Family violence and COVID-19: 20 Tips for Psychiatrists

Audience: RANZCP members in Australia and New Zealand

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COVID-19 does not cause family violence, but as with all natural and man-made disasters that generate a state of national emergency, social inequities are widened and family violence escalates.¹ Lockdowns with enforced association during the acute crisis exacerbate risk factors for family violence, as does the adversity of the ensuing socio-economic instability. ² Indigenous, migrant and refugee women and children are particularly vulnerable.³ ⁴

The impact of disasters on mental health is well-recognised, with vulnerable peoples being differentially and disproportionately affected. ⁵

The Australian Institute of Criminology has found that two-thirds of women who experienced physical or sexual violence by a current or former partner since the start of the COVID-19 pandemic said the violence had started or escalated in frequency and severity in the three months prior to May 2020.⁶

For patients with whom the psychiatrist has already obtained a therapeutic alliance, identify which behaviours have escalated, build on the current trauma work you may be doing, and consider strengthening the woman’s plans to leave. The COVID-19 crisis has shone a spotlight on women and their children who face barriers to leaving a violent partner, for example, women with no access to income, housing, healthcare, or legal resources.

The ability of psychiatrists to recognise and respond to family violence is crucial, particularly during this current pandemic. Here are 20 tips to assist psychiatrists:

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¹ Houghton, R. (2010). "If there was a dire emergency, we never would have been able to get in there: Domestic Violence Reporting and Disasters." International Journal of Mass Emergencies and Disasters 28(2): 270-293.
Risk Assessment and avoid re traumatising
1. Use trauma-informed principles.
2. Establish immediate safety.
3. Assess risk for family violence and identify protective factors, from a COVID-19 perspective.
4. Ask screening questions (repeatedly) when safe to do so – does she feel safe at home? What changes in the family’s situation is she most worried about? (Include perpetrator’s access to children).
5. Agree on a codeword for urgent safety concerns & communicate this with the mental health crisis line.
6. Ask about alcohol and drug use in the household.

Establishing and maintaining therapeutic alliance
7. Reassure about confidentiality and establishing trust by informing all relevant staff members to not provide patient details to the perpetrator.
8. Make regular appointments so that the patient has reason to leave the house.
9. Maintain therapeutic contact to monitor mental state, using their preferred method of safe contact.
10. Reassure the patient/victim/survivor that she and her children are not alone. Give her contact details of organisations like Police or DV organisations who are there to support if safety is at risk.

Treatment considerations
11. Keeping trauma-informed principles, start education about red flags.
12. Think about the appropriateness of giving a psychiatric diagnosis as it may harm the patient in future access battles to children. Consider trauma-informed formulation.
13. Advice around technological abuse – monitoring, turning off location services, keeping mobile at the front desk during session.
14. Be alerted when the perpetrator/partner insists on joining each session, and keep in mind that a tele-consult may be overheard by the perpetrator.
15. When dealing with suicidality, or treatment-resistant depression in women from diverse communities think of family violence in the context of culturally nuanced abuse like forced marriage, dowry or financial demands, entrapment, and inability to escape abusive marriage with few options.7

Safety Plans

16. Agree on a safety plan informed by a perpetrator perspective and current COVID-19 requirements. Ask what may have already been tried to maintain safety for the patient/victim/survivor & her children – what worked and what didn’t work?

17. When safety is judged to be at risk or children are at risk - alert Police, family violence agencies including indigenous and other cultural support services, Refuge & Child Protection agencies of the need for proactive monitoring & support.

18. Consider alerting safety fears to local pharmacy/supermarket/ Petrol Station/ GP and other legitimate places to visit during lockdown.

19. Use a nationally-agreed codeword if this exists.

20. Encourage maintenance of social, employment, and school connections and routines as appropriate & where possible.

This list is not in order of priority or exhaustive.

Of note, maintenance of the psychiatrist’s own wellbeing and welfare is essential to be able to safely treat and support others.

Disclaimer:

This COVID-19 relevant document is a resource to support members’ clinical practice but should not be a substitute for individual clinical judgement. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances, information or material that may have become subsequently available. This document has been approved via a rapid review, as delegated by the RANZCP Board.

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