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Domestic violence against women and the COVID-19 pandemic: What is the role of psychiatry?

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ABSTRACT

A heightened risk of domestic violence has been associated with infection-reducing measures undertaken by governments during the COVID-19 pandemic. Psychiatric services can play a key role in addressing this issue by (a) addressing certain risk factors for perpetration of domestic violence through, for example, assertive identification and management of substance misuse; (b) providing support, advocacy and treatment services for victims of domestic violence; and (c) multi-agency working to strengthen medical and social responses to domestic violence. At a time like this, it is important that multi-disciplinary mental health services are strengthened, rather than depleted, in order to address the pressing issues at hand.

1. Introduction

Addressing domestic violence is a global public health priority in light of both the prevalence of domestic violence and the associated physical morbidity, psychological morbidity and mortality (World Health Organization, 2013). Domestic abuse can involve physical, sexual, psychological and financial components, as well as controlling or coercive acts and behaviours. Domestic violence, often referred to as intimate partner violence, disproportionately affects women, with nearly one in three women victimised by physical or sexual violence through their lifetimes (Devries, Mak, Bacchus, et al., 2013).

A legal definition for domestic violence does not exist in every jurisdiction and where present, can vary across jurisdictions, for example in whether it includes perpetrator-victim relationships other than married/heterosexual couples. Variability also exists in whether legislation provides support for victims or special protection for minors (see ADVN, 2013 for a comprehensive review of legislative frameworks).

Rates of reporting of domestic violence vary across jurisdictions and cultures, but while the prevalence of domestic violence is linked with socio-economic variables such as homelessness and poverty, domestic violence is reported across all countries and in all socio-economic groups (Thompson et al., 2006).

Increased concerns about domestic violence have been expressed in many countries, including China, France, Spain, Italy and the United Kingdom, since governments restricted travel to prevent the spread of COVID-19 (Taub, 2020). A heightened risk of domestic violence is associated with this and other infection-reducing measures (van Gelder et al., 2020). The reasons cited include social isolation, exposure to economic and psychological stressors, increase in negative coping mechanisms (such as alcohol misuse) and an inability to access usual support mechanisms or escape abusive households, owing to quarantine measures or travel restrictions.

Disruptions to usual health and social services that have been reconfigured in light of the pandemic, as well as diminished access to supports such as shelters and charity helplines may negatively impact the reporting of domestic violence. The Committee of the Parties to the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) has issued a declaration alerting member states to the problems of domestic violence during the pandemic and asking them to fortify their responses (Council of Europe, 2020).

2. Mental health services

Do mental health services have a specific role to play in addressing the challenge of increased domestic violence during this pandemic? Three aspects of this issue merit consideration: (2.1) possible associations between specific mental or behavioural conditions and the perpetration of domestic violence; (2.2) the association between mental illness and victimisation; and (2.3) the potential impact of social measures to reduce transmission of COVID-19 and pandemic-related service reconfigurations on domestic violence.

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2.1. People with mental illness as perpetrators of domestic violence

Before commenting on any association between mental illness and domestic violence, two preliminary points should be set out so as not to add to the stigma that is commonly but wrongly associated with mental illness (Ahonen et al., 2019). First, although there is an association between mental illness and violence (Fazel, Gulati, Linsell, Geddes, & Grann, 2009), the vast majority of people with mental illness will never be violent (Fazel & Grann, 2006). Mental illness does not cause domestic violence in and of itself. The most robust evidence for a single factor linking schizophrenia and violence is for substance misuse (Rund, 2018). Domestic violence almost invariably involves issues of power and control which are not necessarily related to the perpetrator's mental illness, even if they have one.

Having noted these points, there is a reported association between certain mental disorders and domestic violence. A large Swedish registry study found that, in comparison to general population controls, all psychiatric diagnoses studied (except autism) were associated with an increased risk of domestic violence against women in men (Yu et al., 2019). Using sibling analysis (which can control for socio-economic confounders), this study found that men with depressive disorder, anxiety disorder, alcohol use disorder, drug use disorder, attention deficit hyperactivity disorder and personality disorders had a higher risk of domestic violence against women compared to their unaffected siblings. Individuals with alcohol use disorders and drug use disorders had the highest rates.

These findings are in keeping with previously published systematic reviews which suggest an association between mental illness and perpetration of domestic violence (Oram, Trevillion, Khalifeh, Feder, & Howard, 2013; Spencer et al., 2019). It is, however, notable that substance use disorders, as principal or comorbid diagnoses, carry the highest absolute and relative risks of domestic violence, so treatment for these, alongside any co-existing mental illness, should be prioritised and might reduce risk (Yu et al., 2019).

2.2. People with mental illness as victims of domestic violence

People with severe mental illness are at increased risk of becoming victims of domestic violence (Khalifeh, Oram, Trevillion, Johnson, & Howard, 2015). One systematic review and meta-analysis of 42 published studies investigating domestic violence victimisation in psychiatric patients found a median prevalence of lifetime partner violence of 30% among female in-patients and 33% among female out-patients (Oram, Trevillion, Feder, & Howard, 2013).

These may well be under-estimates. People with mental illness can be reluctant to disclose abuse. One qualitative study in a socio-economically deprived south London borough found that patients described several barriers to disclosure of domestic violence to professionals, including fear of consequences (e.g. further violence), fear of social services involvement (e.g. child protection proceedings), fear that the disclosure would not be believed, and feelings of shame (Rose et al., 2011).

Mental ill-health can also be a consequence of victimisation (Resnick, Acierno, & Kilpatrick, 1997) and can involve post-traumatic stress disorder, depression (Mechanic, Weaver, & Resick, 2008), suicidality (Devries, Mak, García-Moreno, et al., 2013) and alcohol or substance misuse (Golding, 1999). This psychological morbidity is in addition to the physical sequelae of abuse.

One study suggests that information about community based resources to victims by frontline medical services may be beneficial (Muelleman & Feighny, 1999). Psychiatric services often fulfil this role for people with mental illness, many of whom are socially marginalised and access care only through assertive outreach programmes. Psychological approaches to depression and post-traumatic stress disorder through counselling, cognitive behaviour therapy and interpersonal therapy are especially important (American Psychiatric Association, 2020; Condino et al., 2016).

2.3. COVID-19-associated impact and mitigation by psychiatric services

Addressing domestic violence requires a careful combination of legal measures (e.g. arrest of perpetrators, barring orders, safety orders), societal responses (e.g. bystander responses, advocacy services, shelters) and heightened awareness in frontline community services such as medical services, where victims can present with physical or psychological trauma, sexually transmitted infections, neglect or other sequalae of abuse. There are key roles for psychiatric services in the identification and management of certain risk factors (e.g. substance misuse) and providing support, advocacy and treatment services to victims. Regrettably, there are several reasons to be concerned about the ability of mental health services to fulfil these roles during the current pandemic.

First, it is now clear that, as the outbreak of COVID-19 has developed, referral rates to mental health and psychology services have declined (Thomas, 2020), despite a likely increase in psychological distress, victimisation and mental illness. It is possible that many people are not seeking help owing to fears that services are overwhelmed and that attending face-to-face appointments might put them at risk (Gunnell et al., 2020). This is most concerning: not only is domestic violence on the increase, but there is also reason for concern about psychological distress associated with the pandemic itself, arising in response to fears about personal and familial infection as well as the sequelae of social distancing and quarantine measures (Kelly, 2020).

These trends are consistent with experience in previous pandemics (Brooks et al., 2020). It is, therefore, particularly important that mental illness is recognised at primary care level and that onward referrals are made to specialist services. Issues such as domestic violence often become apparent only during comprehensive psychiatric assessment and through the development of trusting therapeutic relationships over time (Rose et al., 2011). It is also through effective treatment of mental illness and substance misuse that the risk of domestic violence by people with these diagnoses is reduced. In order for this to occur, people must present or be referred to mental health services and there are strong indications that this is not occurring at present.

Second, there are concerning reports of staff redeployment from psychiatric services to other health services in response to the pandemic (Ford, 2020; ITV News, 2020). While the immediate illness caused by COVID-19 is primarily respiratory in nature and requires a great deal of human resources to treat, redeployment of mental health service staff for this task carries many risks (Cullen, Gulati, & Kelly, 2020). In the first instance, people with mental illness tend to experience difficulties accessing medical care and are therefore at increased risk of both the infection itself and problems accessing information, testing and treatment. Multi-disciplinary mental health teams routinely assist with these tasks and can thus reduce infection rates and pressures on hospitals if they remain in their present posts.

Redeploying mental health staff also disrupts continuity of care, especially for marginalised populations such as the homeless, people with severe illness, people with comorbid drug or alcohol use disorders, and the very many people with mental illness who live in poverty. A lack of consistent and assertive follow-up will increase risks of mental illness, physical ill-health (including COVID-19) and domestic violence, especially among potential victims who depend on psychiatric services for safety, advocacy and facilitating the wellbeing of their children. It is therefore vital that parity of esteem is maintained for mental and physical health services over the course of this pandemic.

Third, the charities sector, which provides extensive supports for victims of domestic violence and people with mental illness, faces many challenges at the present time in respect of staffing and budgetary constraints – all of which might be further magnified in the context of the predicted economic recession. Any significant contraction of this sector would greatly impede access to health and social services for

victims of domestic violence and people with mental illness.

The National Institute for Health and Care Excellence (2014) recommends the creation of a protected environment for revealing domestic violence and specific routes to access specialised treatment. It recommends multi-agency working to support victims of domestic violence. It is often through inter-agency efforts involving charities that someone at risk of domestic violence is identified and steps taken to ensure their safety and the safety of their children. In some jurisdictions, multi-agency public protection panels involving police, probation, housing, child protection services, addictions services, adult safeguarding services, counselling services and specialist mental health teams work together to ensure the safety of victims. Ongoing public support and funding for charities, along with fully staffed mental health services, are crucial if this system is to work.

3. Conclusion

The continued provision and expansion of psychiatric services have a vital role to play in addressing the increased rates of domestic violence associated with the COVID-19 pandemic. The effective and sustained provision of such services is relevant to both reducing the risk of domestic violence in the first place and identifying and supporting victims when it occurs. Any multi-agency response to domestic violence would be incomplete without the involvement of mental health teams whose functions include health promotion, advocacy and public education in addition to their role in the assessment and treatment of mental ill-health.

The 1993 United Nations' *Declaration on the Elimination of Violence against Women* acknowledged that violence against women is an important international public health, social policy and human rights concern (Office of the United Nations High Commissioner for Human Rights, 1993). The current COVID-19 pandemic is a time when the most basic human rights of women are at particular risk. Psychiatry has a key role to play in protecting and promoting those rights, now more than ever.

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Declaration of Competing Interest

GG is Chair of the Faculty of Forensic Psychiatry at the College of Psychiatrists of Ireland; the views expressed are his own. BDK has no conflicts of interest to declare.

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