

SAVING LIVES: Meeting the Needs of Intimate Partner Violence Survivors Who Use Opioids

RESEARCH AND POLICY BRIEF | MAY 2019

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INTRODUCTION

Survivors of intimate partner violence (IPV) who use opioids have unique needs that have not been part of the national conversation on addressing this public health crisis. This paper focuses on the research available on the intersection of opioid use and intimate partner violence with specific information on the needs of IPV survivors who use opioids. It also highlights newly explored tactics, known as substance use coercion, used by abusive partners to initiate and entrap survivors in opioid use.

Intimate partner violence, also referred to as domestic violence, is a pervasive and substantial public health issue in the United States. IPV is best understood as intentional, ongoing, and systematic abuse intended to exercise power and control over an intimate partner (Warshaw, C. & Tinnon, E., 2018). 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 (Bancroft, L., 2003; Johnson, M.P. &

Leone, J.M., 2005; Stark, E. 2007).

The rate of opioid use among survivors is relatively high, and a significant proportion of participants in opioid use treatment programs have experienced IPV. Abuse, trauma, and violence throughout the lifespan play a key role in survivors' use of opioids.

IPV survivors who use opioids encounter a constellation of unique risks, including substance use coercion, that directly threaten their physical safety and wellbeing. Survivors of color face additional risks and barriers to treatment because of systemic bias. Without an understanding of the specific ways that IPV and opioid use interact in the lives of survivors, substance use disorder treatment programs will not be as effective and may actually place survivors at greater risk of injury or overdose. This report presents research and policy recommendations so policymakers and practitioners can make substance use disorder treatment programs safer, more accessible, and more effective for IPV survivors.

The Impact of IPV on Health, Mental Health, and Substance Use

Over the past 30 years, research has clearly demonstrated that experiencing abuse by an intimate partner can have profound effects on the health and wellbeing of survivors. This includes physical injuries and homicides as well as longer-term risks for developing trauma-related mental health conditions, chronic health conditions, and problematic substance use (Phillips, H. 2014). The impact of IPV on health and wellbeing can also be measured in dollars. A recent study from the CDC found that the lifetime per-survivor cost of intimate partner violence is \$103,767, with 59% going to medical costs; public funding pays 37% of this total cost (CDC, 2018).

Research consistently shows that being abused by an intimate partner increases one's likelihood of substance use as well as associated harmful consequences. At the same time, research suggests that people who use substances are significantly more likely to experience abuse by intimate partners, as compared to people who do not use substances (Rivera, E.A. et al., 2015). Studies have found that 47% to 90% of women in substance use disorder treatment settings report experiencing domestic violence during their lifetime, and 31% to 67% report experiencing IPV within the past year (Rivera et al., 2015). In addition, survivors who use substances are at increased risk for assault by intimate partners and others, including while using or intoxicated (Mohler-Kuo, M. et al, 2004; Jessell, L. et al., 2017). Because both victim-blaming and substance use-related stigma are so common, it is imperative to recognize that it is the abusive partner who is responsible for the violence and abuse—not the survivor—including when substances are involved.

Some information is available specifically on opioid use and intimate partner violence. Abuse by an intimate partner has been shown to increase the likelihood of opioid use, including problematic opioid use, among survivors (Smith, P.H. et al, 2012; Hemsing, N. et al 2016). A study of women who attended a methadone clinic found that 90% had experienced IPV in their lifetime (Engstrom, M. et al., 2012). Overall, studies suggest that most people, particularly women, who use opioids have been abused by an intimate partner at some point in their life.

The Role of Gender and Trauma in Opioid Use

There are notable gender-related trends within the opioid epidemic¹. Opioid overdoses are currently most prevalent among men. However, the rate of opioid overdose deaths among women has increased at a startling rate. From 1999 to 2015, the rate of death from prescription opioid overdoses increased 471% among women; synthetic opioid-related deaths increased 850% among women in that timeframe [Office on Women's Health OWH), 2017]. A more recent analysis examining opioid use suggests that the overdose epidemic among women continues to worsen.

¹ The vast majority of studies cited within this brief either did not explain their conceptualization of gender or used a binary female/male categorization of gender. When gender-specific language is used within this brief, it is reflective of the research being cited.

From 1999 through 2017, among women aged 30-64, there was a 915% increase in heroin-related deaths and a 1,643% increase in synthetic opioid-related deaths (VanHouten, J.P. et al., 2019). The continued increase in opioid-related deaths among women is likely due to multiple factors. As compared to men, women are more likely to experience chronic pain, to be prescribed opioids to manage pain, to be prescribed opioids at higher doses, and to stay on opioids for longer periods of time (CDC, 2013). Furthermore, as compared to men, women may progress to opioid dependence more quickly and may also experience more frequent opioid cravings (Back, S.E. et al, 2011).

In discussing gender and opioids, we cannot understate the role that traumatic life experiences such as IPV, abuse, and violence play in the development of opioid use-related problems, particularly among women and transgender people (Keuroghlian, A.S et al., 2015). Researchers have found that psychological and emotional distress are risk factors for opioid use among women, but not among men (ApA, 2017). As compared to men, women have three times greater odds of having both posttraumatic stress disorder (PTSD) and problematic prescription opioid use (Meier, A. et al., 2014). There is also evidence to suggest that people who are transgender may be at increased risk for problems associated with opioid use, in part because of trauma and stressors associated with gender-based discrimination and violence (Nuttbrock, L. et al., 2014; Stevens, S. et al., 2012). Women and people who are transgender are at risk for developing problematic opioid use, in part due to traumatic life experiences including IPV.

Opioids and Abusive Partners: A Double Threat

Abusive partners often play a role in survivors' initiation into opioid use. Research suggests that women are more likely to begin using substances while in an intimate relationship, particularly after their partner introduces the substance (Brecht, M.L., et al., 2004). Abusive partners have been found to utilize a range of coercive tactics to both entrap survivors in opioid use and in the abusive relationship itself. Collectively, these tactics are known as "substance use coercion": abusive tactics targeted towards a partner's substance use as part of a broader pattern of abuse and control (Warshaw, C. & Tinnon, E. 2018). Within abusive relationships, substance use coercion has chilling effects on survivors' options for staying healthy and safe.

Substance use coercion plays out in survivors' lives in myriad ways (Warshaw, C. & Tinnon, E. 2018). As mentioned above, abusive partners are often responsible for initiating their partners into using opioids and for encouraging their use as a way to gain control. Pressured or coerced initiation into opioid use and subsequent addiction is also a route into human trafficking, including by an intimate partner or someone posing as such (Lederer, L.J. and Wetzel, C.A., 2014). Abusive partners may also sabotage survivors' opioid recovery or efforts to reduce use. This may include forcing survivors to use opioids when they are trying to stop, encouraging survivors to use directly or indirectly such as

by keeping opioid-related paraphernalia around the house, or intentionally stressing survivors as a way to get them to use opioids. Abusive partners may also utilize a number of coercive tactics to prevent survivors from accessing substance use disorder treatment services. Additionally, abusive partners may make threats around survivors' opioid use to make them reluctant to seek assistance or contact police out of fear of being arrested, deported, or referred to Child Protective Services. These threats are effective because they leverage the fact that opioid use is criminalized and stigmatized in many places, particularly if a person is pregnant or parenting. Finally, leaving an abusive relationship is both extremely stressful and dangerous: survivors are at greatest risk for homicide during separation and the post-separation period. The stress associated with leaving an abusive relationship can lead survivors to resume opioid use or use more than they want.

A 2014 study of callers to the National Domestic Violence Hotline found that substance use coercion is common (Warshaw, C. et al., 2014). Among 3,025 hotline callers:

- ▶ 26.0% reported that they have used alcohol or other drugs to reduce the pain of abuse.
- ▶ 27.0% reported that their abusive partner has pressured or forced them to use substances or made them use more than they wanted.
- ▶ Of the 15.2% of all callers who have recently tried to get help for their substance use, 60.1% of those callers reported that their abusive partner tried to prevent or discourage getting that help.
- ▶ 37.5% reported that their abusive partner threatened to report their substance use to the authorities to keep them from getting something that they want or need, including custody of children, a job, benefits, or a protective order.
- ▶ 24.4% reported that they have been 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 for being under the influence of alcohol or other drugs.

In reviewing these results, it is important to keep in mind that the only eligibility criteria for participating in this study were (1) identifying as a domestic violence survivor, (2) not being in immediate crisis, and (3) agreeing to participate in the survey after the topic was described. Callers were not prescreened for whether they use substances. This context makes these prevalence rates even more troubling.

In the context of substance use coercion, criminalization of survivors is a major concern, particularly among survivors of color. Abusive partners often threaten to report survivors' substance use to the police, tell survivors that the police will not believe them because they are using, or instill fear by

telling survivors that they will be arrested for their substance use if they reach out to the police for help (Warshaw et al., 2014). This is especially concerning given research findings indicating that within the opioid epidemic, communities of color are disproportionately targeted by the law enforcement system and arrested for opioid use (Netherland, J. & Hansen, H., 2017), rather than being offered access to treatment services and supports. For survivors of color, this represents a major barrier to health, safety, and any attempts towards recovery.

Pregnant survivors are also vulnerable to threats by their abusive partner to disclose their opioid use to child protective services or law enforcement. While estimated rates of experiencing IPV during pregnancy vary (e.g., between 0.9% and 20.1%), research consistently indicates that women in their childbearing years (18-34) have the highest overall rates of IPV (Phillips, H., 2015). Some states have sought to criminalize individuals who have used substances during pregnancy and/or to view drug use during pregnancy as a basis for terminating parental rights. While intended to protect infant health and well-being, such measures are counterproductive because they discourage pregnant individuals from seeking prenatal care for fear that they will be arrested and/or reported to child welfare agencies (Stone, R., 2015). They also run counter to current evidence-based treatment guidelines (Klaman, S.L. et al., 2017; SAMHSA 2018, Patrick S.W., 2017). This results in worse health outcomes for both the parent and the newborn.

These policies also place infants and children at greater risk of having the abusive parent as a primary caregiver, which often leads to child maltreatment and abuse. It also increases the likelihood of placement within the foster care system, which can be traumatic for children while simultaneously overburdening state child welfare systems. Additionally, parental separation as a result of incarceration is recognized as traumatic and an Adverse Childhood Experience in itself (Felitti, VJ et al., 1998), placing children at greater risk for physical health problems, mental health challenges, and early mortality as adults. Taken together, these policies can have devastating consequences for the safety, health, and wellbeing of survivors and their infants/children.

Chronic Pain, IPV, and Opioids

Along with the impact of trauma and abuse, there are additional factors that may place IPV survivors at heightened risk for harms associated with opioids. Survivors may be at particular risk for problems associated with the non-medical use of opioids because **1)** they are more likely to experience chronic pain, as compared to people who have not been abused, **2)** their reports of pain may not be believed by medical professionals, particularly if they are people of color, **3)** they may be less likely to have access to medical care and insurance due to interference by abusive partners, and **4)** pregnant survivors may avoid seeking opioid treatment or neonatal care due to abusers' threats or punitive policies.

Pain, Trauma, and IPV

Survivors of trauma, including domestic violence, are overrepresented among individuals who experience pain. Acute and chronic pain are among the most common reasons for the prescription of opioids (Rosenblum, A. et al., 2008). Domestic violence can cause acute pain from abuse-related injuries. It can also cause chronic pain. Chronic pain can result from injuries (Coker A.L. et al., 2005), but it can also occur as a type of complex physiological response generated from traumatic experiences, particularly in the case of ongoing, sustained, or multiple stressors such as is found in IPV (Wuest, J. et al, 2009; Tiwari, A. et al, 2013).

Research consistently links experiencing abuse with developing chronic pain conditions; domestic violence in adulthood combined with abuse in childhood can further magnify this risk. People who have been abused by a partner and/or in childhood report significantly more pain symptoms and more severe pain than people who have not been abused (Green, C.R. et al., 2003; Kendall-Tackett, K., et al, 2003; Wuest, J. et al., 2008). There are also high rates of IPV and lifetime abuse among people attending chronic pain clinics who have been prescribed opioids (Balousek, S. et al, 2007). As compared to people who have not been abused, IPV survivors may therefore be more likely to use opioids and be at increased risk for developing problematic opioid use.

However, for a survivor experiencing IPV, managing pain is vital. Relief from pain can lessen some barriers to social support and employment as well as pain-related mental health challenges. The relief provided by opioids, while risky, may be necessary to a survivor's day-to-day survival as well as their attempts to access safety. These factors are important to keep in mind in balancing both the needs of people with chronic pain who use opioids as well as the risks associated with prescription opioid use. They underscore the importance of opioid-related policies being driven by the needs of people living with chronic pain and listening to survivors as part of a patient-centered care approach.

Bias Affecting Survivors of Color with Chronic Pain

Intimate partner violence affects people of all races and ethnicities. An estimated 51.7% of American Indian/Alaska Native women, 51.3% of multiracial women, 41.2% of non-Hispanic black women, 30.5% of non-Hispanic white women, 29.7% of Hispanic women, and 15.3% of Asian or Pacific Islander women report experiencing physical violence by an intimate partner during their lifetimes. These statistics do not include sexual, psychological, or other forms of non-physical violence and are therefore likely an underestimate. While IPV, trauma, and abuse are known risk factors for the development of chronic pain, it is important to recognize that survivors' experiences of pain are not treated uniformly or equally.

As compared to white people, people of color are less likely to be prescribed opioids for chronic pain and physicians take their experiences of chronic pain less seriously (Green, C.R., et al., 2003).

Research has found that physicians are much less likely to prescribe opioids to people of color, as compared to white people (OWH, 2017); this has widely been attributed to prescriber bias and racism. As compared to middle class women of color, middle class white women are more likely to be treated for chronic pain including via opioid prescriptions (Schrager, A., 2015). Racial and ethnic disparities in opioid prescribing rates also exist among women who are low-income and receiving Medicaid: white women were nearly 1.5 times more likely to receive an opioid prescription, as compared to Hispanic women and non-Hispanic black women (CDC, 2015). Compounding this issue, pharmacies in segregated lower-income communities of color are less likely to stock prescription opioids (Childress, S., 2016), as compared to pharmacies in more affluent and/or white areas. Taken together, this research suggests that a sizeable number of survivors, primarily survivors of color, are at risk of having their chronic pain go unrecognized and untreated by the healthcare system. This places them at additional risk for harm, including through the non-medical use of opioids.

Linking Healthcare Access and Non-Medical Opioid Use

Access to physician-directed treatment for pain is contingent upon being able to afford medical care. A recent survey on the economic effects of IPV found 16% of survivors stayed in an abusive relationship longer for health insurance while 68% said their partner's behavior had a major, negative effect on their financial well-being (IWPR, 2018). Some survivors do not have access to medical care, insurance, or public benefits because of interference by abusive partners.

People without access to healthcare or insurance, including survivors, may use opioids non-medically. Survivors who do not have access to physician-directed treatment for chronic pain are at greater risk for drug-related health problems, overdose, and death (SAMHSA, 2015). Non-medical opioid use introduces additional risks to survivors, including the street purchase of opioids that have been cut with fentanyl. The high potency of fentanyl greatly heightens the risk of overdose death, and fentanyl-related overdoses are harder to reverse with naloxone.

All of these factors highlight the importance of ensuring equity in access to comprehensive chronic pain management and of ensuring that the voices of people living with chronic pain are part of the public policy discourse.

Substance Use Disorder Treatment Accessibility for IPV Survivors

There are disparities in the accessibility of substance use disorder treatment programs by gender, race, ethnicity, pregnancy and parenting status, and sexuality. Men are most likely to enter into treatment for opioid use problems (ApA, 2017) and overall, substance use disorder treatment services tend to be centered on the needs and experiences of men (OWH, 2017). As of 2014, only 44% of substance use disorder treatment programs in the United States provide specialized services

for adult women and only 20% offer programs or groups for pregnant or post-partum women (SAMHSA, 2015). There are very few programs that provide specialized opioid treatment services for LGBTQ+ individuals. This is essential as gender-appropriate, LGBTQ+-affirming, and culturally responsive services improve short- and long-term outcomes and therefore save lives (SAMHSA, 2014; Mooney, E., 2011). Therefore, the lack of specialized services for women and LGBTQ+ people is a major barrier to treatment access and ultimately recovery.

Survivors of color may face additional difficulties in accessing services and supports to help address problematic opioid use, as there are marked disparities in substance use disorder services, supports, and treatment options related to race and ethnicity. Evidence suggests that substance use disorder treatment programs and systems often do not adequately meet the needs of people of color, leading to decreased treatment attendance (Marsh, J.C. et al, 2009; SAMHSA, 2018). This is critical as the ability to access and utilize substance use disorder treatment programs can mean the difference between life and death.

Survivors with children face specific barriers to accessing substance use disorder treatment programs, including difficulty in managing both childcare responsibilities and the time and work that treatment programs require, as well as reasonable fears that the authorities could remove their children from their care because of their opioid use (SAMHSA, 2006). Furthermore, many residential drug treatment programs do not allow children to be present, thus creating dilemmas and challenges for survivors with children who wish to seek treatment for opioid use (OWH, 2017). However, in recognition of this need, there are emerging best practices, such as 2-generation residential programs, that do allow young children to be present with their parent who is receiving services.

Abusive partners may compound these issues by accusing survivors of “abandoning their children” if they seek in-patient or residential opioid treatment to gain custody as another tactic of control. The stigma associated with opioid use makes it less likely that survivors will be seen as “good parents” even after they are in recovery (Warshaw, C. & Tinnon, E., 2018). Abusers may leverage this stigma to further harm, isolate, and undermine survivors who are parenting as they attempt to access services.

Additionally, while there are exceptions, survivors report that substance use treatment programs sometimes do not understand the threats posed by abusive partners, thus placing survivors in danger. This is a major accessibility issue. Abusive partners may actively interfere with or forcibly prevent survivors from accessing opioid use treatment services or supports. This may include threats of violence for accessing services, forcing a partner into withdrawal, or withholding money or transportation needed for attending appointments, including court-ordered treatment, which can result in probation or parole violations (Warshaw, C. & Tinnon, E., 2018). When programs do not understand the dynamics of IPV and substance use coercion, they often place survivors in Catch-22 scenarios or dangerous situations. For example, a survivor may miss appointments at a substance

use disorder treatment agency because of interference from their abusive partner, leading to a termination of services at that agency.

Medication Assisted Treatment Options

When survivors develop problems because of their opioid use and choose to seek services and supports to address them, we want to ensure that opioid use disorder treatment programs, including Medication Assisted Treatment (MAT), are accessible and safe for survivors.² One critical safety-related issue is that regularly scheduled MAT appointments make it easier for abusive partners or ex-partners to stalk survivors (Warshaw, C. & Tinnon, E., 2018). This may be even more problematic and complex for survivors with court-ordered MAT.

Survivors of color may face additional systemic challenges and accessibility barriers related to MAT. Methadone and buprenorphine are two of the three currently available forms of MAT. Methadone, while highly effective, is seen by some as a less desirable form of MAT for a variety of reasons: methadone users required to visit a methadone clinic daily for long periods of time, often at an inconvenient time of day, and at times far away from home. Furthermore, methadone clinics often have restrictive rules and strict monitoring policies that make it more challenging for patients to access treatment (Salsitz, E. et al, 2015). In contrast, buprenorphine treatment has largely been marketed to higher income, suburban, and predominantly white communities and can be accessed within a patient's primary care office, with fewer rules and less marked stigma (Hansen, H. et al, 2016).

Evidence suggests that people of color are more likely to be directed to access methadone than buprenorphine, and white people are more likely to be directed to access buprenorphine than methadone (Hansen, H.B. et al, 2013; Hadland, S. et al, 2017; Netherland, J. & Hansen, H., 2017). To compound the issue, methadone is generally less accessible to people of color than to white people, in some instances due to a lack of cultural competency among providers (Zaller, N.D. et al, 2009). As mentioned above, the stringent rules and regular appointment times mandated by methadone treatment may place survivors at risk of stalking and violence by abusive partners. For survivors of color, racial disparities impacting access to methadone versus buprenorphine treatment can seriously impact their health, safety, and wellbeing.

Survivors who are pregnant and use opioids face additional and specific barriers. The use of opioids during pregnancy and the increasing rates of neonatal opioid withdrawal syndrome (NOWS) have become major public policy concerns. Medication assisted treatment - not opioid withdrawal - is associated with the best outcomes for women and their newborns (Klaman, S.L., 2017; SAMHSA,

² "Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, including long acting opioids, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders." SAMHSA <https://www.samhsa.gov/medication-assisted-treatment>

2018; Patrick, S.W., 2017). However, opioid use during pregnancy is considered child abuse in 23 states and in Washington, D.C. In some states, illicit drug use during pregnancy is a prosecutable offense (Guttmacher Institute, 2018). Also, 24 states and Washington, D.C. require health care professionals to report suspected prenatal drug use. These policies continue to be promoted despite clear evidence demonstrating that supporting mother-infant bonding and attachment shortens the course of NOWS and improves infant wellbeing. Given the evidence that abusive partners leverage the illicit status of substances in reporting survivors' use to the authorities, this is a major concern. In order to save lives and improve infant and survivor health, it is critical to incorporate an understanding of the dynamics of IPV and substance use coercion into state and federal opioid policy.

Recommendations for National Policymakers

While Congress enacted the SUPPORT for Patients and Communities Act (P.L. 115-270) in 2018 to address the opioid crisis from a public health approach, IPV survivors' unique and specialized needs were not addressed as part of this legislation. Recommendations for national policymakers to better serve survivors include:

- 1. Investing in access to specialized treatment:** As policymakers continue their efforts to address barriers to accessing treatment, it is critical to invest in more specialized services for survivors. This includes services that are gender-responsive, culturally-responsive, domestic violence-informed, and trauma-informed, with accompanying childcare availability and child-parent services. As part of this investment, timely same-day access to treatment is important to support survivors once they decide to get help.
- 2. Supporting new trauma-related provisions:** The needs of IPV survivors who use opioids should be considered by HHS and other federal agencies as they administer the trauma provisions included in the SUPPORT for Patients and Communities Act. This includes the Interagency Task Force on Trauma-Informed Care in its work to develop best practices for children and families who have experienced trauma.
- 3. Supporting systems collaboration with domestic violence organizations:** Federal programs that fund domestic violence services need to be strengthened and expanded to support collaboration with public health and behavioral health systems. As legislation related to supporting domestic violence survivors is considered, there is a bipartisan proposal in Congress (H.R. 973) that would create a state-level pilot program. This program would incentivize substance use disorder treatment providers, including those that support pregnant and parenting individuals, to be trained on key issues such as substance use coercion, IPV, and survivors' safety. **The pilot program would also include partnerships with domestic and sexual violence organizations at the state and local level.** The National Center on Domestic Violence, Trauma & Mental Health provides training

and technical assistance materials that support state coalitions and community-based domestic violence programs in responding to survivors who use substances and survivors in recovery.

- 4. Training primary care and behavioral health professionals:** In addition to increasing availability of specialized services, primary care and behavioral health providers should understand and be incentivized to receive training on:
- a. The increased risk of chronic pain among survivors of IPV and other trauma,
 - b. The impact of substance use coercion on opioid use, addiction, treatment and recovery,
 - c. The need for safety planning to address barriers to treatment posed by abusive partners, and
 - d. How to appropriately incorporate responses to IPV and substance use coercion into clinical practice. (See *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* released by the National Center on Domestic Violence, Trauma & Mental Health, March 2018)

5. Authorize new research and improve data collection: Federal surveys should include questions about substance use coercion, including efforts by an abusive partner to interfere with treatment and/or sabotage recovery.

Recommendations for State-Level Policymakers

Many states are engaged in a variety of initiatives to address the opioid epidemic, but despite the clear links between opioid use and experiences of violence, many of these initiatives do not incorporate policies to address past trauma or ongoing domestic violence. The following recommendations are for incorporating IPV into some of the common types of initiatives that states have engaged in to respond to the opioid epidemic.

- 1. Hotlines:** Some states have launched hotlines to triage calls from individuals who need support related to their opioid use and from concerned friends and family. For some of these callers, addressing opioid use will be connected to addressing IPV. Thus, staff on these hotlines should receive cross-training on IPV, including how to identify IPV-related safety issues, and how to warmly refer callers to local domestic violence programs.
- 2. Data collection initiatives and Maternal Mortality Reviews:** Some states have begun collecting data about opioid use, overdose, and mortality rates. Incorporating mechanisms for collecting information about the role of IPV in a person's opioid use may provide helpful information that can ultimately contribute to effective prevention and intervention policies. At the same time, disclosure of IPV information can put survivors at risk. For example, IPV survivors may be at risk of retaliation by their abusive partners if they disclose the abuse to providers. Thus, safety issues must be carefully attended to with tailored protocols for ensuring survivors' confidentiality and

safety. In addition, some states, such as Illinois, have begun to include violent deaths in their maternal mortality reviews. Incorporating attention to the role of IPV-related suicide, homicide and overdose can also help to inform state-level policy, prevention and service initiatives.

- 3. Good Samaritan Overdose Prevention Laws:** As of July 2017, 40 states and Washington, D.C. have some version of these laws, which shield individuals experiencing an overdose and those who assist them from criminal penalties (National Conference of State Legislatures, 2017). However, states vary on how expansive their laws are (e.g., many do not protect individuals from parole or probation violations or do not protect them from other substance or paraphernalia possession charges), and 10 states do not have an overdose prevention law in place at all. Furthermore, the laws in this area are not always applied uniformly: people of color and street-based individuals are more likely to be penalized for making emergency calls. When in place and better understood, these laws greatly increase the chances that individuals, including survivors who may be experiencing a forced or coerced overdose, will obtain life-saving emergency medical assistance. Thus, more awareness and understanding of the protections these laws provide is needed, and the remaining states should consider passing Good Samaritan laws that do not have any restrictions.
- 4. Opioid initiatives that impact pregnant individuals:** Instead of criminalization, states can support policies to address IPV during pregnancy by: A) changing statutes that consider substance use during pregnancy to be child abuse, B) expediting access to services for people who are pregnant, and C) investing in evidence-based public health initiatives to address opioid use during pregnancy. These initiatives should include protocols for supporting pregnant individuals in accessing methadone or suboxone. Initiatives on supporting parenting and nurturing healthy families more broadly should have provisions on enhancing parent-child attachment in the presence of neonatal opioid withdrawal syndrome. Further, health insurance, including Medicaid, which covers half of all new births, should cover MAT without pre-authorization requirements or lifetime limits. Health insurance, including Medicaid, should also support electronic and telephonic prescribing of MAT, rather than requiring paper MAT prescriptions. This would allow survivors to more readily access MAT via telehealth from the safety of a shelter or other safer spaces.
- 5. Naloxone:** Every state should institute a standing order for naloxone and both allow and encourage community distribution of naloxone by lay people/peer educators, as well as by domestic violence and sexual assault programs.

Recommendations for Practice Change

IPV survivors have unique needs when accessing substance use treatment. As previously described, abusive partners may actively discourage or prevent survivors from accessing treatment. Or the regularity of appointment times (e.g., for methadone) may make it easier for an abusive partner or ex-partner to stalk a survivor. In small communities including rural, immigrant, and religious communities, a survivor may be in the same treatment program as their abusive partner, creating

risks for the survivor. These are just a few examples of IPV-specific risks that substance use treatment providers must account for in how they provide services.

At minimum, substance use treatment providers should institute policies, procedures, and practices to accomplish the following:

- ▶ Develop a collaborative relationship with local domestic violence programs, including engaging in regular cross-training and jointly developing a protocol for making warm cross-referrals.
- ▶ Ensure that all staff receive basic training on domestic violence from a local domestic violence program or other organization or individual with domestic violence expertise.
- ▶ Incorporate questions about domestic violence into agency-wide screening and assessment protocols, including questions designed to identify substance use coercion tactics.
- ▶ Incorporate protocols for designated staff to assess for domestic violence, provide brief counseling, and make warm referrals to local domestic violence programs (this is currently a billable service as women's preventive health service under the Affordable Care Act).

Ideally, best practices for responding to intimate partner violence should be incorporated at all levels of substance use treatment agencies, including intake and assessment, counseling and treatment, MAT, overdose prevention and trauma treatment, staffing, documentation and information sharing protocols, referral protocols, and all outreach and programming.

While national and state policymakers can take actions to incentivize substance use treatment providers to adopt these policies, substance use disorder treatment practices and agencies can also institute these policies on their own.

Finally, local community-based nonprofits working in this area can continue to support needle and syringe exchange programs and safe spaces that help survivors of IPV.

- ▶ **Needle and syringe exchange programs:** Needle and syringe exchange programs are harm-reduction measures. Substance use coercion tactics include controlling access to substances and substance-use paraphernalia, as well as forcing or coercing partners to use dirty needles. For survivors of IPV who use injectable drugs, needle and syringe exchange programs can mean access to clean needles, which can allow them to avoid infection and stay healthier while using. They can also decrease abuse-related isolation and increase connection to community supports. Some exchange programs offer support specifically designed for survivors of IPV.

- ▶ **Safe Spaces:** For people who experience homelessness or housing instability and use opioids, especially women and LGBTQ+ individuals, the risk of being assaulted while using is extremely high (Jessell, L. et al., 2017). As part of a broader harm-reduction approach, some non-profit organizations provide safe space where individuals can be safer while they are high or coming down from a high (Knight, H., 2018). These locations can help to significantly reduce sexual assaults and other forms gender-based violence.

Best Practices for Healthcare and Behavioral Health Providers

There are a number of current and emerging best opioid use disorder treatment practices for IPV survivors. In general, integrated IPV and substance use services appear to offer the best outcomes for survivors and their children (Armstrong, E.M, Glover Reed, B., Bennett, L.W., 2019; Fowler, D.N. & Faulkner, M., 2011). Current best practices for treating opioid use disorder include the full range of MAT treatment options in the context of comprehensive wrap-around services embedded in a recovery-oriented system of care (SAMHSA, 2009; SAMHSA, 2018; Klamann, S.L. 2017). Given the significance of trauma in the lives of IPV survivors, it is essential that substance use disorder treatment programs utilize gender-responsive, trauma-informed models of service delivery (Bailey, K., et al., 2019). Additionally, there are a number of evidence-based treatment models for addressing the intersections of gender, trauma, and substance use. Examples include: Helping Women Recover and Beyond Trauma (Covington, S.S., 2008), Women's Recovery Group (Greenfield, S.F., 2014), Seeking Safety (Najavits, L.M., 2002), and Relapse Prevention and Relationship Safety, the only intervention that specifically focuses on opioids and IPV (Gilbert, L., et al., 2006). Other best practices include gender-responsive, trauma-informed, 2-generation residential programs for women, such as the Horizons Program at the University of North Carolina and programs supported by SAMHSA's Services Grant Program for Residential Treatment for Pregnant and Postpartum Women.

Access to comprehensive pain management services is also critical for survivors of IPV. Recent publications from the National Academy of Sciences and updated guidance on opioid prescribing from the CDC highlight the importance of individualizing treatment for chronic pain and ensuring people have access to a full array of treatment options (National Academy of Sciences, 2017; Dowell, D. et al., 2019). This particularly salient for IPV survivors: abusive partners may be both causing the pain while controlling access to pain-relieving medication and other treatment.

To access copies of this report or to discuss the policy and practice changes recommended, please contact Carole Warshaw MD, Director, National Center on Domestic Violence, Trauma & Mental Health at cwarshaw@ncdvtmh.org, (312) 726-7020 ext. 14 or go to www.nationalcenterdvtraumah.org

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