



City Research Online

City, University of London Institutional Repository

Citation: Hisham, I. N., Sin, J., Rouf, K., Taggart, D., Townsend, G. & Sweeney, A. (2022). Domestic abuse and mental health: The amplified risks created during the pandemic. *BJPsych Advances*, 28(5), pp. 316-327. doi: 10.1192/bja.2021.69

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: <https://openaccess.city.ac.uk/id/eprint/27446/>

Link to published version: <https://doi.org/10.1192/bja.2021.69>

Copyright: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

Reuse: Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

City Research Online:

<http://openaccess.city.ac.uk/>

publications@city.ac.uk

TITLE PAGE BJ Psych Advances

Title:

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

Authors: Idura N. Hisham, Jacqueline Sin, Khadj Rouf, Danny Taggart, Giles Townsend and Angela Sweeney

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;

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

49
50 In this paper, we use the term "domestic abuse" to cover all broad categories and types of
51 abuses and violence (including but not limited to sexual violence, emotional abuse, coercion
52 and controlling patterns, and physical aggression) that occur in domestic settings and among
53 familiar or intimate partner relations.
54

55 **Section 1: Understanding risk factors for domestic abuse**

56 The often hidden nature of abuse in domestic settings makes it hard to detect and harder still
57 during the lockdown environments of COVID-19. At the same time, disasters such as
58 pandemics are known to increase domestic abuse rates and severity. In a report on domestic
59 abuse and COVID-19 published in November 2020, the UK's Office for National Statistics
60 (ONS) found an increased demand for domestic abuse services, particularly helplines, during
61 and continued even after initial lockdown measures were eased. The increased demand was
62 partly due to an increase in the severity of the abuse that people experienced and a lack of
63 access to normal coping mechanisms, such as leaving home or periods of respite away from
64 the abusive relationship (ONS, 2020). It was also found that children are at an increased risk
65 of experiencing or witnessing violence and abuse within the home during the pandemic.

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

73

74 **Poverty**

75 COVID-19 saw the UK officially fall into recession in 2020, with further economic
76 downturns predicted for 2021 and 2022, making a protracted recession likely. An association
77 between economic downturns and increased violence is well established in the literature
78 (Durrance, 2013). Women who experience domestic abuse are at increased risk of exposure
79 to more serious and repeated abuse if they live in economically precarious circumstances
80 (Benson and Fox, 2001). Research commissioned by the Joseph Rowntree Foundation found
81 that domestic violence and poverty are connected by rigid and unhealthy gender norms
82 regarding resources and caring responsibilities (see Box I). Poverty can exert a dual effect by
83 increasing domestic stressors whilst simultaneously limiting resources that women can access
84 to respond to these stressors, making it harder to leave abusive relationships (Fahmy et al.,
85 2016). This may have been exacerbated through COVID-19; for instance, it has been argued
86 that lockdown measures have disproportionately disadvantaged working women (compared
87 to working men) through disruptions to childcare and income reduction (Bangham, 2020).

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

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

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

101

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

102

103

104

105 Alcohol use

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

113 Alcohol may be used as a coping mechanism for dealing with the pandemic. For men in
114 particular, each additional stressor experienced - unemployment, emotional distress, isolation
115 - increases the likelihood of heavy drinking (Dawson et al, 2005). Between 2010-2011, 39%
116 of domestic violence reports found that perpetrators were drinking alcohol at the time of
117 perpetration (Institute of Alcohol Study, 2014). Further, when alcohol is involved, the
118 violence and resultant injury are often more severe. For survivors, alcohol could be used to
119 cope with the trauma of violence and abuse. For instance, research has found that abuse
120 victims were twice as likely to drink after an abusive event (Barnett and Fagan, 1993).
121 However, amongst women, alcohol use during or after attacks is associated with increased
122 levels of self-blame and more blame attributed to them by the public and perpetrators alike
123 (Institute of Alcohol Study, 2014). In a recent briefing created in collaboration with Alcohol
124 Change UK, Fox and Galvani (2020) provided insight into the existing relationship between
125 alcohol use amongst survivors and perpetrators and how the pandemic could impact this (Box
126 II).

127

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.

128

129

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

136

137 For children in homes affected by alcohol use, deprivation, and domestic abuse, the impacts
138 on mental and physical health and social wellbeing could be lifelong (Bywater, Featherstone
139 and Morris, 2019). Consequently, the UK government has classified children in a household
140 where abuse and violence are perpetrated as victims themselves, regardless of whether the
141 abuse was directed at them or not (Domestic Abuse Act, 2021).

142

143

144 **Mental Distress**

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

147

148

1. Impacts on the mental health of frontline staff in services that were already stretched pre-COVID.
- 149 2. Social and physical distancing measures which exacerbate social inequalities,
150 particularly in the BAME population, older people, domestic abuse survivors, and
151 children.
- 152 3. The economic impact leading to potential austerity measures which often
153 disproportionately disadvantage people on state benefits or who are already
154 economically deprived. Further, austerity would deplete mental health services that
155 are already severely weakened by past austerity measures.

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

159 The negative impacts of social distancing on mental health are well established (Brooks,
160 2020). These impacts are believed to be exacerbated for domestic abuse or childhood trauma
161 survivors during the pandemic due to a triad of interlocking factors: i) social marginalisation
162 and disadvantage; ii) pre-existing physical health problems; and iii) the exacerbation of pre-
163 existing mental distress caused by pandemic restrictions that mirror features of abuse (e.g.
164 lack of control and entrapment) (Taggart et al., 2021). The impact of childhood trauma
165 reverberates through to adulthood for survivors, increasing the risk of various adverse
166 outcomes – including domestic violence; as such, in assessing and treating adult survivors,
167 developmental trauma and its associated social, physical and psychological impact has to be
168 considered as an integral part of the care plan (Taggart et al., 2021).

169 Mental Health services have historically received less funding than other healthcare services
170 and this contributes to longer waiting times and time-limited support in many cases. BAME
171 communities' specific services are also more vulnerable to cutbacks (Taggart et al., 2021). In
172 a system where the service provision for abuse survivors were inadequate pre-COVID, in a
173 post-COVID time of a struggling economy and potentially more robust austerity measures,
174 the increased demand could paradoxically be met with further reductions creating a bigger
175 backlog. Effective support at multiple levels for those experiencing poverty, alcohol use and
176 significant mental distress will be vital to reducing levels of domestic abuse. Social policies
177 should be implemented at multiple levels, given the ecological nature of stressors.

178
179 As in past lockdowns, it may be that the true scale of domestic abuse and violence will only
180 emerge once restrictive measures are eased, with many disclosures unlikely to be made for
181 years afterwards, if ever. Furthermore, epidemiological research has shown that gender-based
182 violence intensifies not just during current catastrophic events but also after that (Emezue
183 2020). Risk factors such as increased alcohol intake because of a catastrophe have been
184 shown to peak one to three years after the event (Grossman, 2021). This means that survivors
185 are likely to present to services for many years to come. It is critical that mental health
186 practitioners feel competent and supported to respond.

187

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 domestic 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.

188

189

190 Section 2: How can mental health practitioners respond?

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

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

197 However, there are concerns that the recent Domestic Abuse Act (2021) does not address the
198 chronic under-provision of services. This means that mental health practitioners must respond
199 to domestic abuse without necessarily having adequate services available locally.

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

205 Reporting and detecting domestic violence

206 Research evidence demonstrates that over one-third of female services users in mental health
207 settings are experiencing current domestic abuse (Scott, 2016), the Ask and Take Action
208 campaign was launched in 2019. NICE recommends that routine enquiry - the practice of
209 asking all service users about their experiences of domestic abuse, regardless of the presence
210 or absence of warning signs – should be standard practice in mental health settings (NICE,
211 2014). Despite this, a recent survey found that of 42 mental health Trusts investigated, 15 had

212 no routine enquiry policies. Of those who did, effectiveness varied, with some Trusts having
213 enquiry rates of as low as 3% (Agenda, 2019).

214 Multiple barriers exist to reporting and detecting domestic abuse, ranging from the
215 normalisation of violence and abuse to clinicians' stigmatised beliefs on what abuse or abuse
216 victims should look like. Research in a socioeconomically deprived area of south London
217 found that service users face multiple barriers in disclosing domestic abuse, including shame
218 and fear; fear of not being believed; fear of the consequences, such as further violence; and
219 fear of possible social services involvement and child protection proceedings (Rose et al.,
220 2011).

221 For some, having repeated past experiences of violence and abuse, could make current
222 disclosures more challenging due to prior negative institutional or service responses,
223 complicating access to treatment and support. The impact of childhood trauma reverberates
224 through to adulthood for survivors, increasing the risk of various adverse outcomes –
225 including domestic violence; as such, in assessing and treating adult survivors, developmental
226 trauma and its associated social, physical and psychological impact has to be considered as an
227 integral part of the care plan (Taggart et al., 2021).

228 Thus, routine enquiry does not mean that all those who are asked will disclose, nor does it
229 mean that enquiry is risk-free, and practitioners must take care that enquiries do not cause
230 further harm. As Agenda (2019) described, frontline staff must have access to training in
231 making sensitive routine inquiries about domestic abuse and ongoing supportive supervision.
232 Alongside understanding how to ask, mental health practitioners must also understand how to
233 respond to disclosures, including translating disclosures into meaningful individualised
234 support. This requires that there are appropriate services to refer survivors to, including
235 services that understand people's needs in the context of intersecting identities, such as
236 services for women of colour, men, and people from LGBTQ communities (Scott, 2016).

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

239

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.

240

241

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

243 Abuse can be normalised in different ways (Gillett 2018) and this can mean that people do
244 not always recognise that what they are experiencing is abuse. Coercive and controlling
245 behaviours can be particularly hard to identify and communicate to others (Brennan et al.,
246 2018). Moreover, abuse is often thought of in discrete and clear categories of physical,
247 sexual, or emotional abuse; however, abuse often does not happen in neatly nameable boxes
248 but is a messy and overlapping experience of multiple forms of abuse. This can mean that the
249 journey towards understanding experiences as abuse can take many years (Survivors Voices,
250 personal communication).

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

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

266 Moreover, women may fear that the negative consequences of leaving a relationship are
267 worse than the abuse that they experience within it. Leaving abusive relationships could
268 trigger the loss of physical and emotional safety, social support, financial stability, home,
269 control over parenting and personal freedom (Thomas et al, 2015). The well-documented lack
270 of justice for women survivors, particularly survivors with intersecting minority identities,
271 may also mean that mothers lose custody of their children or are forced to accept shared
272 custody. Therefore, they can no longer protect their children from direct abuse.
273

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

- 276 • Listen without judgement, and without the assumption that a decision to remain in an
277 abusive situation is a simple choice borne of a personal deficit.
- 278 • Considering trauma history, social support levels and the person's understanding of
279 abuse may help mental health practitioners scaffold support accordingly.
- 280 • When making enquiries, be mindful of the potential weight of the word 'abuse' to
281 survivors including the potential for this not to feel recognisable to survivors.
282 Acknowledging that experiences are not acceptable is also an important step.
- 283 • The terminology used by survivors to describe their experiences should be respected
284 and used in discussion in favour of terms such as 'abuse'.
285

286 **Telemedicine and reporting and detecting abuse**

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

291 Domestic abuse by definition happens in people's own homes, typically perpetrated by people
292 who live in the same household. It is therefore vital that clinicians are mindful of this and
293 conduct consultations accordingly. AVA, a national violence against women and girls
294 charity, has provided guidance for mental health practitioners dealing with patients
295 experiencing domestic abuse during COVID-19. In it, ways enquiries can be made safely and
296 sensitively are discussed (See Box V). Further details on safety planning and safe referral can
297 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”.

298
299
300
301
302
303
304
305

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

306
307
308

309 **Reporting and detecting abuse in older people**

310 Elder abuse can occur in domestic as well as institutional settings such as care homes.
311 According to NHS Digital (2020) data, elderly people constituted the majority of
312 safeguarding referrals, with those aged 65 and over making up for over 60% of referrals since
313 2009 (the year data collection began). In the year 2019-2020, it is estimated that 1 in 38
314 adults aged over 85 years were involved in a section 42 referral, with neglect and omission of
315 care being the main form of maltreatment. Perpetrators of abuse in this group are often
316 caregivers, both from inside and outside the family (Age UK, 2020).

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

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

322
323 The responsibility and load of informal, unpaid, and long-term caregiving can cause high
324 levels of distress in family carers; with distress levels positively correlated with increasing
325 amount of time spent on caregiving (Sin et al, 2021). Worsening anxiety and depression in
326 carers can impair their caregiving capacity, potentially leading to neglect and abusive
327 behaviours toward those they are caring for (Cooper et al., 2010). In the context of dementia,
328 carers are often elderly spouses of these service users; the perceived neglect can be a
329 manifestation of their own inability to cope with the added pressure brought on by COVID-
330 19.

331 Whilst COVID-19 has intensified the risk factors for caregivers, placing the elderly at a
332 higher risk of abuse or neglect, support from external agencies (e.g. social services) and
333 informal resources (e.g. friends, relatives) has simultaneously decreased in both frequency
334 and intensity. A significant proportion of the elderly population are also considered 'high-risk'
335 and are encouraged to 'shield', reducing their contact with the outside world even more than
336 others. Ensuring that older adults and their family carers are well supported may help prevent
337 abuse perpetration. The Social Care Institute for Excellence (SCIE), in partnership with the
338 Alzheimer's society, has published guidance on safeguarding adults with dementia during the
339 COVID-19 pandemic, emphasising the importance of ensuring carers are well supported and
340 made aware of available support resources (see supplementary material for further resources)

341 **Reporting and detecting abuse in Black and Minoritized Ethnic communities**

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

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

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

362

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.

363

364

365

366 **Taking action: developing trauma-informed relationships**

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

378 Whilst trauma-informed approaches describe a process of organisational change that embeds
379 an understanding of trauma throughout service planning and delivery (Sweeney & Taggart,
380 2018), service providers can also engage in trauma-informed relationships where the
381 organisation has not yet embedded trauma-informed approaches (Sweeney et al. 2018). (see
382 supplementary material for further resources)

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

388 Alongside this shift away from a pathologising model of symptoms, adopting strengths-based
389 approaches can help people in their journeys to healing and recovery (Xie, 2013). A
390 strengths-based approach is a counter to the deficit model that focuses on an individual's
391 weaknesses, with an alternative focus on the strengths that people have developed to help
392 them survive and thrive. Strengths-based approach supports people to find more time and
393 space to draw on these coping strategies and personal resources. This approach requires the
394 practitioner not to make assumptions, listen carefully, and be service user-led, ultimately
395 adopting a position of 'how can I help?'.
396

397 **Health practitioners who experience domestic abuse**

398 A report by the British Medical Association estimated that healthcare professionals,
399 particularly midwives and health care assistants are three times more likely to experience
400 domestic abuse, when compared with the general population (BMA, 2019). Despite this,
401 when compared with the general public, it is harder for healthcare professionals to get
402 support for domestic violence; additional barriers to disclosure and detection for this group
403 includes societal expectations of the role, and clinicians' own beliefs. The British Medical
404 Association in their publication regarding support for doctors affected by domestic abuse, has
405 highlighted some of these unique challenges (see Box VIII). Additionally, certain norms of
406 the medical profession – such as the focus on resilience, empathy and sympathy, and
407 frequently dealing with challenging behaviour – extended to their personal lives and
408 normalised 'abusive' behaviours within their own interpersonal relationships (Donovan,
409 2020).
410

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 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, and the impact of patients’ trust if their survivor status were made public are also prevalent.

411

412 The effects of domestic abuse on survivors extend to the workplace, contributing to slower
413 career progression and reduced attendance, with those still in training worst affected. A lack
414 of support by employers, emphasis on 'resilience' despite poor mental and physical health
415 further compounds this effect (BMA 2019, Donovan, 2020). Amongst trainees, a lack of
416 control and consideration surrounding rotas and deployment, and unsympathetic educational
417 supervisors have been cited as a contributing factor to their increased distress and social
418 isolation (Donovan, 2020). Despite the many negative effects of DA on survivors in the
419 workplace, there continues to be a lack of awareness amongst employers and healthcare
420 practitioners themselves; the BMA found that 32% of NHS trust do not currently have a
421 domestic abuse policy for staff. DA is a workplace issue that requires its own specific
422 solutions with consideration of the unique challenges and barriers healthcare professionals
423 face.

424

425 **Taking action: small steps, big impact**

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

430 **For commissioners and mental health services**

- 431 ▪ Commissioners and local mental health services may wish to focus on increasing the
432 availability and range of support offered, including those provided by individuals with
433 lived experiences.
- 434 - Review current trust policies and practices, particularly on these key areas:
- 435 ○ Routine enquiry – is there a current routine enquiry policy in place? If there is
436 one, how well is it being adopted. Look into local and national campaigns and
437 initiatives on domestic abuse, such as *Ask and Take Action* by Agenda.
- 438 ○ Is the clinical environment currently conducive for disclosure of abuse as per
439 NICE guidelines (Box IV)
- 440 ○ Does the trust have a policy for supporting staff members who are
441 experiencing domestic abuse? If there is one, does the current policy addresses
442 the key challenges DA survivors could face, including acknowledgment and
443 appropriate support for how DA could impact on job performance and meeting
444 training requirements.
- 445 - Provide training for staff to better deal with patient disclosure of being a victim or
446 perpetrator of abuse. Ensuring adequate knowledge in detection, and management of
447 disclosure.
- 448 - Joint up communication and working with other agencies working with survivors, e.g.
449 police, social care, housing, charities

450

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

- 454 • Recognising how DA could affect job performance through lower productivity,
455 increasing absenteeism, etc. What support/adjustments are available to help them
456 navigate this – with particular consideration for those still in training and/or working
457 less than full time.
- 458 • Lone working – staff members experiencing domestic abuse in a public-facing role
459 working alone in the community may be more vulnerable to their perpetrators.
460 Measures including lone working alarms or moving staff who are currently
461 experiencing abuse out of community roles could be needed.

462

463 **For mental health practitioners:**

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

- 477 ○ Awareness of mental health practitioners on routes for escalations and
478 referrals if a patient were to disclose DA.
479

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.

480
481

482 **Conclusion**

483
484 The health and social impacts of the COVID-19 pandemic are only beginning to be
485 understood. They are likely to become clearer once the immediate public health crisis abates
486 in the wake of mass vaccinations, at least in the UK context. Domestic abuse is one area of
487 social life that we already know has been exacerbated by the crisis and has major health
488 implications for individuals, families, and communities. What makes domestic abuse and its
489 impacts particularly insidious is that it often occurs in secret and its hidden nature has
490 increased with social isolation.
491

492 The restricted and remote provision of healthcare, particularly mental health, whose service
493 users are at higher risk of domestic abuse even pre-COVID, makes assessment, detection and
494 treatment of domestic abuse more challenging. These factors combined can present a
495 daunting picture for survivors of domestic abuse, their children and the healthcare
496 professionals serving them. In this paper we have outlined some of the factors to consider
497 when working with service users who might be victims of or at risk of domestic abuse. There
498 has also been consideration of the additional complexities of working with victims of
499 domestic abuse from different cultural contexts and generations. An underpinning trauma
500 informed approach, coupled with sensitive investigation and non-stigmatising, victim
501 blaming responses will go some way to mitigate some of the additional barriers caused by the
502 pandemic.
503

504 For any lasting change to happen, current practices needs to be audited. On a trust level, this
505 could mean organising regular audits or quality improvement projects; Getting specific
506 feedback from patients and staff on their current barriers to detection and disclosure;
507 providing remedies for identified issues either through increase training or policy changes.
508 On an individual level, reviewing current practices and reflecting on current held beliefs is
509 essential so any gaps in knowledge and unhelpful beliefs could be identified, challenged and
510 improved.

511
512
513
514
515

Supplementary materials: Useful resources	
Responding to Interpersonal Violence	<ul style="list-style-type: none"> - 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 <i>Confronting Gender Based Violence: Global Lessons for Healthcare Workers</i>: 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	<ul style="list-style-type: none"> - 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/x54hw431/nationaltraumatrain ingframework.pdf
Telemedicine	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - <u>AVA' Complicated Matters – A Toolkit Addressing Domestic and Sexual Violence, Substance Use and Mental Ill-health</u> https://avaproject.org.uk/wp-content/uploads/2013/05/AVA-Toolkit-2018reprint.pdf

	<ul style="list-style-type: none"> - 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

516
517
518
519
520

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

521 **Five multiple choice questions**

522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554

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.

- 555 4. How can being in a domestic abuse relationship affect survivors ability to maintain
556 work?
- 557 a. Perpetrators employing job-interference methods as part of their abusive
558 tactics, effect the victims ability to get a job or maintain one
 - 559 b. The COVID-19 pandemic has not changed the provision of paid childcare by
560 working women and therefore their ability to maintain quality of work are
561 unaffected
 - 562 c. Men are more likely than women to experience domestic abuse when
563 experiencing poverty related to unemployment
 - 564 d. Disruptions In childcare and pay cuts related to lockdown have equally
565 affected both working men and working women.
 - 566 e. Domestic violence and poverty are relationship are NOT related to gender
567 norms regarding resources and caring responsibilities
- 568 5. A report by the British Medical Association estimated that healthcare professionals,
569 are three times more likely to experience domestic abuse. There are suggestions that
570 amongst doctors, the negative career impact of being a DA survivor are worse for
571 those still in training. Which of the following factors are specific to DA survivors who
572 are trainees:
- 573 a. A lack of support by employers, emphasis on 'resilience' despite poor mental
574 and physical health.
 - 575 b. A lack of control and consideration surrounding rotas and deployment, and
576 unsympathetic educational supervisors It is important to consider that different
577 cultures can understand and experience trauma in different ways.
 - 578 c. Concerns that disclosure could raise questions about their professional
579 capability.
 - 580 d. Doctors often have a visible community profile and may be worried about
581 being seen using these services, or potentially encountering their own patients
582 there.
 - 583 e. Survivors reported guilt, shame and difficulty reconciling their status as a
584 victim with their identity as a doctor.

585 **Answers:**

- 586 1. D
- 587 2. C
- 588 3. A
- 589 4. A
- 590 5. B

591

592 **Author details**

593 Idura N. Hisham

594 Jacqueline Sin PhD, RMN, Professor of Mental Health Nursing, School of Health Sciences,
595 City, University of London, UK.

596 Khadj Rouf, Consultant Clinical Psychologist, Complex PTSD service, Northamptonshire
597 Healthcare NHS Foundation Trust

598 Danny Taggart, DCLinPsy, Academic Director Doctorate in Clinical Psychology, University
599 of Essex

600 Giles Townsend MRCPsych. Consultant Psychiatrist for Older Adults, Surrey and Borders
601 NHS Foundation Trust, UK

602 Angela Sweeney PhD, Senior Lecturer in User Led Research, Institute of Psychiatry,
603 Psychology and Neuroscience, King's College London, UK.

604

605 **Author biographies**

606 Dr Idura N. Hisham is a current junior doctor working as a foundation year 1 trainee at St
607 Helier hospital.

608 Dr Jacqueline Sin is a mental health nurse whose clinical research interest focuses on
609 providing effective psycho-social treatments for people affected by mental health problems
610 and for their informal carers. In addition to optimising conventional interventions, Jacqueline
611 has particular interest in co-designing digital interventions which mobilise both clinicians'
612 and peers' expertise.

613 Dr Khadj Rouf is a Consultant Clinical Psychologist, Complex PTSD
614 service, Northamptonshire Healthcare NHS Foundation Trust

615 Dr Danny Taggart is a Clinical Psychologist at the University of Essex. He is currently on a
616 career break to work at the Independent Inquiry into Child Sexual Abuse where is he the
617 Clinical Lead for the Truth Project. Danny is particularly interested in the impact of trauma
618 on social and psychological functioning across the lifespan.

619 Dr Giles Townsend is a Consultant Psychiatrist specialising in the care of Older Adults and
620 people with dementia.

621 Dr Angela Sweeney is a survivor researcher, Senior Lecturer in User-Led Research and
622 Director of the Service User Research Enterprise (SURE), King's College London. She is Co-
623 Chair of the Trauma-Informed Community of Change. Angie has particular interests in
624 gender-based violence, parenting and trauma-informed approaches.

625

626 **Declaration of interest**

627 None

628

629 **Funding Statement**

630 This research received no specific grant from any funding agency, commercial or not-for-
631 profit sectors.

632

633 **Acknowledgements**

634 ?

635

636 **Author contributions**

637 IBIH wrote the first draft of the paper. AS, JS, DT and KR wrote sections of the paper. All
638 other authors gave extensive comments on drafts.

639

640

641

642 **References**

- 643 1. Age, UK 2020, *Safeguarding older people from*
644 *abuse and neglect*, Age UK.
- 645 2. Agenda 2019, *Ask and Take Action: Why public services must*
646 *ask about domestic abuse*, Agenda, London, UK.
- 647 3. Alcohol Change 2020, 3 July,-last update, *Research: drinking in the UK during lockdown and*
648 *beyond*. Available: [https://alcoholchange.org.uk/blog/2020/drinking-in-the-uk-during-lockdown-](https://alcoholchange.org.uk/blog/2020/drinking-in-the-uk-during-lockdown-and-beyond)
649 [and-beyond](https://alcoholchange.org.uk/blog/2020/drinking-in-the-uk-during-lockdown-and-beyond) [2020, Dec 27,].
- 650 4. AVA: *Domestic abuse during COVID-19: Guidance for mental health practitioners*.
651 Available: [https://avaproject.org.uk/wp-content/uploads/2020/04/FINAL-AVA-Briefing-for-MH-](https://avaproject.org.uk/wp-content/uploads/2020/04/FINAL-AVA-Briefing-for-MH-professionals-1.pdf)
652 [professionals-1.pdf](https://avaproject.org.uk/wp-content/uploads/2020/04/FINAL-AVA-Briefing-for-MH-professionals-1.pdf).
- 653 8. Bangham, G. 2020, *Time with the kids • Resolution Foundation*, Resolution Foundation.
- 654 9. Barbosa, C., Cowell, A.J. & Dowd, W.N. 2021, "Alcohol Consumption in Response to the
655 COVID-19 Pandemic in the United States", *Journal of Addiction Medicine*, vol. Publish Ahead of
656 Print.
- 657 10. BARNETT OW, FAGAN RW. Alcohol use in male spouse abusers and their female partners.
658 *Journal of family violence* 1993;8(1):1-25.
- 659 11. Benson, M.L. & Fox, G.L. 2001, *Economic Distress, Community Context and Intimate Violence:*
660 *An Application and Extension of Social Disorganization Theory, Final Report*.
- 661 12. Blanch A, Filson B, Penney D, et al. 2012, *Engaging Women in Trauma-Informed Peer Support:*
662 *A Guidebook. National Centre for Trauma-Informed Care*. National Centre for Trauma-Informed
663 Care.
- 664 13. BMA. Support for doctors affected by domestic abuse. 2019. Available at:
665 <https://www.bma.org.uk/media/3476/bma-domestic-abuse-briefing-nov-19.pdf>
- 666 14. Bourquin, P., Delestre, I., Joyce, R., Rasul, I. & Waters, T. 2020, *The effects of coronavirus on*
667 *household finances and financial distress* , The Institute for Fiscal Studies.
- 668 15. Brennan, I.R., Burton, V., Gormally, S. & O'Leary, N. 2018, "Service Provider Difficulties in
669 Operationalizing Coercive Control", *Violence against women*, vol. 25, no. 6, pp. 635-653.
- 670 16. Brooks, S., Webster, R., Smith, L., Woodland, L., Wessely, S., Greenberg, N. and Rubin, G.,
671 2020. The Psychological Impact of Quarantine and How to Reduce It: Rapid Review of the
672 Evidence. *SSRN Electronic Journal*,.
- 673 17. Bywaters, P., Featherstone, B. & Morris, K. (2019) Child Protection and Social Inequality:
674 Editorial, *Social Sciences*, 8, 42, doi:10.3390/socsci8020042
- 675 18. Cooper, C., Blanchard, M., Selwood, A., Walker, Z. & Livingston, G. 2018, "Family carers'
676 distress and abusive behaviour: longitudinal study", *British journal of psychiatry*, vol. 196, no. 6,
677 pp. 480-485.
- 678 19. Crowe, A & Murray, C. (2015) Stigma from professional helpers to survivors of intimate partner
679 violence, *Partner Abuse*, 6,2, DOI: 10.1891/1946-6560.6.2.157
- 680 20. Dawson, D.A., Grant, B.F. & Ruan, W.J. 2005, "The association between stress and drinking:
681 modifying effects of gender and vulnerability", *Alcohol and Alcoholism (Oxford,*
682 *Oxfordshire)*, vol. 40, no. 5, pp. 453-460.
- 683 21. Dias, M.C., Joyce, R. & Keiller, AN 2020, *COVID-19 and the career prospects of young*
684 *people*, The Institute for Fiscal Studies.
- 685 22. Do, K.N., Weiss, B. & Pollack, A. 2013, "Cultural Beliefs, Intimate Partner Violence, and Mental
686 Health Functioning Among Vietnamese Women", *International perspectives in psychology :*
687 *research, practice, consultation*, vol. 2, no. 3, pp. 149-163.
- 688 23. Dom, G., Samochowiec, J., Evans-Lacko, S., Wahlbeck, K., Van Hal, G. & McDavid, D. 2016,
689 "The Impact of the 2008 Economic Crisis on Substance Use Patterns in the Countries of the
690 European Union", *International journal of environmental research and public health*, vol. 13, no.
691 1, pp. 122.
- 692 24. Domestic Abuse Act 2021. Available at:
693 <https://www.legislation.gov.uk/ukpga/2021/17/part/7/crossheading/final-provisions/enacted>
694 (Accessed at: 16th June 2021)
- 695 25. Donovan E, Santer M, Daker-White G, Morgan S, Willcox M. Domestic abuse amongst female
696 doctors: thematic analysis of qualitative interviews. *British Journal of General Practice* 2021 8 feb,

- 697 26. Durrance, C.P., Perreira, K.M. & Golden, S.D. 2013, "Troubled Times, Troubled Relationships:
698 How Economic Resources, Gender Beliefs, and Neighborhood Disadvantage Influence Intimate
699 Partner Violence", *Journal of Interpersonal Violence*, vol. 28, no. 10, pp. 2134-2155.
- 700 27. Ellinghaus, C., Truss, K., Liao Siling, J., Phillips, L., Eastwood, O., Medrano, C. & Bendall, S.
701 2020, "'I'm tired of being pulled from pillar to post': A qualitative analysis of barriers to mental
702 health care for trauma-exposed young people", *Early intervention in psychiatry*, .
- 703 28. Elliott, D.E., Bjelajac, P., FalLOT, R.D., Markoff, L.S. & Reed, B.G. 2005, "Trauma-informed or
704 trauma-denied: Principles and implementation of trauma-informed services for women", *Journal
705 of community psychology*, vol. 33, no. 4, pp. 461-477.
- 706 29. Emezue, C. 2020, "Digital or Digitally Delivered Responses to Domestic and Intimate Partner
707 Violence During COVID-19", *JMIR public health and surveillance*, vol. 6, no. 3, pp. e19831.
- 708 30. Fahmy, E., Williamson, E. & Pantazis, C. 2016, *Evidence and policy review: Domestic
709 violence and poverty*, Joseph Rowntree Foundation.
- 710 31. Finlay, I. & Gilmore, I. 2020, "Covid-19 and alcohol—a dangerous cocktail", *BMJ*, vol. 369, pp.
711 m1987.
- 712 32. FitzGerald, C. & Hurst, S. 2017, "Implicit bias in healthcare professionals: a systematic
713 review", *BMC medical ethics*, vol. 18, no. 1, pp. 19.
- 714 33. Fox S, Galvani S. Briefing: Alcohol and domestic abuse in the context of Covid-19 restrictions.
715 2020; Available at: [https://www.mmu.ac.uk/media/mmuacuk/content/documents/rcass/Briefing-
716 on-alcohol-and-domestic-abuse-in-context-of-Covid-19-1st-April-2020.pdf](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).
- 717 34. Garcia-Moreno, Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A. Abrahams, N.,
718 Monotoya, O., Bhate-Deosthali, P. Kilonzon, N. & Watts, C.. Addressing violence against
719 women: a call to action. *Lancet* 2014; 385: 1685–95
- 720 35. Gillett, R. 2018, "Intimate intrusions online: Studying the normalisation of abuse in dating
721 apps", *Women's Studies International Forum*, vol. 69, pp. 212-219.
- 722 36. Golding, J. 1999, "Intimate Partner Violence as a Risk Factor for Mental Disorders: A Meta-
723 Analysis", *Journal of family violence*, vol. 14, no. 2, pp. 99-132.
- 724 37. Grossman, E.R., Benjamin-Neelon, S.E. & Sonnenschein, S. 2020, "Alcohol Consumption during
725 the COVID-19 Pandemic: A Cross-Sectional Survey of US Adults", *International journal of
726 environmental research and public health*, vol. 17, no. 24, pp. 9189.
- 727 40. Howell, E.F. 2014, "Ferenczi's Concept of Identification with The Aggressor: Understanding
728 Dissociative Structure with Interacting Victim and Abuser Self-States", *The American journal of
729 psychoanalysis*, vol. 74, no. 1, pp. 48-59.
- 730 41. Institute of Alcohol Studies 2014, *ALCOHOL, DOMESTIC ABUSE AND SEXUAL ASSAULT*,
731 Institute of Alcohol Studies, London.
- 732 42. Mason C, Taggart D, Broadhurst K. Parental Non-Engagement within Child Protection Services—
733 How Can Understandings of Complex Trauma and Epistemic Trust Help? Societies (Basel,
734 Switzerland) 2020 Jan 1,;10(4):93.
- 735 43. Molodynski, A., McLellan, A., Craig, T. & Bhugra, D. 2020, "What does COVID mean for UK
736 mental health care?", *International journal of social psychiatry*, , pp. 2076402093259-
737 20764020932592.
- 738 44. National Institute for Health and Care Excellence 2014, *Domestic violence and abuse:
739 multi-agency working*, National Institute for Health and Care Excellence.
- 740 45. NHS Digital 2020, Nov 12,-last update, *Safeguarding Adults England, 2019-20*.
741 Available: [https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-
742 adults/2019-20](https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2019-20) [2020, Dec 28,].
- 743 46. Office for National Statistics 2020, *Domestic abuse during the coronavirus (COVID-19)
744 pandemic, England and Wales: November 2020* .
- 745 47. Reay, A.M.C. & Browne, K.D. 2001, "Risk factor characteristics in carers who physically abuse
746 or neglect their elderly dependants", *Aging & Mental Health*, vol. 5, no. 1, pp. 56-62.
- 747 48. Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. Barriers and facilitators of
748 disclosures of domestic violence by mental health service users: qualitative study. *British journal
749 of psychiatry* 2011 Mar;198(3):189-194.
- 750 49. Scott, S. & McManus, S. (2016) Hidden Hurt: Violence, abuse and disadvantage in the lives of
751 women (DMSS research for Agenda)

752 50. Sin, J., Elkes, J., Batchelor, R., Henderson, C., Gillard, S., Woodham, L., Chen, T., Aden, A.,
753 Cornelius, V. 2021. Mental health and caregiving experiences of family carers supporting people
754 with psychosis. *Epidemiology and Psychiatric Sciences*, 30, E3. doi:10.1017/S2045796020001067
755 51. Swanberg, J. and Logan, T., 2005. Domestic Violence and Employment: A Qualitative
756 Study. *Journal of Occupational Health Psychology*, 10(1), pp.3-17.
757 52. Sweeney, A., Filson, B., Kennedy, A., Collinson, L. & Gillard, S. 2018, "A paradigm shift:
758 relationships in trauma-informed mental health services", *BJPsych advances*, vol. 24, no. 5, pp.
759 319-333.
760 53. Sweeney, A. & Taggart, D. 2018, "(Mis)understanding trauma-informed approaches in mental
761 health", *Journal of mental health (Abingdon, England)*, vol. 27, no. 5, pp. 383-387.
762 54. Taggart D, Rouf K, Hisham IBI, Duckworth L, Sweeney A. Trauma, mental health and the
763 COVID-19 crisis: are we really all in it together? *Journal of mental health (Abingdon, England)*
764 2021 February 1,;ahead-of-print(ahead-of-print):1-5.
765 55. Thomas, K. A., Goodman, L., & Putnins, S. (2015, January 12). "I Have Lost Everything": Trade-
766 Offs of Seeking Safety From Intimate Partner Violence. *American Journal of Orthopsychiatry*.
767 Advance online publication. <http://dx.doi.org/10.1037/ort0000044>
768 56. Xie, H. 2013, "Strengths-based approach for mental health recovery", *Iranian journal of*
769 *psychiatry and behavioral sciences*, vol. 7, no. 2, pp. 5-10.
770
771