Mental health, substance use, and IPV

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What We Know About...

• The relationship between poor mental health, harmful alcohol use, and IPV

• Our ability to intervene effectively to improve mental health and reduce problematic alcohol use in low resource settings

• The effect of alcohol and mental health interventions on frequency and severity of IPV and/or other forms of violence in the family

• The prospect of taking such programs to scale
Take home messages

• Interventions exist that can be delivered by lay providers that successfully reduce hazardous drinking, depression, anxiety and trauma-related symptoms (CMDs)

• Emerging evidence and theory suggest that such programs can also reduce violence in the family, including partner violence

• Existing programs are brief, seldom lasting longer than 4 to 8 sessions

• While offered now largely for “treatment,” many of the strategies used in these programs, could productively be integrated into future prevention programming
What do we know about how mental health, alcohol use and violence relate?
Poor mental health and IPV
Complex, inter-related linkages; often bi-directional

STRONG EVIDENCE
(systematic review of cohort studies)

• Women experiencing recent IPV are more likely to experience depressive symptoms
• Women experiencing depressive symptoms are more likely to experience subsequent IPV
• Positive association between recent IPV and postpartum depression
Men’s hazardous drinking and IPV

• Partner alcohol use is a robust correlate of IPV victimization among women globally

• Drinking, especially binge drinking by a male partner, increases frequency and severity of abuse episodes

• Magnitude of effect of alcohol on IPV is greater in countries with lower overall levels of drinking

• Association confirmed in longitudinal studies and episode-level analysis
Women’s drinking and IPV

Women’s Drinking

- Longitudinal studies find no association in either direction between recent IPV and heavy /binge drinking by women
- Meta-analysis finds positive association between heavy/binge drinking and lifetime experience of IPV – but could be driven by abuse in childhood
Strong evidence that we can reduce hazardous drinking; moderate evidence that this in turn will reduce IPV

Few studies examine IPV as an outcome
Two APPROACHES

REDUCTIONS IN AVAILABILITY OF ALCOHOL VIA LAW, POLICY AND REGULATION

LOW COST INTERVENTIONS
(SUPPORT GROUPS OR BRIEF INTERVENTIONS BY LAY PEOPLE OR NON-SPECIALIST PROVIDERS)
Population-level strategies for reducing harmful alcohol use

• Laws and policies that decrease alcohol accessibility:
  • Reduce consumption and alcohol-related harms even among heavy drinkers
  • Prevent the initiation of drinking, an important strategy for countries in the Global South where many people currently abstain

• Alcohol taxation and pricing policies are among the most effective and cost-effective measures to reduce alcohol consumption and related harms

• Longitudinal studies have demonstrated that limiting outlet density can reduce IPV and other types of violent crime.

• In Greenland, a ‘coupon-based’ program limiting adults to 72 beers per month achieved a 58% reduction in the number of police calls for IPV
Low-cost interventions

**SELF HELP**

- AA attendance is prospectively associated with increased abstinence at 12 and 24 months.
- In 5 of 6 RCTs, AA participation had a genuine benefit on reduced drinking not attributable to self-selection bias.

**INTERVENTION IN PRIMARY CARE**

- Counselling for Alcohol Problems (CAP), a simple, 5 session intervention delivered by non-specialist providers is associated with sustained effects on drinking outcomes over a 12-month period.
- Brief advice by health providers (5 to 30 mins) can modestly reduce harmful drinking compared to usual care among individuals not severely dependent, when measured 12 months later.

Cochrane Systematic review 2018
Meta-analysis of >30 RCTs show that brief interventions can reduce mental health symptoms when implemented by non-specialists in LMICs.
Most share common strategies

• Thinking differently (Cognitive Behavioral skills)
• Motivational interviewing
• Stress management (breathing; relaxation)
• Getting active
• Problem solving

• BUT most focus on a single outcome (e.g. depression or trauma)
Until recently, few studies included IPV, alcohol abuse, or violence against children. This is changing...

**Problem Management Plus**
- Endorsed by WHO
- 5 weekly sessions of 90 minutes
- Lay providers
- 8 days of training with practice cases and weekly group supervision
- Competency testing

*Effective trials in Pakistan, Nairobi, India*

**CETA - transdiagnostic**
- Family-based TI-CBT intervention
- 4-10 sessions, as needed
  
  *Effective trials in Iraq, Ethiopia, Ukraine, Thai/Burmese Border*

**WW Zambia trial added:**
- CBT for alcohol reduction and relapse prevention
- Confronting fear and trauma memories
- Safety assessment and planning for suicide, IPV and homicide
“What Works” trial of CETA stopped early because of large reduction of IPV and hazardous alcohol use by men

** Similar drops in violence reported by men
New efforts to examine even cheaper, simpler strategies

Grannie Benches in Zimbabwe

Self help CBT manuals effective in reducing alcohol and mental distress in Thailand
Mindfulness & Mindfulness CBT

• Studies suggest that mindfulness-based interventions can have moderate benefits for some people with depression and anxiety.

• More rigorous research, as well as a clearer definition of mindfulness, are needed.
Next Steps

Refine: Refine (and simplify) interventions that collectively address intersecting problems of harmful alcohol use, violence in the family, and poor mental health.

Integrate: Integrate skills and strategies from effective “treatment” programs (such as CBT and alcohol reduction) into IPV prevention programming.

Scale: Scale CETA and similar programs as part of primary health care and global mental health investments.

Test: Test new strategies for reducing alcohol availability and harmful use as part of integrated IPV prevention programs.