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# Substance use Coercion as a Barrier to Help-Seeking among Intimate Partner Violence Survivors with Opioid use Disorder

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## Abstract

While Intimate Partner Violence (IPV) is common among people with Opioid Use Disorder (OUD), the role of abusive partners has been under-recognized as a barrier to OUD treatment and recovery. Substance use coercion, or ways that abusive partners leverage a survivor's substance use against them as a tactic of power and control, is both highly prevalent and presents unique challenges to accessing services or achieving recovery. This includes threats to report a survivor's substance use to law enforcement, the immigration system, or the child welfare system as a way to maintain control within the relationship. Because opioids are largely illicit within the United States, these threats are deeply coercive and increase the risk of criminalization for survivors, which creates additional barriers to help-seeking. These findings underscore the need for integrated IPV, OUD, and recovery support services; policy changes including to state-level substance use laws that consider substance use to be a form of child abuse and endangerment; and for a coordinated public health response to substance use coercion as a critical factor driving morbidity and mortality within the opioid epidemic.

**Keywords:** Intimate Partner Violence; Opioid Use Disorder; Trauma; Child welfare

## Introduction

Survivors of Intimate Partner Violence (IPV) who use opioids face unique risks and barriers when attempting to access services and are rarely a focus of research or dialogues within public health. IPV is best understood as intentional, ongoing, and systematic abuse used to exercise power and control over an intimate partner [1]. This can take the form of intimidation, threats, physical violence, verbal abuse, sexual violence, enforced isolation, economic abuse, stalking, psychological abuse, or coercion, among other abusive tactics [2-4]. Abuse by an intimate partner has been shown to increase the likelihood of opioid use, including Opioid Use Disorder (OUD), among survivors [5,6]. A systematic review on IPV and OUD found that 36%-94% of women. Who had used opioids has experienced IPV in their lifetimes 32%-75% had experienced IPV in the past year [7]. In one study, 90% of women attending a methadone clinic had experienced IPV in their lifetime [8]. We would like to emphasize that people of any gender can experience abuse by an intimate partner. The gender identifiers used in this paper are reflective of the ways that gender is defined within the referenced research.

While traumatic stress and chronic pain resulting from IPV-related injuries contribute to the increased rate of opioid use among survivors, abusive partners themselves play a significant yet under recognized role [9,10]. Abusive partners leverage survivors' substance use against them, as part of a broader pattern of abuse and control; this is known as substance use coercion [11]. Substance use coercion is highly prevalent. Among a sample 3,025 National Domestic Violence Hotline callers,

(a) 26% used substances to reduce the pain of abuse

(b) 27% reported that their abusive partner pressured/forced them to use, or made them use more than they wanted

(c) 38% said that their abusive partner threatened to report their substance use to authorities to prevent them from getting something they wanted/needed (child custody, a job, benefits, and a protective order)

(d) 24% were afraid to call the police for help because their partner said that they wouldn't believe them because they were using, or that they would be arrested.

Over 60% of callers who tried to get help for their substance use reported that their abusive partner prevented/discouraged them from doing so.

### The Role of Substance Use Coercion among Survivors with OUD

Recent research has identified opioid-specific substance use coercion tactics, all of which are barriers to survivors' safety, ability to access services, and/or attempts at recovery [7,12-19]. This includes stalking survivors during regularly scheduled OUD treatment appointments; harassing survivors to avoid or disengage in OUD treatment; forcing survivors to use unclean injection equipment, increasing their chances of developing serious health conditions; forcing survivors into withdrawal as a coercive tactic or threatening them with withdrawal; coercing survivors into unwanted sex work to obtain money and/or opioids; keeping opioids in the house to tempt survivors to use, particularly when they are working toward recovery; and stealing or selling survivors' medication used to manage their OUD (i.e., buprenorphine). Additionally, survivors report fears of retaliatory violence including homicide by their partners if they attempt to seek services for IPV or OUD.

Stigma associated with opioid use further contributes to the success of these tactics [11]. Survivors have reported that shame, self-blame, and anticipated judgement from others for both their opioid use and the abuse they have experienced are common barriers to help-seeking [12]. This includes fearing that they would be blamed for the abuse because of their opioid use, or that people would not believe them. Some survivors reported being judged and mistreated by the police and child welfare system, including not being believed, being made to feel like they were "crazy" and not worth helping, and being blamed for their partner's abuse and violence.

In addition, abusive partners have weaponized the law enforcement, child welfare, and immigration systems against survivors, threatening to disclose their substance use to these systems as a way to maintain control within the relationship [1,7,11,13,15,16,20,21]. Because illicit opioid use is criminalized in the United States, threats of reporting survivors to law enforcement, the immigration system, and child welfare for substance use are credible and deeply harmful. This is especially true for survivors of color, immigrant survivors, low-income survivors, survivors with disabilities, LGBTQIA survivors, and others who are already disproportionately targeted and harmed by these systems [22-24]. Survivors who have a criminal record due to substance use coercion face significant barriers to help-seeking and accessing housing, employment, and governmental financial assistance.

Taken together, this increases the risk for overdoses, homelessness, physical and mental health conditions, and IPV-related homicides and injuries, among other adverse outcomes [14].

## Discussion

These findings underscore the need for integrated IPV, OUD, and recovery support services, and for a coordinated public health response to substance use coercion as an under-recognized factor driving morbidity and mortality within the opioid epidemic.

Integrated IPV and substance use treatment services may be especially beneficial for survivors though few programs offer this [25-27]. Emerging research and practice-based evidence suggests that integrated service models may uniquely benefit survivors and are associated with decreased substance use, and in some cases, a reduction in violence [21,25,28-33]. Additional research is needed to better understand ways that integrated services may uniquely benefit survivors who use opioids and who are experiencing substance use coercion.

Programs and systems can better support survivors facing substance use coercion by building partnerships across systems that they commonly access. In addition, it is critical for programs, systems, and providers to deepen their understanding and opportunities for training on substance use coercion and ways it may come up within services. This can be supported through state-level funding initiatives that incentivize cross-sector collaboration and training. An important aspect of increasing education and training on IPV and substance use coercion is supporting providers and systems in understanding ways that abusive partners can impact survivors' treatment engagement and outcomes. For example, abusive partners may use the regularity of substance use disorder treatment services, including treatment appointments, to stalk and harass them. This can understandably decrease a survivor's treatment attendance and lead to them being discharged from the program.

There is also an urgent need for gender and LGBTQIA-responsive substance use disorder treatment services. Some substance use disorder treatment programs offer services in mixed-gender settings; this means that survivors and their abusive partners may be accessing services together. Survivors with abusive partners of the same gender may also access services together. This is a significant problem, creating treatment and safety barriers for survivors. Because providers may not know that abusive partners' threats and violence often increase when they access substance use disorder treatment services [31,34-36], it is important to work with survivors to figure out safer ways to offer treatment. Providers can also use abbreviated versions of scales that measure IPV lethality, such as the Danger Assessment, to assess risk for intimate partner homicide [37]. Programs can increase service accessibility for survivors by providing transportation, childcare, peer support services, and a comprehensive array of trauma-informed, culture-and gender-responsive services.

There is a critical need for a public health response to ways that abusive partners use stigma associated with substance use within systems (e.g., child welfare, criminal justice) to harm and control survivors. This is in the context of state-level substance use policies that consider substance use to be a form of child abuse and endangerment [38,39]. Abusive partners take advantage of these policies to deter pregnant and parenting survivors from seeking services by leveraging the fear of loss of child custody to the child welfare system. Pregnant survivors experiencing substance use coercion face additional risks: In 25 states and the District of Columbia, health care providers are required to report suspected prenatal drug use; 8 states require them to test for prenatal drug exposure if they suspect drug use

[40]. Therefore, it is essential for service providers to be transparent about any child welfare reporting requirements and provide services that support survivors' ability to maintain custody of their children. Public health officials and advocates can work through state and professional organizations to change policies that harm survivors and their children. This includes the decriminalization of substance use, advocacy for wraparound IPV-informed services to support child-parent attachment, and changes to child welfare policies that run counter to evidence-based practice and separate children and parents [41].

## Conclusion

IPV and substance use coercion are complex issues that profoundly affect the ability of survivors to access and engage in treatment and achieve safety and recovery. There is a critical need for additional research to delineate the prevalence and impact of substance use coercion on a population-level and within specific clinical settings and communities. Additional research is needed to identify and evaluate interventions, like integrated services, that are most likely to improve outcomes for survivors experiencing substance use coercion. Given the barriers that survivors of color, low-income survivors, and LGBTQIA survivors face in interacting systems that have histories of structural inequities against their communities, additional research is needed on substance use coercion tactics that focus on turning systems against survivors to harm them. Finally, most research on barriers and facilitators to help-seeking among survivors who use substances relies on samples of survivors who have in fact accessed services. Learning about the experiences of survivors who have not been able to access services will also be important for future research.

## Conflict of Interest

Dr. Krans is an investigator on grants to Magee-Women's Research Institute from the National Institutes of Health, Gilead, and Merck outside of the submitted work. The other authors report no conflicts of interest.

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