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SPECIAL COMMUNICATION

Addressing the Shadow Pandemic: COVID-19 Related Impacts, Barriers, Needs, and Priorities to Health Care and Support for Women Survivors of Intimate Partner Violence and Brain Injury

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Abstract

Intimate partner violence (IPV) affects 1 in 3 women and has intensified during the COVID-19 pandemic. Although most injuries are to the head, face, and neck, leaving survivors vulnerable to sustaining traumatic brain injury (TBI), the intersection of IPV and TBI remains largely unrecognized. This article reports on COVID-19−related effects, barriers, needs, and priorities to health care and support services for women survivors of IPV-TBI. Using a participatory research model, we engaged 30 stakeholders in virtual meetings drawn from an IPV-TBI Knowledge to Practice Network in two virtual meetings. Stakeholders included women survivors, service providers, researchers, and decision makers across the IPV, TBI, and healthcare sectors. Data were gathered through small group breakout sessions facilitated by the research team using semistructured discussion guides. Sessions were recorded, transcribed verbatim, and analyzed using thematic analysis techniques. Stakeholders were given the opportunity to contribute to the analysis and knowledge transfer through member checking activities. Ethics approval was obtained through the University of Toronto. Stakeholders shared that COVID-19 has increased rates and severity of IPV and barriers to services and help-seeking. These effects have been exacerbated by infrastructure difficulties in rural and remote areas, including limited access to services. They noted the need to carefully consider implications of virtual care such as safety, privacy, and usability. Requests from survivors for peer support have increased significantly, indicating a need for more formalized and better-supported peer roles. Stakeholders further noted that an overwhelming lack of awareness of the intersection of IPV-TBI continues. Increasing education and awareness among health care and IPV service providers, survivors, and the public remains a priority. The COVID-19 pandemic has intensified IPV-TBI, increased challenges for women survivors, and accentuated the continued lack of IPV-TBI awareness. Key recommendations for health care and rehabilitation to address this priority are discussed.
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Intimate partner violence (IPV) is a significant public health concern affecting 1 in 3 women in their lifetime.[1,2] The most common injuries experienced by IPV survivors result from battery to the head, face, and neck, including strangulation,[3] which leaves survivors at risk of traumatic brain injury (TBI). Strangulation can

deprive the brain of oxygen and nutrients, resulting in hypoxic brain injury.[4,5] Hypoxic brain injury and TBI pose similar challenges to survivors of IPV, and both are often overlooked.[4-7] Up to 75% of survivors have a probable TBI, which is often inferred from violence history and symptom reports.[4,8-10] Women with disability, including TBI, are also at higher risk of experiencing IPV.[11,12] Combined, IPV and TBI (IPV-TBI) are associated with significant cognitive, physical, and mental health challenges that can be transient or lead to longer-term disability.[13-15] Untreated, these challenges lead to substantial social and economic repercussions, such as high rates of unemployment, poverty, and homelessness, as well as increased social and health-related support costs.[8,16-18]

The COVID-19 pandemic has intensified IPV globally, a crisis referred to as the shadow pandemic.[19,20] Canada's Minister for Women and Gender Equality consulted with frontline organizations across the country who estimated Canadian rates of IPV have increased up to 30%,[21] accompanied by higher levels of severity[21] and more demand for emergency shelter.[22] Physical IPV in particular has increased, resulting in a greater number of more severe injuries.[23] Simultaneously, many victim services organizations saw a decline in new clients, which has been attributed to women being trapped and having limited opportunities to report their victimization,[22] as well as a fear of COVID-19 exposure in shelters or hospitals.[23] In remote and rural communities, a survey of more than 250 Indigenous women reported 1 in 5 experienced physical or psychological violence in the first 3 months of the pandemic.[24] This is compounding the prepandemic rates of violence in northern communities, with 74% of Inuit women in Nunavik experiencing violence in the home, and 46% experiencing sexual assault.[25] Pandemic-related factors, including scarce resources because of disruption of livelihoods;[19] lack of adaptive coping strategies;[26] and increased opportunities for power, control, and manipulation by perpetrators,[27] have been linked to these alarming rates. Although the World Health Organization has called on governments to include measures to address IPV as part of their pandemic emergency preparedness and response plans,[28] TBI continues to be overlooked as a dire and prevalent consequence of IPV and its many health, social, and economic repercussions.[29]

To address these gaps in IPV-TBI—specific services during the COVID-19 pandemic, an emergency 2-day summit was called, supported by Parachute with funding from the Community Foundations of Canada's Emergency Community Support Fund and by the Acquired Brain Injury Research Lab at the University of Toronto with funding from the Canada Research Chair Program. The summit brought together stakeholders including service providers, survivors, and researchers from IPV, TBI, and health care sectors with 2 objectives: (1) to identify key needs, facilitators, and barriers to care for women survivors of IPV presenting with TBI, both specific to the COVID-19 pandemic and more broadly, and (2) to co-create ideas for resources and principles for identification, clinical care, and support for health care practitioners who treat women exposed to IPV-TBI. Because there were rich and varied discussions around these topics, this article reports findings on COVID-19−related effects, needs, priorities, facilitators, and barriers to health care and support services for women survivors of IPV-TBI. Additional findings are reported elsewhere.[30]

Methods

Using a community-based participatory research approach,[31,32] an emergency summit consisting of 2 virtual meetings 3 weeks apart was convened with key stakeholders from the IPV, TBI, and health care sectors. Participants were able to stop their participation and/or remove their data at any point up to the publication of this article; however, at the time of this publication, no participants have chosen to withdraw. Approval for this research was granted by the Research Ethics Board at the University of Toronto (Protocol #39927).

Participants and recruitment

Key stakeholders were recruited directly from a Knowledge to Practice (K2P) Network and using snowball sampling. The K2P Network is an informal, pan-Canadian network of service providers, persons with lived experience, decision makers, and researchers who have expertise in health care delivery, gender-based violence, IPV, and/or TBI, developed by members of the research team from the Acquired Brain Injury Research Lab since 2015.[33] Interested stakeholders were provided study information including the consent package, a demographic questionnaire, resources for emotional support, and discussion questions. All stakeholders provided written informed consent prior to participating in the summits.

These summits involved 30 stakeholders from across Canada, 12 from the IPV sector, 6 from the TBI sector, 7 from the health care sector, and 4 from population-specific advocacy organizations. A total of 27 stakeholders participated in 1 or both virtual summits, and 3 additional stakeholders provided written comments. Many stakeholders self-identified as working in TBI advocacy/support or IPV advocacy/support and had an average of 17.4±8.3 years of experience in their sector. As is the case in many advocacy and support organizations, many participants identified as survivors of IPV and/or TBI. Most participants were women (93%), 67% identified as White, and

List of abbreviations:

IPV	intimate partner violence
K2P	Knowledge to Practice
TBI	traumatic brain injury

Table 1 Stakeholders represented

	N=27*	%
Sector†		
TBI direct service	9	33
TBI advocacy/support	11	41
IPV direct service	3	11
IPV advocacy/support	10	37
Other	9	33
Years worked in the sector (mean ± SD)	17.35	8.25
Focus of work/primary clientele†		
Individuals with disability	10	37
Indigenous peoples	5	19
Black community	4	15
Refugees or immigrants	3	11
Other	8	30

* Based on the 27 participants who filled out demographic forms.
† Some stakeholders represented more than once.

Table 2 Participant characteristics

	N=27*	%
Gender (the psychosocial construct)		
Women	25	93
Men	2	7
Identity†		
Black	3	11
Indigenous	2	7
White	18	67
Non-Black or non-Indigenous POC	3	11
Immigrant	2	7
LGBTQ2S	2	7
Disability	7	26

Abbreviations: LGBTQ2S, lesbian, gay, bisexual, transgender, queer, two-spirit; POC, people of color.
* Based on the 27 participants who filled out demographic forms.
† Some stakeholders represented more than once.

26% identified as having a disability. Stakeholder representation and participant characteristics for 27 participants who completed demographic forms are displayed in table 1 and table 2, respectively.

Data collection and analysis

Discussion questions were designed to obtain in-depth information on the following topics: knowledge and service gaps, knowledge transfer tools and approaches, service provision and implementation, and COVID-19−related effects. Breakout sessions and group discussions lasting 40-60 minutes were facilitated by members of the research team, audio recorded, and transcribed by an external transcription service.

Qualitative data were analyzed using thematic analysis techniques,[34,35] using descriptive codes, which were then grouped into broader, topic-oriented categories. Key themes were identified after multiple meetings with the team for review and consensus, which were then developed into a master coding scheme. To be identified as a theme, a topic needed to be discussed across multiple focus groups or to have achieved agreement among all participants within a focus group. All transcripts and individual written comments were then analyzed using this coding scheme. Synthesized member checking, a method of member checking used both to confirm and clarify emergent themes as well as allow for further comment,[36] was used during and after the meetings to validate and gather feedback on a summary of the findings and drafts of this article.

Findings

Because these findings were part of a larger conversation seeking input on broader issues of gaps in IPV-TBI knowledge and services within health care, much of the discussion was focused on gaps that existed pre-COVID and have subsequently been exacerbated. While many of the themes from the larger conversations were similar to those focused on COVID-related experiences, there are striking COVID-related challenges to be recognized, which have been grouped into 3 main themes: (1) effects of COVID-19 on women survivors of IPV-TBI, (2) priority areas for support, and (3) barriers and facilitators to support services. The following sections discuss these themes, with supporting stakeholder comments found in tables 3-11.

Impacts of COVID-19 on women survivors of IPV-TBI

Increase in rates and severity of IPV
Stakeholders reported an increase in women at shelters and emergency departments who have experienced extreme violence, resulting in more significant injuries. Stakeholders from advocacy and support organizations noted an increase in survivors reaching out for support, including women who had never sought support

Table 3 Stakeholder quotes: Increase in rates and severity of intimate partner violence

"We have noticed about a 2000% increase in outreach from survivors, not just women who are members of the organization, but women who are experiencing the impact and had never reached out to any other organization but are looking specifically for survivor led supports."

"The isolation itself puts you at more risk with your - the abuser because neither one of you has an outlet . . . So he gets more violent, so she gets hurt more, I'll use he she just to make it easy. He's got no place to let out his rage so he takes it out on her. And she has no place to go because she's kind of tied down, she's got kids, she may have no money, no place to go . . . it's sort of a volatile home environment for everybody that lives in that household."

"The general sense is that things have got worse for people who experience intimate partner violence during COVID because people are more stuck in wherever they're living and they don't have as many opportunities to leave and get out . . . Certainly on the brain injury side of things I hear from folks who provide care in the community how there were people who weren't in abusive situations prior to COVID who are now in abusive situations so it's not just that things are more intensified for those who were experiencing abuse before."

"So when COVID first hit in March and April, people shut down, it was interesting. Volumes dropped off, sexual assault client numbers dropped off . . . And then as that eased up in the summer then things - our volumes went back . . . we were getting more calls however specifically related to domestic violence. I think it was a balance and conversations with some of the people at shelters was am I more afraid of getting COVID or living with what's happening at home and choosing not to go? . . . Now the volumes for our specific services have not gone down yet, but we're monitoring them. So and still a lot of calls specific to domestic violence. And the women we see as I've said have - the injuries are a lot more significant."

"I'm not sure if government has conducted anything related to race-based data on cases reporting from COVID-19 testing . . . because without this data it's easy to overlook the structural inequities in housing, in income, health care services for Inuit that contribute to the higher rates of COVID-19 transmissions, illness, and death."

Table 4 Stakeholder quotes: Availability of and access to services

"For a lot women who have - are fleeing violence and also in terms of sort of the women who are dealing with a brain injury, it's - that might not be the best way to connect with people, is through a virtual connection or even when they're trying to sort of seek out services and realizing that the services - no one is there and it's all over the phone."

"[The charitable sector has] seen a lot of sponsorships and donations, just the revenue generation in general, decrease. So [they may not be] able to offer the same types of services that these women need going forward and will these charities even exist in 6 months? So will there be - the need is not going to go away, but will the ability to meet that need go away?"

"With some of the systems that are either reduced because of COVID or shut down because of COVID, they're not getting any of their counseling or their support from those systems either. And sometimes that's all they had, because some people prefer to talk to somebody outside rather than tell somebody in the family everything about themselves."

"A lot of time they're doing screening on the phone and only seeing patients in person where needed, where there's a requirement for something, otherwise they'll do virtual appointments . . . if she's still at home and he is there or the kids are around and can hear, she's probably not going to disclose something that's going on. It's also harder to detect or sense some thing's not right here, so or perhaps something is different. So I think it's - I think COVID has changed that part of it in a negative way."

"If you go back to the chat on the homeless population and housing, affordable housing, I don't know about every place but I know rentals and real estate's sort of closed, shut down for a while during the first part of COVID. And so people were stuck living where they were, which had a huge impact on some people, because they couldn't go anywhere else, they couldn't leave and find an apartment. "

"One of the benefits, small little benefits we've seen in [location] anyways with COVID is with the housing market having changed so rapidly during COVID, we've actually been able to rehouse people quicker than we had been before COVID."

"I'd like to add something, which I think is kind of a positive out of COVID, is in [location] there's a group of people that started mutual aid society, which is based on food security for hundreds of people actually. I think there's about 6000 or 7000 people that are now connected that Facebook page. And they do food deliveries regularly, hampers, but also cooked meals for people that aren't able to access. This is outside of these government charity structures. It's based on real social justice, and I really do think that there's models that are outside our - how we defined community care and just being good neighbors again. We have to kind of change the paradigms of the charity model. And really to focus on - maybe this is an opportunity now to focus more on social justice model of care and community."

in the past, while stakeholders working in health care similarly noted an increase in IPV-related calls and women presenting with more significant injuries. Individuals with disability, including TBI, were noted as being particularly at risk for IPV and increased violence. Some mentioned an initial lull in calls during the first wave, likely because of fear of virus exposure, which reversed as restrictions lifted. Many attributed the increase in IPV to the loss of coping mechanisms for the survivor and the perpetrator. With physical distancing measures and widespread shutdowns, access to informal supports have been interrupted, potentially causing more violence. The impact of COVID-19 on survivors' families and the added stress of parenting were also discussed, including increased exposure for children, many of whom are remote learning, and parenting pressures on survivors, with formal and informal childcare supports unavailable. Other factors thought to increase the risk of violence included increased stressors (eg, lack of resources and support, food insecurity, job loss) and social isolation, making it difficult for the survivor's community to recognize signs of abuse. It was also noted that the lack of race- and cultural-based data has led to an incomplete picture, with the interaction of COVID with preexisting structural inequities being overlooked, particularly among First Nations and Inuit communities. A sample of supporting quotes for this theme from stakeholders are presented in table 3.

Availability of and access to services

IPV services, particularly those that are charitable organizations, were identified by stakeholders as being significantly affected by the pandemic, experiencing decreased revenue generation from sponsorships, fundraising activities, and donations. Service shutdowns, staff layoffs, and limited access to volunteers because of public health restrictions led to services operating at reduced capacity, with fewer staff dealing with a larger number of clients. COVID-19 also resulted in barriers to help-seeking among

survivors who may be experiencing increased surveillance or fear, preventing them from disclosing IPV or seeking help, despite having knowledge of protective measures. Stakeholders questioned what contracting COVID-19 might mean for survivors seeking help and getting the care they need; specific concern was noted with the neurologic implications of COVID-19 and how that may intersect with an existing brain injury. Along with the fear of COVID-19 came the perception that services were either shut down or only offered virtually because of public health restrictions. This raised barriers to care, including access to technological devices and Wi-Fi as well as issues around security and privacy, both further explored below. Stakeholders noted that one positive outcome of the pandemic was bringing communities together to care for one another. One example provided was a mutual aid society started in a Facebook group supporting community food security.

Stakeholders also spoke about the ongoing impact of the pandemic on housing services and supports for survivors. Although some support for survivors was provided early on through temporary spaces in hotels, this has since waned. Some discussed moving away from major cities because people want to get out of crowded spaces; however, this may make the cost of living even less affordable for people in need of housing. Differences in rental markets were also noted, with some regions having a dearth of available housing and others seeming to have an increased supply. Stakeholders emphasized the need for women to have safe places to go. Samples of supporting quotes are presented in table 4.

Impact on remote and rural communities

Stakeholders reported the amplified effects of COVID-19 in remote and rural communities, including Indigenous communities, which experienced a lack of services and resources long before the pandemic started. Many communities have put restrictions on inbound travel, resulting in women seeking care being sent away

Table 5   Stakeholder quotes: Impact on remote and rural communities

"Some of the key impacts of the COVID-19 pandemic, it has really clearly demonstrated the lack of infrastructure within Indigenous communities on responding to domestic violence . . . some of the challenges that we have seen is having individuals removed from the communities, because of the travel restrictions and permitted travel in and out of communities . . . unless [you're] taken out of there by medevac, you're not going to be able to access those services."

"Many of our [communities] are being hit with COVID. And we have families with 10, 20, 30 people in a home. It's impossible to isolate. And whereas women who might be experiencing forms of violence could maybe go to a neighbors, a home of a friend or a relative, that is not happening because of the need to stay in place and isolate. And so it is a huge - I mean the geographic - both physical, but also in terms of what kind of services people are getting in Canada is enormous, there's so many huge disparities."

"When we're talking about remote settings - internet, access to internet. We take it for granted that in cities and towns, that everyone has internet. But it's access, it's in affordability, and so we are excluding a major portion of the population by moving everything virtual, which I understand we've had to do because of the pandemic. But my fear is that a lot of organizations, because it's more affordable than sending care workers out long distances, that we're going to sort of stay with this, and there'll be a huge portion of the population that suffers as a result."

from their communities. Stakeholders shared that some regions only have traveling physicians, forcing survivors to repeat their story each time they see a different provider, which can result in revictimizing/retraumatizing the survivor and may serve as a barrier to seeking care. Many Indigenous communities had limited or no immediate access to health care services even before the pandemic, which has only been exacerbated. Consequently, women survivors are required to travel to large urban centers to receive support that is often not culturally safe. Broader reductions in medical travel favoring the use of telemedicine and virtual care have made access to health care even more difficult. Specifically, many survivors living in remote and rural communities face infrastructure challenges, often lacking the devices or connectivity required to access virtual care and are thus harder to reach. Stakeholders feared that these women may be further excluded as the pandemic pushes more services to move online. Crowded living conditions and the public health mandate to limit interactions outside one's household have removed survivors' option of going to stay with a neighbor or family member, which is particularly problematic in communities where there is no access to shelters. The pandemic has also exacerbated existing difficulties in getting supplies to the more remote communities. Supporting quotes are presented in table 5.

Priority areas for support

Increasing awareness among survivors and the public
The COVID-19 pandemic has resulted in considerable disruption to supports and services, with some offering modified in-person services, some moving to virtual care, and others closing entirely.

Stakeholders discussed the need to increase awareness of service availability during the pandemic, noting how important it is for survivors to be aware of shelters, hospital treatment centers, and community services they can call for help. Aligned with this is the need to support survivors in navigating the new ways of accessing these services (eg, remote access using technologies), which may be more difficult for survivors living with brain injury who have cognitive or memory challenges.

Communication through a multitude of channels, such as Facebook, radio, or local community newsletters, were noted as preferred platforms for accessing information, particularly in remote communities, with stakeholders noting successes using these channels in their organizations. Government or organization web pages were reported as being less useful for dissemination because survivors do not look for information there. Stakeholders shared some strategies they used to spread awareness, such as using printed materials instead of online media and working with grocery stores, libraries, pharmacies, community health centers, family physician's offices, and faith-based communities, so that these materials are placed in spaces that are frequented by women survivors. Supporting quotes are presented in table 6.

Cross-sector education and awareness
With the exacerbation of IPV and the subsequent increased risk for TBI, stakeholders discussed the urgency of educating health care providers to recognize signs of IPV-TBI and to provide support for survivors. Emergency department staff may be missing signs of IPV-TBI because the focus is typically on treating immediate, visible injuries. This also spoke to a larger concern around

Table 6   Stakeholder quotes: Increasing awareness among survivors and the public

"I think there's an assumption, I mean until you need the service, a lot of people just don't know that there is a service. So I think making the awareness that there are shelters; there are hospital treatment centers; there are community services to call etcetera, for help because it's not all shut down, which is one of the impressions that I think people have . . . I think that's the biggest thing, because people simply won't know where to turn right now.

"It's so great that so many services are still happening and so many services were able to pivot. But I think sometimes the education piece is also teaching people how to now access this service. So it's there, but it's changed. So what does that mean, what does look like? Because for someone with a brain injury, that's a new learning and sometimes they might not have the problem solving ability to do that independently."

"There's that perception that the services are completely shut down to elders and stuff across the country . . . . But we did some radio ads, because we knew that the infrastructure for technology was a challenge, so we found innovative ways to inform communities that there were still shelters and everything that were open."

"I also think that there's a real good role for magazines that you get at the grocery store that could provide information and support to women. Perhaps a - some articles that are written by survivors and how they seem to manage. I don't expect that the perpetrators would read women's magazines as closely as perhaps women would."

COVID's impact on survivors' ability to manage their health care needs, discussed in the availability of and access to services theme. Stakeholders suggested education strategies for health care professionals, including making curriculum changes for health care trainees, developing and mandating continuing education credits, and making use of meetings where providers are kept up to date about COVID-related information to remind providers of the IPV-TBI intersection and the specific effects facing survivors during the pandemic.

Finding appropriate care in general is a noted challenge among survivors of IPV-TBI, with providers in the IPV sector being unaware of the resources and supports available in the TBI sector and vice versa. Stakeholders noted the challenges this can cause for survivors navigating the system. One suggestion to ameliorate this challenge was more education across sectors about the resources and supports available outside an individual provider's area of expertise. In this way, even if one provider does not have the expertise to support a survivor in a particular area, they will have awareness of other professions or agencies and can help the survivor find the care they need. To this end, stakeholders spoke of the importance of interdisciplinary and cross-sectoral collaborations in supporting survivors but noted the difficulty in developing these partnerships. Many stakeholders citing examples from their own experience where collaboration and partnership made a notable difference in their organizations' awareness of IPV-TBI and the support they were then able to provide; however, they also noted that funding to support the time to develop those relationships is needed. Supporting quotes are presented in table 7.

Peer support and navigator models

Throughout the discussion, stakeholders emphasized the need for survivors to have someone they can go to for support. Peer supports featured most prominently in this discussion, specifically from women with lived experience of IPV-TBI and the various systems and structures a survivor must navigate from the survivor perspective. Stakeholders reported an increase in requests for peer supports during the COVID-19 pandemic, highlighting the desire among survivors to connect with someone who truly understands their experience. There was strong agreement among stakeholders that finding some way to formalize access to peer supports was critical. It was additionally noted peer support should be funded to allow for better access to peer support, which is currently inconsistent and reliant on meeting survivors who share their experiences and agree to stay in touch or finding an organization that has developed their own network. Survivors should be given the option to connect with other survivors in a peer support capacity should they choose. Spinal cord injury peer support networks were highlighted as one successful model that could inform a similar network for survivors of IPV-TBI.

Related to the concept of peer support was an emphasis on the need for support navigating the myriad systems that survivors may interact with. Particularly for survivors of IPV-TBI with children, there are medical, legal, childcare, brain injury, housing, and IPV systems that must all be juggled, each with their own forms and appointments and unique quirks. For any individual, this can be overwhelming, but especially so for survivors of trauma and brain injury. A system navigator who could support the survivor in finding the care they need and the logistical requirements of accessing that care in a way that is culturally relevant and safe is critical. Supporting quotes are presented in table 8.

Barriers and facilitators to service delivery and access

Technology as a support and an obstacle

With many services moving to virtual care, technology is an indispensable need during the pandemic. Technology was identified throughout conversations as both a potential barrier and a potential facilitator. Although virtual services enabled ongoing access to programs, several stakeholders shared that some clients are much

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Table 7	Stakeholder quotes: Cross-sector education and awareness

"So whether you're in a domestic situation or whether you're just a person on your own, it's really difficult with COVID, to really look after your health care. And if you go to the hospital, you go to the ER you're worried about COVID. But they also will only look after whatever is wrong. Say you're having trouble breathing, they'll get you breathing again, then they send you home. They won't look to see what the cause is. They won't investigate because they're not - that's not what their job is, they're there to fix you up and send you home. So health care is kind of a bit of a problem at this point I guess, because of some of the restrictions."

"I have to say with respect to rehab too, persons with disabilities are so at risk of - so much more at risk of violence. I am really surprised at how little it's emphasized in the curriculum. I think it should be."

"The psychologist, because she works with us as a brain injury organization it twigged for her, OK I'm not just focusing on the trauma here, I need to bring in this piece about the brain injury and she just talked to me last week, she was like, 'If I wasn't working with a brain injury organization I would be solely focused on the trauma piece.' And she was like, 'I feel like I would have just missed it.' . . . we can't be everything to everybody, but are there ways, and I know this is happening, but are there ways to tap into the professional networks to just kind of plant that seed and say, 'You don't have to know everything about this, but let's just make sure that every door is the right door.'"

"As we all know relationships are key, partnerships are key and so in a smaller community like [location] we kind of know who's who in the zoo in terms of our community organizations, but as [name] said we're all so stretched too, and nobody funds us for collaboration. So we're just we're so, and I see everybody nodding, we're like OK yeah. People want to see partnerships and then we're like mm, you're not funded, every penny that we get has a string tied to it, to the funder, which then requires us to report on that specific thing. And so without you know coming back to that unrestricted funding where we can fund that collaboration, that partnership is so key"

"The ripple effect of bringing everybody together in a symposium around brain injury and intimate partner violence . . . there was such an overwhelming response of like, 'Yeah. Let's totally have these conversations. You want to know about this, we're going to have these conversations.' That now we have those relationships in our community, we have the strength and again in a small community we can kind of know that we've got . . . these beacons of light that'll help me navigate. So all this to say that I think relationships are key and it takes time, but when we come to the table with this sense of partnership there are ripple effects that we don't even know are happening in our community."

Table 8   Stakeholder quotes: Peer support and navigator models

"You can't be a jill-of-all-trades and a mistress of none, but you can have these peer navigators who understand in really particular ways, understand the experience that clinicians don't and frontline IPV support services don't. You have these survivor peer support navigators who are centered in the middle who their experiences are linked and those are the ones, when women speak to them, have provided really foundational shift in the way that other survivors are understanding the experiences and understanding what options are there and understanding what they can do to keep themselves, you know keep yourself moving forward and keep yourself going. So, peer support, I said all of that to say peer support."

"That's pretty much what I've tried to do here in [location] just as person to person, which is me talking to survivors I met on the street sharing my experience, they share with me, we created a bond, they know they can reach out to me when they need to, I can reach out to them . . . . But that's as far as we've been able to get is just peer to peer - has never been able to reach a provincial or level or anything like that."

"I think that's something that I personally would like to spend a little bit more time thinking about is how people can connect into these peer support network groups, not by accident, but by design you know so that it becomes more institutionalized, to use that awful word, but you get what I'm saying, like it just becomes more of a norm that it's not so hard to connect."

"Well one thing, and I think that it was brought up earlier is assistance for navigating the system for survivors . . . because usually you end up meeting with one person and then they're like well I can help you with this, but you'll need somebody else to go for that. And especially if you have a brain injury or your memory and all of that, having somebody that can help guide you through, so that you're not really left on your own and missing appointments and then you're just - it's too much."

Table 9   Stakeholder quotes: Technology as a support and an obstacle

"So health care is kind of a bit of a problem at this point I guess, because of some of the restrictions. I can understand it all and I mean I think the virtual phone calls with the doctors is a good thing, it saves you going in if you can help it and that's a good thing. But anyways, I think the doctors need to maybe come up with a little bit of a better idea - a better way of doing the service so that people aren't left behind for - or end up with something really serious that could have been prevented if they had seen you in a timely manner."

"We really tried to be adaptable to whatever worked for that client, because it's different for everybody. Some people have the internet, some don't. Some can call, some can't. We - and then we adapted our program and kept going . . . . But the feedback from the women that we were serving was just that, that no one gave up on me, that I kept getting support, somebody just kept showing up."

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more difficult to reach virtually. Stakeholders expressed particular concern for survivors who struggle with technology (eg, because of TBI-related cognitive challenges) or do not have access to the appropriate devices or network connections (eg, lack of infrastructure in rural and remote communities) to facilitate virtual care. Stakeholders raised concerns about the impacts of virtual care on individuals with TBI, both in terms of the physiological symptoms, such as headaches or visual sensory issues, and in cognitive capacity to learn and work with a new platform. Regardless the modality, stakeholders highlighted how important it was to "keep showing up" for survivors, noting that, in their experience, the effort to do so did not go unnoticed.

Safety and privacy were also noted concerns, especially for women living with abusive partners. Stakeholders reported having little control over their virtual environment. For example, perpetrators may enter the virtual room without their knowledge. If survivors are at home with the perpetrator or their children during the appointment, they may be unable to disclose information, further masking possible signs of IPV-TBI. Similarly, providers may not be able to diagnose conditions via virtual care, delaying access to care and healing, frustrating survivors, and leaving women at risk of further injury. Supporting quotes are presented in table 9.

Leveraging local expertise

Stakeholders emphasized working with local expertise in supporting survivors as a significant facilitator to service provision, both during the pandemic and beyond. For Indigenous communities, working with Indigenous-led services and culturally safe service providers was highlighted as critical. Local brain injury associations were also noted as a valuable resource for survivors of IPV-TBI because they are often one of the only brain injury resources

that do not require a formal diagnosis to access supports. However, stakeholders also acknowledged that brain injury associations are already overwhelmed because of the lack of supporting infrastructure for individuals with a brain injury without a diagnosis. Funding for brain injury associations, which are often nonprofits that rely on grant funding or fundraising, has also been affected by COVID. Opportunities for cross-training and generally building rapport with communities, individuals with lived experience and expertise, and service providers was one example provided of a means of building capacity and increasing meaningful access to services. Supporting quotes are presented in table 10.

Functional supports

Throughout the pandemic, there has been messaging using the metaphor "we're all in the same boat." However, our discussions with stakeholders emphasized the fact that we are not in the same boat, but rather in the same storm—some individuals have big, well-equipped yachts, while others are in small, broken-down rowboats. One key barrier that many stakeholders discussed was the metaphorical boat each survivor has in this storm. Access to safe, adequate housing and financial resources were discussed as 2 critical pieces in supporting survivors that often end up as barriers. Both the lack of availability of these resources, notably in First Nations and northern communities, and high bureaucratic requirements to access them were discussed as common barriers in these areas.

COVID has also been recognized as an amplifier of existing systemic inequities. Systemic racism in health care, chronic underfunding of Indigenous communities, a dearth of supports tailored to lesbian, gay, bisexual, transgender, queer, and two-spirit IPV survivors, and a lack of fully accessible services or supports for

Table 10   Stakeholder quotes: Leveraging local expertise

"I think when you're working with Indigenous communities that it be led by Indigenous service providers, in partnership with other resources. Because they have the - they know the community and they can lead to whoever or even inform and get that information out that these other supports and resources exists. It could even be led in partnership."

"We have a brain injury association that is really the only resource for a brain injury survivor that doesn't have you know a diagnosis. And so it is something, it's sort of our one size fits all kind of referral that sort of the basic referral, but I think there's a recognition that we're putting a lot onto our local brain injury association and so we've tried to be sure that they're invited to any cross training and getting that information about IPV, which has been really good and we've had those relationships."

Table 11   Stakeholder quotes: Functional supports

"Without these functional pieces in place, people who don't have access to housing, people that don't have access to financial resources, they're still going to be left behind, so I think to [name's] point, until we build up the system where people are in an even playing field, really not going to be at a point where people can access the services, even if they're there."

"We see a lot of individuals who fall through the cracks or return to situations, because when they're trying to access income assistance and that's a real struggle for many, just having to have that appointment, prove this, prove that. That there has to be a mechanism that's readily available for those survivors of intimate partner violence to have those supports readily available to them. Especially if there's no shelter available within the area that they're living in. It could be that - that could be what saves their lives."

disability organizations in supporting IPV survivors are all preexisting issues faced by IPV survivors and the sectors providing supports. The COVID-19 pandemic has shone light on these cracks in our system and worsened them, highlighting an urgent need to address them in our efforts to "build back better." Supporting quotes are presented in table 11.

Discussion

The COVID-19 pandemic has amplified the shadow pandemic of IPV, increasing the rates and severity of violence.[19-21] The pandemic has also shed light on preexisting inequities, barriers, and structural flaws that failed to support survivors long before the pandemic started and will continue to fail survivors unless there are systemic changes. Over the course of the 2-day summit, 30 stakeholders from across Canada representing the IPV, TBI, and health care sectors highlighted several key considerations for IPV-TBI in relation to the COVID-19 pandemic. Stakeholders verified the increased rates and severity of violence among IPV-TBI survivors and the myriad of factors that may contribute to that increase. The strain on support services was acknowledged, along with uncertainty and confusion among survivors around what services were still available and how to access them.

For services now offered virtually, access to and knowledge of technology were noted barriers for survivors, particularly among survivors with brain injury who may encounter cognitive challenges in using new technology or physical challenges with the increased screen use and for those living in remote areas with infrastructure barriers who may not have access to the bandwidth or the technology required. The significant technological challenges that survivors face in relation to TBI symptoms and violence-related safety and privacy concerns were emphasized by stakeholders in this study as well as in existing commentaries and emerging evidence.[37-39] Although a few articles have provided suggestions to address IPV-related safety and privacy concerns,[37,38,40] there continues to be a gap in support strategies, particularly for navigating technological services, including

essential services and health care, and altered in-person services (eg, lack of aid and family support) for survivors who are also living with a TBI.[39]

Several priority areas were identified through the summits. Combatting an overall lack of awareness of the intersection of IPV and TBI among survivors and the public through general awareness campaigns was noted as a priority. Equipping survivors and their support networks with a better understanding of the intersection and signs and symptoms of TBI empowers them to better identify and advocate for their needs. A lack of knowledge among health care professionals and service providers was also noted. Commentaries on gender-based violence and TBI in women since the pandemic drew attention to the potential surge in IPV-related TBIs, an increase in invisible trauma, and the urgent need for awareness of this intersection among clinicians across sectors.[29,39] To this end, guided by this summit's findings and in consultation with the participating stakeholders, we developed 2 resources to increase awareness and understanding of IPV-TBI. The first was designed to increase awareness and understanding of IPV-TBI among health care providers to facilitate identification and treatment. The second was designed more broadly for survivors and frontline workers outside the health care field to increase awareness of common signs and symptoms as well as ways to support survivors. These newly developed resources are currently distributed in English and French and freely available on the *Abused and Brain Injured Toolkit* (www.abitoolkit.ca). They have also been requested and adapted by several health service organizations across the country. Stakeholders suggested awareness and education should be further expanded to include support for collaborations and partnerships. Although service providers do not need to be able to address all a survivor's needs, they should be able to support the survivor in finding the expertise to fill any gaps. Finally, the development and support of peer models and navigator roles were deemed critical. Several stakeholders noted that survivors have been asking for connections to peers and shared examples of the positive impact of both peer supports and navigators. There are several existing peer support models used in health care, including in spinal cord injury, that could be adapted to serve survivors of IPV-TBI.

Stakeholders' accounts further emphasized the importance of recognizing the unique needs of IPV survivors with brain injury to ensure equitable access to trauma-informed and culturally safe care. Natural disasters and economic crises are known to increase the incidence of IPV, increasing the stressors that contribute to violence;[41,42] however, there is a dearth of research looking at TBI in these contexts. To our knowledge, this research is some of the first to explore the intersection of IPV-TBI in the context of not only the COVID-19 pandemic, but also the broader domain of social and economic turmoil. While this call for TBI and IPV awareness is not new, the COVID-19 pandemic has magnified the experience of violence and, with noted increases in prevalence and severity, reinforced the need for appropriate supports for IPV survivors with brain injury and increased awareness among health professionals such as rehabilitation providers.

Finally, although IPV-TBI prevention was not a focus during the summits, we acknowledge that preventing IPV, and resultant TBI, should be the ultimate goal and will require a foundational societal shift. Our social, legal, and health care systems must be equipped to better identify individuals at risk of perpetrating IPV as well as those likely to be at risk of experiencing it for preventative intervention. Support of perpetrators, ensuring they have a supportive network and access to the required care and healing they require, is also critical for helping to break their patterns of abuse.

Study limitations

The findings presented here are based on a small, emergency summit. Although we strove for representation from diverse perspectives across Canada, the full diversity of survivor and provider experiences cannot be captured in a 30-person summit. Participants were recruited through our existing K2P Network and via snowball sampling, meaning most were at least aware of the intersection of IPV and TBI. Providers or survivors without knowledge of the intersection may identify different concerns than those raised by this group.

Future directions

This summit builds on a previous Canadian multisectoral summit on the intersection of IPV and TBI held in Toronto, Ontario, in 2016 co-led by members of the research team, where education, research, and service provision around IPV-TBI were stated priorities.[33] The K2P Network[33] was developed as a result of this summit, laying the foundation for a national initiative to address critical gaps in knowledge and service provision. The K2P Network now consists of over 300 stakeholders across Canada and is still growing. Also resulting from the previous summit was the development of the *Abused and Brain Injured Toolkit* (www.abi toolkit.ca), the first resource created specifically for Canada in direct response to needs expressed by service providers, women survivors, health care professionals, and researchers.[43] Although initially developed from the findings of the 2016 summit, the Toolkit is a living resource, being expanded and adapted as knowledge in this field grows, including as a result of the summit reported on herein. The Toolkit and related knowledge mobilization activities have resulted in changes to service design and policy among service providers, health care professionals, and the policing sector.[44] Finally, the senior author has been funded through a Tier 1 Canada Research Chair in TBI in Underserved Populations that has a major focus on TBI in the IPV context and

provides infrastructure support for the *Toolkit* and knowledge translation activities.

Although progress has undoubtedly been made since, there is still much to be done. Awareness of IPV-TBI was flagged by stakeholders as the most important action needed to support survivors. Therefore, education and awareness campaigns for survivors and the general public as well as service and health-care providers are needed. For physicians, rehabilitation professionals, and other health care providers, there is a need for broader education on how to address IPV-TBI among clients and integrate this knowledge into practice. Tailored resources are needed that can be used to improve patient education on the intersection between IPV and TBI and available supportive resources. There is work to be done across health care professions in developing and implementing protocols to better identify and support survivors of IPV-TBI. Stakeholders also emphasized the need for research that is inclusive and diverse to meet the needs of underrepresented populations, such as Black and Indigenous women survivors of IPV-TBI. It is also important to develop in-person and online IPV-TBI service delivery models, sensitive to relevant safety and trauma-related needs, that can be continued beyond the current pandemic. Having identified important future directions for this field, ongoing work is needed to ensure progress to support survivors of IPV-TBI. The findings presented here will inform our research moving forward. It is our hope that the findings further provide an evidence base for stakeholders—those who participated, members of the K2P Network, and beyond—to help inform local, provincial, and national initiatives for planning, funding requests, and policy development.

Conclusions

The COVID-19 pandemic has exacerbated rates and severity of IPV globally, putting survivors at increased risk for TBI. Our 2-day emergency summit highlighted the need for action on this neglected public health issue, including increasing awareness of IPV-TBI among health care providers including rehabilitation service providers, ensuring accessible and equitable services for survivors, and integrating this intersection into national policy strategies addressing gender-based violence.

Keywords

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Acknowledgments

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