box VI below.

Box VI: Potential Third Sector Services That Could Be Useful for Patients

- Women's Aid Directory: https://www.womensaid.org.uk/domestic-abuse-directory/
- National Domestic Violence Helpline: 0808 2000 247
- Download Hestia's Bright Sky app: this is a free mobile application that includes information on UK-wide directory of specialist domestic abuse support services with contact details and nationwide helplines available 24/7.

Whilst extensive discussion surrounding dealing with disclosure of perpetration of DA is beyond the scope of this paper, it is worth noting these resources that could be useful when dealing with disclosure from patients who perpetrate DA:

- Safelives Guidance for practitioners working with those who harm: https://safelives.org.uk/sites/default/files/resources/Guidance%20for%20professionals%20working%20with%20perpetrators.pdf
- Respect helpline for those worried about their own behaviour: : 0808 802 4040

Reporting and detecting abuse in 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 constituted the majority of safeguarding referrals, with those aged 65 and over making up for over 60% of referrals since 2009 (the year data collection began). In the year 2019-2020, it is estimated that 1 in 38 adults aged over 85 years were involved in a section 42 referral, with neglect and omission of care being the main form of maltreatment. Perpetrators of abuse in this group are often caregivers, both from inside and outside the family (Age UK, 2020).

A study identified 15 risk factors in caregivers that increase the risk of mistreatment (Reay and Browne, 2001). Three of them are particularly relevant during the current outbreak:

1. caregivers who are subject to high stress and strain;
2. those who live with elderly service users, often an elderly partner/spouse; and
3. those who are isolated and lack community and personal support.

The responsibility and load of informal, unpaid, and long-term caregiving can cause high levels of distress in family carers; with distress levels positively correlated with increasing amount of time spent on caregiving (Sin et al, 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 et al., 2010). In the context of dementia, carers are often elderly spouses of these service users; the perceived neglect can be a manifestation of their own inability to cope with the added pressure brought on by COVID-19.

Whilst 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 and intensity. A significant proportion of the elderly population are also considered 'high-risk' and are encouraged to 'shield', reducing their contact with the outside world even more than others. Ensuring that older adults and their family carers are well supported may help prevent abuse perpetration. The Social Care Institute for Excellence (SCIE), 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 carers are well supported and made aware of available support resources (see supplementary material for further resources)

Reporting and detecting abuse in Black and Minoritized Ethnic communities

Whilst domestic abuse occurs across cultures and in all countries, rates vary considerably cross-culturally (Do, Weiss and Pollack, 2013). In multicultural societies, mental health practitioners and others make clinical decisions about people from backgrounds different to 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 based on unconscious assumptions about the other person based on their ethnicity, gender, sexual orientation, disability and other characteristics (Fitzgerald and Hurst, 2017).

Therefore, it is imperative that mental health practitioners adopt a "not knowing" position and understand the need to learn from service users, rather than to risk the stereotyping that can result from focusing on group characteristics. Challenging our assumptions about a person's identity, beliefs, and behaviours could be a key element in improving domestic abuse identification and prevention. Blanch and colleagues (2012) provide recommendations on key factors in engaging trauma survivors in culturally sensitive ways (see Box VII).

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 is 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, this is also an opportunity for us to learn from the longstanding issues COVID-19 has made more evident and finally make the necessary changes.

Box VII: Blanch and colleagues (2012) culturally sensitive approaches to trauma survivors include:

- Understand that violence is inflicted by groups and institutions, not just individuals, and that it is so commonplace people may be desensitised to it.
- Recognise that political and social oppression may impact on 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.

Taking action: developing trauma-informed 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 service users and providers. Research has consistently found that these relationships are central to survivors' experience of services (Elliott, 2005). Unfortunately, research evidence indicates that relationships between service users 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 in 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 a lack of power and pressure from professionals, "to adopt particular perspectives, engage in therapies and use strategies that were in conflict with their own explanatory models".

Whilst trauma-informed approaches describe a process of organisational change that embeds an understanding of trauma throughout service planning and delivery (Sweeney & Taggart, 2018), service providers can also engage in trauma-informed relationships where the organisation has not yet embedded trauma-informed approaches (Sweeney et al. 2018). (see supplementary material for further resources)

Engaging in trauma-informed relationships means understanding that the symptoms or behaviours a person displays - which may seem 'difficult', 'challenging', 'damaging' or 'bizarre' – might be a learned adaptations to trauma that have helped them survive. This extends to understanding the reasons that a person may 'choose' to remain in a violent and abusive relationship and being able to continue providing support.

Alongside this shift away from a pathologising model of 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 people have developed to help them survive and thrive. Strengths-based approach supports 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, listen carefully, and be service user-led, ultimately adopting a position of 'how can I help?'.

Health practitioners who experience domestic abuse

A report by the British Medical Association estimated that healthcare professionals, particularly midwives and health care assistants are three times more likely to experience domestic abuse, when compared with the general population (BMA, 2019). Despite this, when compared with the general public, it is harder for healthcare professionals to get support for domestic violence; additional barriers to disclosure and detection for this group includes societal expectations of the role, and clinicians' own beliefs. The British Medical Association in their publication regarding support for doctors affected by domestic abuse, has highlighted some of these unique challenges (see Box VIII). Additionally, certain norms of the medical profession – such as the focus on resilience, empathy and sympathy, and frequently dealing with challenging behaviour – extended to their personal lives and normalised 'abusive' behaviours within their own interpersonal relationships (Donovan, 2020).

Box VIII: Unique Barriers in Accessing Support (Direct Quotes from "Support for doctors affected by domestic abuse" produced by the BMA in 2019)

- **Self-stigmatisation** - Survivors reported guilt, shame and difficulty reconciling their status as a victim with their identity as a doctor.
- **Stereotypes** - Doctors who experienced domestic abuse described having internalised stereotypes of domestic abuse victim which contributed to their fear of not being believed if they spoke up as they do not fit this image. This was particularly the case in so-called 'medical marriages', where both the victim and perpetrator of violence are doctors.
- **Accessing support services** - Doctors often have a visible community profile and may be worried about being seen using these services, or potentially encountering their own patients there.
- **Professional isolation** - Doctors on less than full time training training struggle to establish supportive workplace networks due to limited contact with their full time colleagues. The resultant sense of isolation makes it harder to discuss sensitive issues with colleagues.
- **Financial concerns –** Support Services assumptions surrounding doctors being affluent without considering the financial control aspect of DV makes it harder for doctors who are also survivors to access emergency financial support**.**
- **Fear of professional consequences –** concerns that disclosure could raise questions about their professional capability. Fears surrounding the potential impact of false allegations perpetrators could make to GMC or social services, andthe impact of patients' trust if their survivor status were made public are also prevalent.

The effects of domestic abuse on survivors 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, emphasis on 'resilience' despite poor mental and physical health further compounds this effect (BMA 2019, Donovan, 2020). Amongst trainees, a lack of control and consideration surrounding rotas and deployment, and unsympathetic educational supervisors have been cited as a contributing factor to their increased distress and social isolation (Donovan, 2020). Despite the many negative effects of DA on survivors in the workplace, there continues to be a lack of awareness amongst employers and healthcare practitioners themselves; the BMA found that 32% of NHS trust do not currently have a domestic abuse policy for staff. DA 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 impacts 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 may wish to focus on increasing the availability and range of support offered, including those provided by individuals with lived experiences.
- Review current trust policies and practices, particularly on these 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 *Ask and Take Action* by Agenda.
    - Is the clinical environment currently conducive for disclosure of abuse as per NICE guidelines (Box IV)
    - Does the trust have a policy for supporting staff members who are experiencing domestic abuse? If there is one, does the current policy addresses the key challenges DA survivors could face, including acknowledgment and appropriate support for how DA could impact on job performance and meeting training requirements.
- 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.
- Joint up communication and working with other agencies working with survivors, e.g. police, social care, housing, charities

In order to better support colleagues who are experiencing abuse themselves, trust needs to ensure that a DV policy for staff members are in place. In making these policies, particular attention needs to be paid to the following areas:

- Recognising how DA could affect job performance through lower productivity, increasing absenteeism, etc. What support/adjusgments are available 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 including lone working alarms or moving staff who are currently experiencing abuse out of community roles could be needed.

For mental health practitioners:

- Identify current gaps in knowledge, beliefs and current clinical practice surrounding DA that could impede detection and support offered to patients. This could be done through:
    - Reflection on current beliefs and biases (both conscious and unconscious); MHPs should familiarise themselves on lived survivor experiences of abuse through methods such as reading survivor testimonies
    - Witholding judgement for reasons that adults may choose to live with violence; people who are abused should not be abused for their abuse.
- Reviewing current clinical practice to identify areas of improvement; in particular, auditing current practice against current guidelines and recommendations:
    - Incorporation of routine enquiry on domestic abuse as a routine part of clinical encounters.
    - Safe enquiry practices as per recommendations outlined in Box V.

- Awareness of mental health practitioners on routes for escalations and referrals if a patient were to disclose DA.

Box VIII: Key takeaway messages for mental health practitioners: section two

- Reflect on how your own internalised beliefs and unconscious bias could affect your ability to detect and support patients experiencing DA.
- 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 minoritized population, might face.
- How to deal with disclosure and potential routes of referral.
- What trauma informed care is and how these values can be adopted to best support patients.

Conclusion

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 in the wake of mass vaccinations, at least in the UK context. 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 social isolation.

The restricted and remote provision of healthcare, particularly mental health, whose service users are 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. In this paper we have outlined some of the factors to consider when working with service users who might be victims of or at risk of domestic abuse. There has also been consideration of the additional complexities of working with victims of domestic abuse from different cultural contexts and generations. An underpinning trauma informed approach, coupled with sensitive investigation and non-stigmatising, victim blaming responses will go some way to mitigate 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 their current barriers to detection and disclosure; providing remedies for identified issues either through increase training or policy changes. On an individual level, reviewing current practices and reflecting on current held beliefs is essential so any gaps in knowledge and unhelpful beliefs could be identified, challenged and improved.

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Supplemetary materials: Useful resources	
Responding to Interpersonal Violence	- AVA's Guidance for Mental Health Professionals Responding to Domestic Abuse in COVID-19: https://avaproject.org.uk/wp-content/uploads/2020/04/FINAL-AVA-Briefing-for-MH-professionals-1.pdf - LARA-VP - A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA) : https://www.kcl.ac.uk/ioppn/depts/hspr/research/ceph/wmh/lara-vp-download-form - The World Psychiatric Association (WPA) International Competency-Based Curriculum for Mental Health Care Providers on Intimate Partner Violence and Sexual Violence against Women : https://images.assettype.com/whiteswanfoundation/2020-09/73d66224-476d-46b7-92ac-839a6e0f8d41/WPA_Curriculum.pdf - Free training from Coursera on *Confronting Gender Based Violence: Global Lessons for Healthcare Workers*: https://www.coursera.org/learn/gender-based-violence - Department of Health and Social Care "**Domestic abuse: a resource for health professionals"** https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals
Trauma-informed approaches	- BJPsych Advances Article on Trauma Informed Care: A paradigm shift: relationships in trauma-informed mental health services (Sweeney 2018) - SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach- https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf - Transforming Psychological Trauma: A knowledge and skills framework for the Scottish Work Force - https://transformingpsychologicaltrauma.scot/media/x54hw43l/nationaltraumatrainingframework.pdf
Telemedicine	- NIHR on Telepsychiatry: https://oxfordhealthbrc.nihr.ac.uk/our-work/oxppl/table-5-digital-technologies-and-telepsychiatry/ - NIHR on Domestic Abuse: https://oxfordhealthbrc.nihr.ac.uk/our-work/oxppl/domestic-violence-and-abuse/ - AVA domestic abuse during COVID-19 guidance for mental health professionals : https://avaproject.org.uk/wp-content/uploads/2020/04/FINAL-AVA-Briefing-for-MH-professionals-1.pdf
Alcohol	- AVA' Complicated Matters – A Toolkit Addressing Domestic and Sexual Violence, Substance Use and Mental Ill-health https://avaproject.org.uk/wp-content/uploads/2013/05/AVA-Toolkit-2018reprint.pdf

	- ADFAM advise on Alcohol, Domestic Abuse and COVID-19: 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 - For Children in Homes with Parents Who Abuse Alcohol: https://alcoholchange.org.uk/alcohol-facts/fact-sheets/parents-who-drink-too-much
Making Policies	Making DV Policies: https://www.nhsemployers.org/-/media/Employers/Publications/Health-and-wellbeing/HSWPG_DV_Policy-document.pdf

5232 words excluding boxes, titles, and in-text citations

Five multiple choice questions

1. In which way has COVID-19 affected domestic abuse?
    a. The rates of abuse has increased, but severity of abuse has not.
    b. There has been no change, reporting has simply increased due to increased awareness of the issue.
    c. COVID-19 directly causes abuse
    d. COVID-19 has increased stressors and reduced protective factors against domestic abuse.
    e. Physical form of domestic abuse is the main form of 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. Which of the following is a barrier to detecting domestic abuse?
    a. Normalisation of what violence and abuse to clinician's stigmatised beliefs on what abuse or abuse victims should look like
    b. Displaying information regarding domestic abuse in the GP waiting area and showing support is available to those who need it.
    c. Information on where to get support is available in a range of formats and locally used languages. The former could include braille and audio versions and the use of large font sizes. There may also be more discreet ways of conveying information, for example, by providing pens or key rings with a helpline number
    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. How can being in a domestic abuse relationship affect survivors ability to maintain work?
    a. Perpetrators employing job-interference methods as part of their abusive tactics, effect the victims ability to get a job or maintain one
    b. The COVID-19 pandemic has not changed the provision of paid childcare by working women and therefore their ability to maintain quality of work are unaffected
    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 lockdown have equally affected both working men and working women.
    e. Domestic violence and poverty are relationship are NOT related to gender norms regarding resources and caring responsibilities
5. A report by the British Medical Association estimated that healthcare professionals, are three times more likely to experience domestic abuse. There are suggestions that amongst doctors, the negative career impact of being a DA survivor are worse for those still in training. Which of the following factors are specific to DA survivors who are **trainees**:
    a. A lack of support by employers, emphasis on 'resilience' despite poor mental and physical health.
    b. A lack of control and consideration surrounding rotas and deployment, and unsympathetic educational supervisors It is important to consider that different cultures can understand and experience trauma in different ways.
    c. Concerns that disclosure could raise questions about their professional capability.
    d. Doctors often have a visible community profile and may be worried about being seen using these services, or potentially encountering their own patients there.
    e. Survivors reported guilt, shame and difficulty reconciling their status as a victim with their identity as a doctor.

Answers:

1. D
2. C
3. A
4. A
5. B

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Declaration of interest

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