Exploring the linkages between substance use, COVID-19, and intimate partner violence

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Introduction

Intimate partner violence (IPV) affects 1 in 3 women globally [1]. In 2020, UN WOMEN, in the context of COVID-19, named violence against women a “shadow pandemic” and called for immediate action to mitigate increases in both domestic violence and sexual assault [2]. In Canada, currently 1 in 10 women are worried about their safety [3], with IPV services experiencing increased pressure as a result of COVID-19. Aspects of social isolation, lockdowns and other containment measures in response to COVID-19 have exacerbated IPV, similar to patterns seen in previous epidemics. Available data indicate that stress, anxiety, and financial worries related to COVID-19 and containment may also lead to increases in substance use (SU). Statistics Canada has reported an increase in alcohol, cannabis and tobacco use [3] during COVID-19 and Angus Reid reported worsening mental health among 50% of Canadians [4]. However, it is unclear how quarantine measures affect both IPV and substance use patterns among women, what additional or different needs women experiencing IPV and substance use might have during the COVID-19 pandemic, and how first responders and frontline workers can respond to women’s needs during and after the pandemic.

Objectives and Methods

This rapid review explores:
RQ1: The role of containment, social isolation, epidemics, pandemics, disasters, lockdowns and intimate partner violence among women; and
RQ2: The role of substance use in intimate partner violence among women.

Academic and grey literature searches were conducted in June 2020 and continue to be updated on a monthly basis until October 2020. Click here for the full methodology to date.

Findings

Evidence on Natural Disasters and IPV

- There is some evidence that IPV increases after a natural disaster [5-11] with an average of 0.52 physically aggressive acts and 1.96 psychologically aggressive acts after the natural disaster [12]. Perpetrators may also use disasters to exercise control [13, 14].
- Domestic violence occurs to women regardless of their educational or social background [15]; however, younger girls and unemployed women are at a higher risk of experiencing IPV in the context of a natural disaster [16].
- However, responses to the IPV experience depend on their socioeconomic background, personal capacity and social networks [15].
- Women who experience post-disaster IPV are more likely to report sleep and appetite dysregulation, low self-esteem, suicidal ideation [17] and a major depressive disorder [18], but it is difficult to distinguish which mental health problems are related to IPV or to the natural disaster itself.
Evidence on SU and IPV & Associated Factors

- Women with a history of IPV are more likely to be current smokers or heavy smokers [19]. Co-occurring IPV, PTSD, and alcohol use may act as barriers for quitting smoking for women [20].
- Trauma and other adverse experiences are associated with IPV. Women who reported alcoholism and child abuse in their families of origin also reported heavy drinking partners [21].
- There is evidence that women’s alcohol use was related to fear felt in their relationships. Women also reported they used alcohol as a coping mechanism to numb their feelings or avoid thinking about the IPV episode [22]. In some cases, perpetrators use women’s mental health issues or their alcohol use as a tactic of isolation and control [21].
- Some studies indicate that poverty is linked to higher alcohol use by men, increasing the risk of IPV towards women [23] and some studies consider alcohol use a disinhibiting factor for aggression among men who perpetrate IPV [24, 25]. However, there is also evidence that the IPV is not the result of alcohol use but is related to unequal gender roles and of men’s control and power over their partners [26, 27].

Implications for service providers and policymakers

- Women who report IPV seek more healthcare resources than women who do not report IPV, but may be less likely to use preventive services [28]. As such, addressing violence issues in community-based mental health services is crucial, even when the IPV is pre-disaster [8] and recognizing that limited safe housing and loss of community networks are important gaps for women experiencing post-disaster IPV [29].
- Inequities experienced by women are the product of previous gender and economic inequities that often become more visible in a post-disaster context [15]. Healthcare providers (HCP) need to be ready for increases in IPV post-disaster and to provide treatment and referrals post-disaster [30] based on best practices for IPV identification and referral. Governments and policy-makers need to consider IPV prevention strategies and response a priority [11].
- It is crucial to collect accurate statistics on IPV and that all personnel responding to the disaster (i.e. health and community service providers, police, housing providers, etc.) is included in disaster preparedness and management [11]. Subsequent responses must be trauma-informed and tailored to women who experience IPV [31].
- Health care providers and substance abuse providers need to work in collaboration with others in education, health and development sectors to tackle substance use, IPV and the many gender inequities related to women’s empowerment, equal rights and women’s roles [32].
- HCP and other frontline providers may also experience vicarious trauma or their own challenges in the post-disaster context, requiring counselling services. However, some service providers identified that asking for counselling for themselves resulted in stigma and potential consequences, such as the removal of responsibilities and/or not being considered for promotion [11].

Conclusions

- The relationship between SU and IPV is extremely complex, with evidence of a bidirectional relationship, as well as multi-faceted contributing factors and numerous resulting health impacts.
- Both SU and IPV appear to rise amidst disasters and post-disaster periods.
- For first responders, substance use, and IPV frontline providers the implications are clear. IPV detection and awareness is essential in disaster and pandemics. Training must be enhanced – and organized across sectors - to understand the additional burdens of IPV, substance use, and increased help seeking in the context of COVID-19 and other disasters.
- In the longer term, reductions in gender inequity linked to power, control and economic supports must be addressed to reduce IPV and respond more adequately and robustly to both SU and IPV in pandemic contexts.

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