Introduction

This Rapid Review, entitled "*Substance use (SU) among women in the context of the corollary pandemics of COVID-19 and Intimate Partner Violence (IPV)*", examines the disparate literatures on a) disasters/pandemics and IPV, and on 2) the relationship between IPV and SU. Examined separately, the syntheses of both of these reviews are presented in this draft. Our aim is to create knowledge products and/or messaging for first responders, substance use service providers, and IPV service providers, useful in the context of COVID-19 and its recovery, and related crises.

Methodological Framework

1. Identifying the research questions

Two research questions were identified for this project:

RQ1. What evidence on the role of natural disasters and pandemics in intimate partner violence among women has been published in the academic and grey literature?

RQ2. What evidence on the role of substance use in intimate partner violence among women has been published in the academic and grey literature?

Eligibility criteria for RQ1

- Studies on women who experience(d) intimate partner violence during a natural disaster.
- Studies that include evidence on natural disasters (e.g. earthquakes, hurricanes, etc.) and IPV, relationships between patterns and prevalence of use, mechanisms between natural disasters and IPV, and impact for service providers.

Exclusion criteria

- Studies on armed conflicts.
- Studies on children.
- Studies on any type of domestic violence that do not define the intimate relationship as a relationship between spouses or partners (*note*: some studies might not always use the term IPV but other terms such as domestic violence but they define it as violence in an intimate relationship between spouses or partners-we will include this papers).

Eligibility criteria for RQ2

- Studies on women, men who have sex with men, LGBT individuals who experience(d) intimate partner violence.
- Studies that do not disaggregate data by sexes and just talk about partners in general.
- Studies on beliefs or perceptions of health care providers or other service providers, if the focus of the study is the IPV and SU relationship in our identified populations.

- Studies that include evidence on substance use and IPV, relationships between patterns and prevalence of use, mechanisms between SU and IPV, and impact for service providers.

Exclusion criteria
- Studies on men as IPV perpetrators and SU (*note*: we include studies if women are the participants and asked about their (male) partners´ SU)
- Studies on children involved in domestic violence with one or both parents.
- Studies on dating violence or any type of domestic violence that do not define the intimate relationship as a relationship between spouses or partners (*note*: some studies might not always use the term IPV but other terms such as domestic violence but they define it as violence in an intimate relationship between spouses or partners-we will include this papers).
- Studies that report findings on IPV or SU separately and they do not report any relationship/mechanism between the two of them.
- We will exclude those papers on sex workers unless they mention the IPV was perpetrated by a spouse/partner.

2. Identifying relevant studies

Academic Search Strategy

The searches were conducted on two topics, integrating two disparate literatures related to: 1) containment, social isolation, epidemics, pandemics, disasters, lockdowns and IPV; and 2) the relationships between the SU (including alcohol, tobacco, cannabis, etc.) and IPV. In alignment with the evolving COVID-19 pandemic, a rapid review approach was chosen to identify the extent of existing literature on how containment and pandemics affect both IPV and SU patterns among women and to summarize and disseminate existing research for service providers and policy-makers.

Hence, two academic literature searches were conducted in Medline, CINAHL, PsycInfo, Cochrane, and Web of Science using keywords for the following concepts: 1) *pandemics* (e.g. "social isolation", "quarantine", COVID-19, etc.) and *IPV* (e.g. "domestic violence", "spousal abuse", etc.); and 2) *substance use* (e.g. "alcohol", "tobacco", "drugs", etc.) and *IPV* (e.g. "physical abuse", "battered women", etc.), and additional analyses of the articles undertaken using sex, gender, equity and trauma-informed lenses .

In addition, the following journals were manually searched: *Violence Against Women, Violence & Victims, Journal of Interpersonal Violence, Trauma, Violence and Abuse, Aggression & Violence Behaviour, Journal of Aggression, Maltreatment and Trauma resulting in* five articles related to RQ1 and one article related to RQ2.

We conducted the search again on July 10, 2020 to iterate the initial findings. We used the same methodology and databases and will continue to update these searches on a monthly basis until

October, 2020. On this first update of the academic literature, there were 73 additional articles identified on RQ1 and 99 articles on RQ2. In addition, seven articles on RQ1 and one article on RQ2 were identified in the grey literature search. These records will be title and abstract screened and all the included papers will be downloaded for the full paper screening. The same inclusion/exclusion criteria will be applied as in the original search.

Grey Search Strategy

To supplement the academic evidence, we conducted grey literature searches (including resources such as infographics, guidelines, recommendations etc.). For RQ1 we searched Data2x using the search terms: *pandemics, social isolation, quarantine, natural disaster, COVID-19* and *domestic violence, intimate partner violence, spousal abuse, physical abuse*. For RQ2 we conducted a targeted search of Canadian and American organizations on IPV and SU including, but not limited to: CCSA, CISUR, CanFASD, Statistics Canada, BCCSU, OAITH, BCSTH, and SAMSHA using the search terms: *alcohol, tobacco, substance, drugs, cannabis* and *intimate partner violence, domestic violence, spousal abuse*. Additional articles were identified in the academic literature (e.g. editorials, commentaries, etc.) and through related email listservs including WUNRN and SVRI.

The findings from the database and targeted searches were documented. The search strategy, name of database and/or website, and date that the search was conducted was entered into an Excel spreadsheet. The first 75 returns from the initial search were reviewed/considered for inclusion.

3. Study Selection

The academic search for RQ1 yielded 2356 unique returns and for RQ2, 3641 unique returns (the search for RQ2 was limited for the last 5 years, 2015-2020). The records were title and abstract screened separately by two independent reviewers. Abstract screening reduced the number of included papers to n = 79 (for RQ1) and n = 332 (for RQ2). Full text articles were screened independently by several reviewers.

4. Quality Appraisal

To assess the quality of the included studies, we used the Mixed Methods Appraisal Tool 2018 Version (MMAT) [1]. Using the MMAT, the included studies were appraised using seven questions designed to appraise the quality of common empirical study designs. The MMAT includes two screening questions that are used for all study types and five different questions for qualitative, quantitative descriptive, randomized control trials, quantitative non-randomized control trials, and mixed methods designs. The response categories include "yes" (when the paper includes the details for the items), "no" (when the paper does not mention any information regarding the items) and "can´t tell" when there is unclear information related to the criterion.

5. Charting the data

Information from the included papers was extracted by one reviewer and charted in Excel using the following categories:

RQ1: Aim; Country; Study design; Population; Type of traumatic event; Findings – relationship between the event and IPV; Findings – mechanisms between natural disasters/pandemics and IPV; Findings – Impact for service providers; and Suggestions for future research

RQ2: Aim; Country; Study design; Population; Findings – relationship between SU and IPV; Findings – mechanisms between SU and IPV; Findings – Impact for service providers; and Suggestions for future research

6. Collating, summarizing and reporting the results

The final stage of the rapid review included a narrative synthesis integrating data synthesis and interpretation from qualitative, quantitative, randomized controlled trials and mixed methods designs.

Findings: Substance Use, Intimate Partner Violence and Pandemics

Introduction

Both SU and IPV appear to rise amidst disasters and post-disaster periods. However, the mechanisms and reasons for this are not completely clear. It may be that disasters highlight or make visible existing patterns and issues, generate more help-seeking for IPV, or indeed provoke heightened rates of both SU and IPV.

In any case, in the context of disasters, women report IPV and experience multiple related physical and mental health issues, including depression, PTSD, trauma, and sleep issues. Perpetrators may also experience trauma, but may also utilize added tactics and methods of IPV, exploiting disaster conditions and/or pandemic related policies, such as social isolation, lockdowns, and inaccessible social networks and helping services. In crisis situations, perpetrators and victims may be seen together, creating less opportunity for first responders and service providers to detect IPV and respond to help-seeking.

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. Research has taken place on either/or/and perpetrator and victim SU addressing the role of SU in aggression, or the role of SU in adaptation or coping with IPV. It also uses multiple theoretical and disciplinary paradigms, and methods including psychological experiments, field surveys, service provision and policy and systems analyses. Numerous countries have been the site of research on this relationship, focusing on one or multi substances, and their context-specific mechanisms and impacts. Nonetheless, alcohol, tobacco and poly-drug use are associated with IPV across countries. Further, the impact of IPV and SU on women's health is significant, including mental and physical health repercussions, contributions to chronic diseases, and ongoing trauma.

For first responders, substance use, and IPV service providers the implications are clear. IPV detection and awareness is essential in disaster and pandemics. Training must be enhanced to understand the additional burdens of IPV and increased help seeking in the context of COVID-19 and other disasters. For those providing services for either IPV or SU, investigation into the other issue is a must. Integrating awareness of the other issue into ongoing help, service provision, or health information is essential, in order to fully respond to women's health needs. In the longer term, reductions in gender inequity linked to power, control and economic supports will assist with both reducing IPV and responding more adequately and robustly to both SU and IPV in pandemic contexts.

Quality Appraisal Results

The included studies in the RQ1 were categorized as quantitative, descriptive studies (*n* = 11), quantitative, non-randomized studies (*n* = 3) and qualitative (*n* = 3). In the RQ2, included studies were categorized as quantitative, descriptive studies (*n* = 54), followed by quantitative, non-randomized studies (*n* = 28), qualitative (*n* = 12) and mixed methods studies (*n* = 5).

Evidence on Natural Disasters and IPV
Relationship between natural disasters and IPV

There is some evidence that IPV increases after a natural disaster [2-7]. A cross-sectional study of 186 Chinese women after the Sichuan earthquake revealed psychological aggression rose from 10.5% to 19.3% and physical violence from 5.0% to 6.6% [3]. However, Frasier et al. (2004), found no significant increase between the IPV experienced by blue-collar women in rural southern communities before and after Hurricane Floyd and later flood [8]. Qualitative data show that IPV might be more visible during a natural disaster due to changes in the setting, but that may not mean it is more common [9]. In some cases, women do not report a continuation of a pre-existing IPV but recount previous incidents. However, those women who experienced IPV pre natural disaster described more severe episodes [9]. New Orleans Police Department's 2002-06 data show increases in domestic violence calls and arrests post-Katrina with more severe cases causing the increase in arrests [10]. Women reported on average 0.52 physically aggressive acts and 1.96 psychologically aggressive acts after a flood [11]. Women who experienced post disaster IPV were approximately 5 years younger than those who did not with two patterns: an increase among women aged 18 to 36 and decrease among aged 37 to 85 [6]. Experiencing IPV pre- hurricane is a predictor for post-hurricane physical and psychological IPV [7].

Mechanisms and impacts of natural disasters on IPV

Women who experience post-disaster IPV are more likely to report sleep and appetite dysregulation, low self-esteem and suicidal ideation [6]. Women who reported IPV post-Katrina were 10.4 times more likely to report a major depressive disorder [5], but it is difficult to distinguish which mental health problems are related to IPV or the natural disaster itself. One study found that women who reported IPV were 25% more likely to report being affected by the

hurricane and flood compared to those women who did not, possibly affecting their overall coping strategies when competing with others for services in the aftermath of the floods [8]. Quantitative findings show that women who are exposed to multiple hurricane-related stressors have an increased risk of physical IPV [7]. Perpetrators may use disasters to exercise control, as previously separated women reporting men using different strategies to move in with them post-disaster [9, 12]. Data from workers post-earthquake and tsunami in Japan reveal that perpetrators used disaster compensation payments for alcohol, gambling and affairs and asking their partners to wear a GPS [12].

Impact for service providers

Several studies recommend including IPV in natural disaster interventions and planning, and anticipating the impact of PTSD on mental health. Addressing violence issues in community-based mental health services is crucial, even if the IPV is pre-disaster [5] and recognizing that limited safe housing and loss of community networks are important gaps for women experiencing post-disaster IPV [13]. It is crucial for first responders and HCP to offer screening and help separate from perpetrators. For example, depressive symptoms such as appetite and sleep dysregulation, low self-esteem and suicidal ideation might indicate post disaster IPV and warrant safe follow-up [6]. Women experiencing IPV present more health issues post-disaster [8] are likely to seek help for psychosomatic complaints-leading to underreporting of IPV [5]. There are barriers to disclosure such as fear of: hurting loved ones, communities, what their partners could do to their children, not being believed, escalating violence and lack of options [9]. Service providers may show more compassion towards men as they are also traumatized during natural disasters, or be in denial and interpret the IPV as an unintentional act related to the disaster trauma [9].

Evidence on SU and IPV & Associated Factors

The relationships between substance use and intimate partner violence is multidirectional and complex: reflecting patterns of substance use by perpetrators and/or victims/survivors, as well as different patterns by substance. Research has been done on SU by both perpetrators and survivors, and on alcohol, tobacco and other drug use. SU is associated with IPV, and both are linked to other psychosocial factors.

Alcohol is one of the most studied substances among both survivors and perpetrators. For example, among a sample of 189 women who experienced physical or sexual IPV in their lifetime, more than half (51.3%) consumed alcohol and 24.7% binge drank in the past year [14]. Mumford et al. (2018) found that maternal high-risk drinkers were more likely to report experiencing IPV [15]. In a longitudinal study that examined the relationship between patterns of drinking in partners of lesbian couples and physical and psychological aggression, Lewis et al. (2015) found a relationship between discrepant alcohol use and psychological aggression [16]. Both psychological and physical aggression predicted future discrepant drinking patterns [16]. Among

perpetrators, an Indian study found that women with husbands who consumed alcohol were 6 times more at risk of physical IPV [17]. The relationship between alcohol use and IPV seems to be independent of use among women. Mumford et al. (2018) found that fathers´ binge drinking habits increased IPV rates by 3 for nondrinking mothers [15] but maternal high-risk drinkers were more likely to report experiencing IPV [15]. In another sample of women aged 20 to 59 years old, there was a relationship between consuming alcohol and both psychological and physical violence [18].

Tobacco use and IPV are also related. Women with an IPV history are more likely to be current smokers or heavy smokers [19]. Among 398 women from three Ohio Appalachian counties, approximately 75% of current smokers reported an IPV history [20] and when controlling for depression, age, and socioeconomic status, IPV remains significantly associated with tobacco use [20]. Among perpetrators, sexual violence is reported more often among those women whose partners smoked [18].

Poly-Drug use is also associated with IPV. Among women who inject drugs in Kazakhstan, 15.87% of women report IPV [21]. Qualitative evidence shows that the substance use happens within 3 hours of the IPV episode [22]. In a study on the effects of alcohol and marijuana on IPV, Low et al. (2017) found no relationship between women´s use of alcohol and cannabis and men´s IPV perpetration [23]. However, women's polysubstance use was predictive of higher levels of victimization [23]. In a study with 612 Ethiopian pregnant women (59% faced at least one type of IPV during pregnancy), partners who consumed alcohol, chewed Khat and smoked cigarettes were linked with IPV [24]. In a meta-ethnography, Gilchrist et al. (2019) found an association between alcohol and stimulant drugs such as methamphetamine and cocaine and IPV [25].
Many other factors contribute to or result from, SU and IPV experiences in women. Trauma and other adverse experiences are associated with IPV. Women who reported experiencing alcoholism and child abuse in their families of origin also report heavy drinking partners [26].
Hispanic women who reported experiencing some type of childhood abuse were more likely to experience IPV, have adulthood depression, and be at high risk for drinking [27]. Binge drinking, among other factors such as depression and PTSD, mediates the relationship between child abuse and recent IPV and are all related to recent IPV [28]. Women in Papua New Guinea are more likely (than men) to have PTSD from IPV, rape and war trauma and IPV was associated with depression and alcohol abuse [29]. UK women revealed that their patterns of alcohol use were related to the fear they felt in their relationships and alcohol was used as a coping mechanism to numb their feelings or avoid thinking about the IPV episode [30]. Some studies indicate that poverty is linked to higher alcohol use by men, increasing the risk of IPV towards women [31] and some studies consider alcohol use a disinhibiting factor for aggression among men who perpetrate IPV [32, 33]. However, there is also evidence that the IPV is not the result of alcohol abuse but is related to unequal gender roles and of men´s control and power over their partners [25, 30]. In some cases, perpetrators use women´s mental health issues or their alcohol use as a tactic of isolation and control [26]. Among 445 lesbians, emotional distress influenced drinking to cope and was associated with greater alcohol use and problem drinking- both directly linked to bidirectional partner violence [34].

Impact of IPV & SU on Women's Health

There are numerous health related impacts of IPV and SU. For example, women´s engagement in alcohol and tobacco behaviours affect their overall health status [35]. Women who report IPV seek more healthcare resources than women who do not report IPV but may be less likely to use preventive services [35]. There is evidence that women who reported experiencing IPV and were smokers had a higher risk of earlier menopause [19]. The co-occurrence of IPV and PTSD and alcohol use may be additional barriers for quitting smoking for women [36]. Discrepant drinking patterns in couples (drinking by fathers with nondrinking mothers) may reflect mothers who have changed their patterns of drinking in self defensive response to drinking and IPV in the partner [15]. Some studies found that alcohol or other substance use in survivors be disinhibiting and make them react and respond with violence in self-defence [25]. Findings from an experiment conducted with 405 women testing the effects of intoxication on decision making regarding condoms in a sexual situation showed that psychological effects of abuse increased condom less sex intentions indirectly through decreased condom negotiation self-efficacy [37]. In a Korean study with 194 foreign-born mothers, alcohol use among fathers was associated with mothers' child abuse through fathers' spousal abuse [38]. Men's drinking has a negative impact on both members of a couple, including ART adherence, couple conflict, IPV, food insecurity, and household poverty [39].

Implications for Service Providers and Policy-Making

The bidirectional relationship between SU and IPV highlights the importance of bidirectional service provision. Addressing substance use among those who experienced IPV, and IPV-related issues among women with substance use/addictions and/or their partners is essential. This can happen on individual, couple, community or society wide levels.

For example, there is also a need to address smoking through interventions for women who report experiencing IPV [19]. Nemeth et al. (2016) recommend including prevention and smoking cessation messages for those service providers that work with women who reported experiencing IPV [20]. On a program level, there is also a clear opportunity to screen for IPV and address the specific related needs when addressing smoking reduction or cessation. It is relevant to design trauma-informed and tailored interventions for those women who experienced IPV as these authors located none [20]. Other studies identified a need to intervene with families where one member misuses alcohol to provide different social roles and work concepts such as self-esteem and emotional balance [33]. For example, Lewis et al. (2018) recommend addressing both emotional distress and alcohol use among lesbians as both factors might reduce bidirectional partner violence [34] and identify individual or dyadic risk factors among same-sex couples [16].

Various system level changes can be made. Massetti et al. (2017) recommend creating partnerships between a range of community services targeted at hard to reach women who experienced IPV, as they might be at higher risk of cancer linked to health behaviors and barriers

to accessing the healthcare system [35]. Others recommend that child protection services address fathers' alcohol use in their IPV intervention and prevention programmes when working with multicultural families in South Korea [38]. Other recommendations include addressing information regarding the relationship between condom negotiation and intoxication when making decisions about sexual activity [37] and screening for IPV in antenatal care services [24]. Overall, there are key society wide issues affecting IPV that rest on gender inequities and the lack of women's power and control compared to men. This underpins ongoing IPV at all levels: in relationships; among bystanders and family members; in communities; among program providers; health care providers; and via social norms and societal institutions [40]. Without changes in gender norms and roles and attitudes, condoning and perpetuating IPV will continue. Fundamentally, health care providers and substance use 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 [18].

Selected Grey Literature

Key graphics and reports on IPV in the context of COVID 19	
	O'Donnell, M. Peterman, A., Potts, A. (2020). *A Gender Lens on COVID 19: Pandemics and VAW and Children.* Center for Global Development. https://www.cgdev.org/blog/gender-lens-covid-19-pandemics-and-violence-against-women-and-children On webpage and in document below the authors provide this visual of **9 (direct and indirect) pathways linking pandemics and VAW/C**, through effects of (on): (1) economic insecurity and poverty-related stress, (2) quarantines and social isolation, (3) disaster and conflict-related unrest and instability, (4) exposure to exploitative relationships due to changing demographics, (5) reduced health service availability and access to first responders, (6) inability of women to temporarily escape abusive partners, (7) virus-specific sources of violence, (8) exposure to violence and coercion in response efforts, and (9) violence perpetrated against health care workers.
	Peterman, A. et al. (April 2020). *Pandemics and Violence Against Women and Children.* Center for Global Development. https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children The fear and uncertainty associated with pandemics provide an enabling environment that may exacerbate or spark diverse forms of violence. • They document the **9 pathways/mechanisms** above • Based on these mechanisms, they **suggest 8 policy and program responses** for action by governments, civil society, international and community-based organizations: 1 Bolster violence-related first-response systems 2 Ensure VAW/C is integrated into health systems response 3 Expand and reinforce social safety nets 4. Expand shelter and temporary housing for survivors 5. Encourage informal (and virtual) social support networks: 6. Clear communication and support during quarantine mandates 7. Integrate VAW/C programming into longer-term pandemic preparedness 8 Implement and invest in flexible funding mechanisms: • The authors lay out a **research agenda** comprising three main streams, to better (1) understand the magnitude of the problem, (2) elucidate mechanisms and linkages with other social and economic factors and (3) inform intervention and response options.
	UN Women. (2020). *COVID-19 and Ending Violence Against Women and Girls.* https://www.undp.org/content/undp/en/home/librarypage/womens-empowerment/gender-based-violence-and-covid-19.html This brief highlights emerging evidence of the impact of the recent global pandemic of COVID-19 on violence against women and girls. It makes recommendations to be considered by all sectors of society. Calls it a shadow pandemic and illustrates numbers with infographics. Describes trends from different countries. Provides examples of increased requests for help (up 40% found by Australian group in NSW, calls down by helpline in Italy). Draws on economic impacts found in other crisis such as Ebola and Zika outbreaks. Provides list of responses re ensuring the safety of women, using technology and making the justice system virtual. Makes recommendations for governments, civil society orgs and women's involvement in action.
	UNDP. (2020). *Gender-based Violence and COVID-19.* https://www.undp.org/content/undp/en/home/librarypage/womens-empowerment/gender-based-violence-and-covid-19.html This is a briefing note from the UN. Section 1 outlines *Dedicated actions and strategies to prevent and address GBV* - and gives examples where different countries are employing these strategies - one example is about supporting police and justice actors to provide adapted services. Section 2 provides *Strategies and actions to mainstream GBV prevention and response in 'non-GBV' interventions* - one example is to integrate GBV prevention into COVID19 interventions. Section 3 provides O*ther Considerations -* such as putting women at the center, engaging boys and men, utilizing data to the fullest.

	Fraser, E. (2020). *Impact of COVID-19 Pandemic on Violence against Women and Girls.* UKAID. https://www.girlsnotbrides.org/resource-centre/impact-of-covid-19-pandemic-on-violence-against-women-and-girls/ This paper discusses how the COVID-19 pandemic may impact on violence against women and girls in a number of settings (domestic, workplace, in emergency settings . . .); provides info about risks, lessons and recommendations from other similar epidemics as to support services for survivors, health sector interventions, security and justice challenges, education and child protection responses, social protection and job creation and actions in humanitarian settings. The following recommendations are included: • Disaggregating data to understand the gendered impacts, with data disaggregated by sex, age, disability and other relevant vulnerability factors. • Understanding which women and girls are at heightened risk of different forms of GBV and understand how these may vary across settings. • Strengthening the leadership and meaningful participation of women and girls in all decision-making processes in addressing the COVID-19 outbreak • Training first responders on how to handle disclosures of GBV that could be associated with or exacerbated by the pandemic, including how to make referrals for further care. • Updating GBV referral pathways so as not to overwhelm tertiary hospitals • Provide psychosocial support to GBV survivors who are also affected by the outbreak. Examples of responses to similar epidemics from various countries are described.
International contextual paper on gender and pandemic	
	UNFPA. (March 2020). *COVID-19: A Gender Lens - Technical Brief.* https://www.unfpa.org/resources/covid-19-gender-lens This technical brief discusses how women and men are impacted differently – that gender norms pose a risk, that the division of labour in care and workforce differs, and increase in gender-based violence Makes 13 recommendations including 2 that are VAW specific: • Consider how the quarantine experience can be different for women and men, such as whether women's and men's different physical, cultural, security, and sanitary needs are being met. Recognize that the home may not be a safe place for some women and may indeed increase exposure to intimate partner violence. • Update gender-based violence referral pathways to reflect changes in available services. • Ensure the response to COVID-19 does not reproduce or perpetuate harmful gender norms, discriminatory practices and inequalities. It is important to recognize that social, culture and gender norms, roles, and relations influence women's and men's vulnerability to infection, exposure, and treatment.

Grey literature identified on IPV and Substance Use Connections

Key graphics and reports on the connections IPV & SU	
	Canadian Women's Foundation, & BC Society of Transition Houses. (2011). *Report on Violence Against Women, Mental Health and Substance Use.* https://www.canadianwomen.org/wp-content/uploads/2018/03/PDF-VP-Resources-BCSTH-CWF-Report_Final_2011_-Mental-Health_Substance-use.pdf This report summarizes the connections between VAW, SU and mental health concerns for women, identifies the barriers women face in accessing each system of care, compares the philosophies of each service system, and identifies key service, funding and policy gaps. They authors summarize the recommendations from the key informants as: 1. Focus needs to be placed on creating and enhancing services, projects and collaborative initiatives that respond to violence against women, mental health and substance use 2. Services in all three sectors need to be violence-informed or, at the least-trauma informed. 3. All relevant agencies/ministries need to be involved in meaningful collaboration – not only representatives from frontline anti-violence, mental health and substance use sectors. 4. Resources should be directed towards the women who are the most marginalized or who are most in need of them 5. Women with lived experience need to be included in any collaborative initiatives around violence, mental health and substance use in the lives of women

	DrugScope, & LDAN. (2013). *Making the connection: Developing integrated approaches to domestic violence and substance use.* *https://www.drugwise.org.uk/wp-content/uploads/dvreport.pdf*
	This report focusses on how the response might be improved by various sectors in the UK, and gives good practice guidelines and examples – but it also mentions types of DV and possible connections to substance use on p.9. "At the final network meeting of the project, Dr Gail Gilchrist of the University of Greenwich gave a detailed presentation on the relationship between domestic violence and substance misuse, with a particular focus on perpetrators. She highlighted that various perpetrator typologies have been identified. Johnson (1995), for instance, describes "patriarchal terrorism" – men controlling women – and ''common couple violence'' – that is, reciprocal violence. Holtzworth-Munroe et al (2000) describe four typologies: family only, low-level antisocial, generally violence, and borderline/dysphoric. Gilchrist et al (2003) identify two typologies: antisocial/narcissistic – hostile and controlling to women – and borderline/emotionally dependent – so, involving high levels of anger/distress. As she noted, substance use may play a different role and be more prevalent in different typologies, and as such, it is important to recognise that a range of different interventions will be needed.
	One of the good practice programs mentioned is the Men and Masculinities programme and several LGBT groups such has Antidote. A list of good practices is provided and a good list of programs and websites in the UK.
	Haskell, R. (2010). *Reducing Barriers to Support: Discussion paper on violence against women, mental wellness and substance use.* British Columbia Society of Transition Houses. https://bcsth.ca/publications/discussion-paper-on-violence-against-women-mental-wellness-and-substance-use/
	This discussion paper explores intersecting social issues and identities of women accessing transition houses in BC and the Yukon who had violence, substance use and mental wellness concerns – and looks in depth at the policies and practices of the houses that create barriers for these diverse women when accessing transition house services.
	Miller, P., Cox, E., Costa, B., Mayshak, R., Walker, A., Hyder, S., . . . Day, A. (2016). *Alcohol/Drug Involved Family Violence in Australia.* National Drug Law Enforcement Research Fund. https://aic.gov.au/file/6967/download?token=uEatLVFi
	This Australian report looks at the following questions from a statistical view: • What is the relationship between AOD use and FDV in the general population? • What role do key demographic, social, and environmental factors play in the occurrence and severity of different types of FDV? • How do variables differ in people who experience FDV where AOD use is involved compared with those where AOD use is not involved? • • What are the major trends in FDV in relation to incidents attended by police and the factors common to them across states and territories?
	Rivera, E. A., Phillips, H., Warshaw, C., Lyon, E., Bland, P., & Kaewken, O. (2015). *The Relationship Between Intimate Partners Violence and Substance Use: An Applied Research Paper.* http://www.nationalcenterdvtraumamh.org/2016/03/new-resource-the-relationship-between-intimate-partner-violence-and-substance-use-an-applied-research-paper/
	This is an excellent applied research paper addressing the connections. They discuss: a) how commonly IPV and substance use coexist e.g. women with recent history of IPV having nearly 6 times the risk of problematic SU, b) the temporal relationship between IPV and SU e.g. it is often seen to be bidirectional, and c) that there are additional factors affecting the relationship between IPV and SU such as depression and trauma e.g. women who have experienced IPV have nearly 3 times the risk of developing depressive disorder, and that PTSD may mediate the relationship between IPV and problematic substance use. They mention our CEWH study about how the determinants of health affect all of IPV, SU, MH and experience of trauma. And they mention how these issues and factors when experienced together, affect help seeking, intensify stigma.
	The authors also outline the strengths and limitation of the research on IPV/SU connections and make recommendations for SU tx providers and research. They see the limitations of the current research as having inconsistent conceptualization and measurement of IPV, highly varied measurement of SU and SUD as well as lack of inclusion of LGBTQ survivors in the research. They recommend that substance use services understand IPV specific factors that influence survivors' access to and outcomes of SUD tx and that services be trauma informed, gender responsive and IPV integrated.

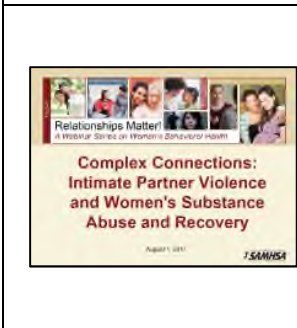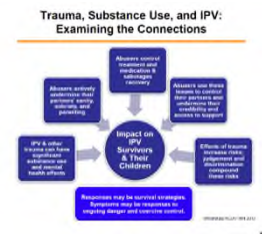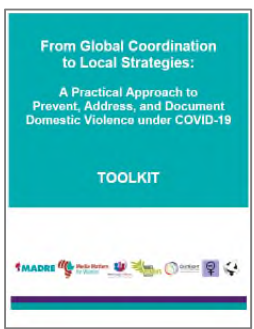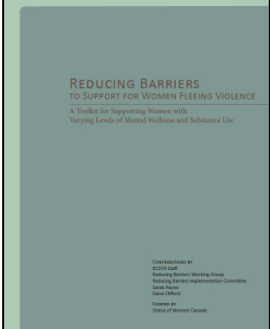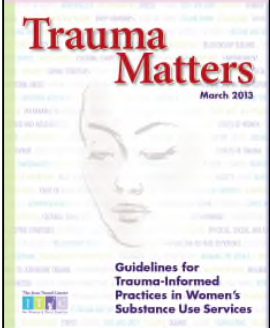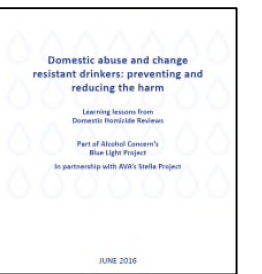|	
	Bennett, L., & Bland, P. (2008). *Substance Abuse and Intimate Partner Violence.* VAWnet.org https://vawnet.org/sites/default/files/materials/files/2016-09/AR_SubstanceRevised.pdf This paper discusses in depth how substance abuse (SA) and intimate partner violence (IPV) is complex and should not be reduced to ideas about one causing the other. Many theoretical perspectives explain the co-occurrence of SA and IPV including: substance use disruption of thinking processes; adverse childhood experiences; power motivation; during the process of obtaining and using substances; and co-occurring situations like hostile personalities, antisocial personality disorder, or poverty; however none of these theories account for all the co-occurrence of SA and IPV to indicate that SA causes IPV. The authors also discuss the victim's substance use and the role of drunkenness on the part of perpetrators, as well as needed services for both victims and perpetrators.
	World Health Organization (2006). *Facts on Alcohol and Violence: Intimate partner violence and alcohol.* https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/prevention-resource-centre/women/who-facts-on-alcohol-violence-intimate-partner-violence-alcohol.html This paper discusses the links between IPV and alcohol use as: • alcohol use directly affects cognitive and physical function, reducing self control and leaving individuals less capable of negotiating a non-violent resolution to conflicts in relationships • excessive drinking by one partner can exacerbate financial difficulties, childcare problems, infidelity or other family stressors • individual and societal beliefs that alcohol causes aggression can encourage violent behaviour after drinking and the use of alcohol as an excuse for violent behaviour • experiencing violence within a relationship can lead to alcohol consumption as a way of coping or self-medicating • children who witness violence or threats of violence between parents are more likely to display harmful drinking patterns later in life They discuss broad alcohol policy measures needed, and the role of public health in collecting disseminating info on prevalence of the two issues, promoting research on the connections, increasing awareness, promoting prevention, promoting multi-agency partnerships, advocating for legal changes and promoting screening and referral for both concerns.
	NCDVTMH – series of 6 infographics on DV, SU and MH connections http://www.nationalcenterdvtraumamh.org/2019/09/information-memorandum-from-samhsa-and-acf-calls-for-collaboration-on-domestic-violence-substance-use-and-mental-health/#infographics6 Based on urgent call for collaboration at the intersections of DV, substance use and mental health SAMHSA issued an Information Memorandum in Sept 2019. **The Information Memorandum cites research with the following findings:** • Domestic violence has significant mental health and substance use effects. • There are high rates of domestic violence among individuals seen in mental health and substance use disorder treatment settings. • Domestic violence is often targeted toward undermining a partner's mental health or substance use treatment and recovery. • Abusive partners undermine their partners' relationship with their children, creating risks for children's health, mental health and well-being. • Experiencing a mental health or substance use disorder places individuals at greater risk for being controlled by an abusive partner. • Stigma associated with substance use and mental illness contributes to the effectiveness of abusive tactics and can create barriers for survivors when they seek help.
	Warshaw, C. (2017). *Relationships Matter.* SAMHSA. This slide deck from a webinar sponsored by SAMHSA includes a presentation by Carole Warshaw that offers both statistical and analytical view of the intersections, and includes this image that portrays the point from the Rivera paper (that Warshaw was also an author on) that decontextualized measurement of acts of violence miss the important element of coercive control. The image captures how abusive partners may undermine a survivors attempt to achieve sobriety, isolate a survivor from sources of support, use a survivor's dependence on substances as a way to further their control, use stigma around SU to call a survivor's credibility into question, including in custody cases, and implicate a survivor in illegal activities thus limiting access to law enforcement.

	Centre of Excellence for Women's Health. *Interconnections and influences on women's experiences of violence and substance use.* This summary of the interconnections was developed by a multisectoral participants in a virtual community hosted by the Centre of Excellence for Women's Health. It has been used over the years to illustrate the not only the connections between substance use, violence against women and mental health concerns, but the centrality of trauma for all three concerns, and the influences of social and structural determinants of women's health, such as child welfare/mothering policy.
	MADRE. (2020). *From Global Coordination to Local Strategies: A Practical Approach to Prevent, Address, and Document Domestic Violence under COVID-19 Toolkit.* https://www.madre.org/sites/default/files/PDFs/From%20Global%20Coordination%20to%20Local%20Strategies_0.pdf This toolkit is a helpful resource for local groups who have experience working on domestic violence issues. It provides strategies developed around the world, for local communities to adapt to their context when planning grassroots responses in the context of the COVID-19 pandemic. It includes approaches to: • text messaging, radio and social media content for violence prevention campaigns • effective approaches for addressing abuse in the environment of physical distancing, isolation, shelter - at - home policies, and remote work of many organizations • strategies to reach men under pressure in social isolation • work with LGBTIQ persons and persons with disabilities recommendations for governments
	Ward, J. (2020). *Feminist Approaches to Specialized Mental Health Care for Survivors of Gender-based Violence.* http://www.sddirect.org.uk/news/2020/06/harnessing-feminist-principles-and-approaches-to-improve-mental-health-care-for-gbv-survivors-in-humanitarian-contexts/ This learning brief provides a preliminary overview of basic principles and approaches to feminist-informed mental health treatment for survivors of gender-based violence (GBV), particularly survivors who are experiencing symptoms of post-traumatic stress or other mental health conditions that cannot be resolved through more generalized GBV case management and/or psychosocial support. It discusses a tiered approach to treatment and support interventions from basic services that are socially and culturally safe, to safe community and family supports, structured emotional and practical support to clinical mental health care. It offers principles of and key approaches for the delivery of feminist-informed mental health interventions for survivors. In a preliminary way it addresses the large gap in guidance related to mental health treatment and support for survivors.

5 Canadian guidance manuals that highlight IPV, SU and MH connections and offer ideas for addressing them

	BC Society of Transition Houses. (2015). *Reducing Barriers to Support for Women Fleeing Violence: A Toolkit for Supporting Women with Varying Levels of Mental Wellness and Substance Use.* https://endvaw.ca/wp-content/uploads/2015/12/ReducingBarrierToolkit.pdf This toolkit designed for transition house or shelter workers, offers background information about the relationships between violence against women, mental wellness and substance use, and why it is important to provide services that recognize these interconnections. It offers core principles that guide promising practices and discusses how the promising principles may be applied. The inclusion of reflection questions throughout is a strength.
	Jean Tweed Centre. (2013). *Trauma Matters: Guidelines for Trauma-Informed Services in Women's Substance Use Services.* Toronto, ON. http://jeantweed.com/ This manual provides comprehensive guidance for implementing trauma informed approaches within substance use services for women. The guidance is also relevant for other services working with substance involved women, and system planners interested in the steps involved in changing organizational cultures, practice, policies, and infrastructures to become trauma informed. The document has 12 sections which together provide specific information about trauma informed practices at the clinical, organizational and systems level.

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	Leslie, M., Reynolds, W., Motz, M., & Pepler, D. J. (2016). *Building Connections: Supporting Community-Based Programs to Address Interpersonal Violence and Child Maltreatment.* https://www.mothercraft.ca/index.php?q=ei-connections This manual was developed to support service providers in community-based programs who work with women and children, where substance use and experience of violence and trauma are common. It considers the impacts of IPV on mothering and on child development and how organizations can respond to women living with IPV and support children identified as living with IPV. It offers practical information on working in a trauma informed way, for example on how to enhance emotional safety for women and children, build compassionate and respectful relationships, build collaborative community partnerships, and work with child protection authorities.
	Mason, R., & Toner, B. (2012). *Making Connections: When Domestic Violence, Mental Health and. Substance Use Problems Co-Occur.* http://dveducation.ca/makingconnections/pdf/making_connections_training_manual.pdf This curriculum was prepared for workers in anti-violence, mental health and substance use services to support understanding and action on the connections that substance use and mental health concerns have with violence against women. It includes sections on 1. practice philosophies, 2. core information on all three issues, 3. the challenges faced by service providers due to the complexities of the co-occurring problems 4. suggestions for assessing, making safety plans, providing other basic supports, and making referrals 5. collaborating across systems and 6. self care on the part of providers.
	OAITH. (no date). *Safe for All: Discussion Guide.* https://www.oaith.ca/assets/library/SafeForAllmanualManual.pdf This discussion guide informs staff in VAW shelters about harm reduction strategies and philosophies. It discusses why it is important to support women who use substances in VAW shelters, the common barriers that women survivors who use substances face in shelters, and specific ways to support diverse women with on site harm reduction supports.

Key International practice-oriented resources on addressing the connections Between IPV and SU	
	Alcohol Concern & Against Violence and Abuse (AVA). (2016). *Domestic abuse and change resistant drinkers: Preventing and reduction harm* https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf This resource provides guidance for those who work with clients who are change resistant drinkers and who are perpetrating or experiencing domestic violence. The UK based authors discuss the complex relationship between alcohol misuse an domestic abuse, and offer tools and techniques, for a range of different service providers and settings, on identification, risk assessment and brief advice on both issues, as well as safety planning when both issues are in play.
	AVA. (2013). *Complicated Matters – A Toolkit Addressing Domestic and Sexual Violence, Substance Use and Mental Ill-health Stella Project.* https://avaproject.org.uk/wp-content/uploads/2013/05/AVA-Toolkit-2018reprint.pdf This is a very comprehensive toolkit providing guidance to professionals in the domestic and sexual violence sector, substance misuse services and mental health services (including primary care) on how they can deepen their understanding of these three inter-linked areas. The toolkit provides practical advice on how to understand the client's issues, ask about their experiences in a sensitive non-judgemental way, find out what their needs are while prioritising safety, considering the needs of the family, and promoting recovery.
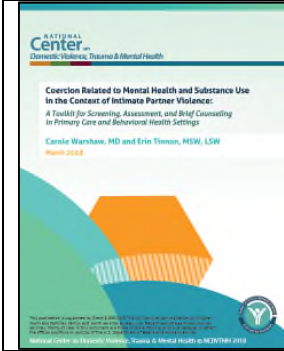
	Warshaw, C., & Tinnon, E. (2018). *Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings.* http://www.nationalcenterdvtraumamh.org/publications-products/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence-a-toolkit/ This toolkit provides trauma-informed guidance on integrating discussion about mental health and substance use coercion into routine mental health and substance use histories and into in-depth intimate partner violence (IPV) assessments in primary care and behavioral health settings. This toolkit is intended to be used in conjunction with comprehensive guidance on trauma-informed approaches to screening, assessment, and brief intervention for intimate partner violence in healthcare, mental health, and substance abuse treatment settings. This resource offers excellent practice advice and wording for offering brief support in a way that integrates the complex understanding of the connections between substance use and VAW.

International contextual resource on women and drug use
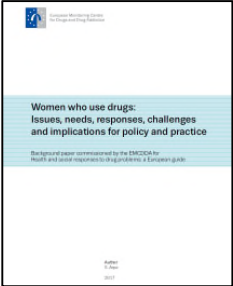
	Arpa, S. (2017). *Women who use drugs: Issues, needs, responses, challenges and implications for policy and practice.* European Monitoring Centre for Drugs and Drug Addiction. https://www.emcdda.europa.eu/system/files/attachments/6235/EuropeanResponsesGuide2017_BackgroundPaper-Women-who-use-drugs.pdf This paper offers an overview of issues facing subgroups of women who use substances including those experiencing trauma and violence. It discusses how there are international instruments, policy statements, drug strategies, best practices, guidelines, standards and reports at various levels about gender informed approaches yet gaps still exist. Recommended actions include reducing knowledge gaps in relation to women's drug use and appropriate responses; increasing awareness and promotion of gender-responsive policies and programmes; introducing and expanding services that meet the needs of women who use drugs, irrespective of drug of use, age or subgroup; gender mainstreaming of policies and practices; ensuring the participation of women who use drugs in policy and programme development; and providing coordinated and integrated services to address issues beyond drug use. They also recommend further epidemiological studies, sex-specific biomedical research, studies on treatment gaps, needs assessments, programme evaluations and cost effectiveness studies.

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