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ORIGINAL ARTICLE

Barriers to Care for Pregnant and Post-Partum Women Experiencing Co-Occurring Intimate Partner Violence and Opioid Use Disorder

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Abstract

Purpose Thecurrent manuscript explores barriers to care for pregnant and post-partum women experiencing co-occurring intimate partner violence and opioid use disorder through the lens of providers who work with this unique population.

Methods We conducted a qualitative study consisting of 49 semi-structured, open-ended interviews with service providers working across contexts (e.g., IPV, prenatal care, substance use, addiction medicine, law enforcement, criminal justice, welfare services, etc.).

Results Participants reported three main types of barriers which can impact outcomes and reduce care for pregnant and post-partum women with co-occurring IPV and OUD (Co-IPV/OUD). 1) Barriers that make it difficult for pregnant or post-partum women to seek, receive, and successfully engage in care for both IPV and OUD. Barriers that providers encounter in trying to care for and/or treat pregnant and post-partum women with Co-IPV/OUD. Lastly, barriers which present a challenge to providing comprehensive, coordinated care for pregnant or post-partum women with Co-IPV/OUD.

Conclusion We conclude that finding ways to improve coordinated or integrated care for IPV and OUD is vital to outcomes for this population, and initiatives which support providers' ability to work across different service contexts are needed.

Keywords Opioid use disorder · Intimate partner violence · Pregnancy · Post-partum · Maternal and child outcomes

Introduction

Intimate partner violence (IPV) represents a significant health risk for women (World Health Organization, 2018) and can include physical, emotional, verbal or sexual abuse, as well as more subtle forms such as financial abuse (e.g., controlling use of funds), reproductive coercion (e.g., forced pregnancy/abortion, contraceptive control), and substance use coercion (e.g., forced use, sabotaging treatment) (Phillips & Warshaw, 2020; Smith et al., 2018; Warshaw et al., 2014). Globally, an estimated 27% of women have experienced some form of IPV in their lifetime (Sardinha et al., 2022); in the US, rates are similar with an estimated one in four women experiencing sexual or physical violence, and/or stalking by an intimate partner during their lifetime (Centers for Disease Control Prevention, 2019). Women experiencing IPV are at risk for a number of adverse health-related outcomes such as physical injuries, chronic conditions (e.g., diabetes, heart disease), gastrointestinal problems, reproductive health issues (Alhusen et al., 2015; Sugg, 2015) and psychosocial conditions (e.g., homelessness and food scarcity) (Ricks et al., 2016; Yu et al., 2020). IPV victimization also puts women at risk for behavioral and mental health issues including depression, anxiety, post-traumatic stress disorder, and substance use disorders (SUDs) (Cafferky et al., 2018; Mason & O'rinn, 2014; Salom et al., 2015). Furthermore, research shows that victims often encounter barriers to help-seeking and have a unique constellation of needs that may go unaddressed (Ponce et al., 2014; Ricks et al., 2016; Wilson et al., 2007; Yu et al., 2020).

Women who are pregnant or immediately post-partum (i.e., < 1 year) are at a particular risk for adverse health outcomes related to IPV. Research shows that reproductively

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aged women are at a heightened risk for IPV in general and pregnancy and the immediate post-partum period can be a particularly vulnerable time for women already experiencing IPV (Agrawal et al., 2014; Chisholm et al., 2017; Román-Gálvez et al., 2021). A recent study by Román-Galvez et al. (2021) found that IPV during pregnancy ranges in prevalence from 1.6 to 78% for physical violence, and 1.8 to 67.4% for psychological violence. Furthermore, IPV during pregnancy has become a leading cause of maternal mortality (Campbell et al., 2017, 2021). Pregnant victims of IPV are more likely to report their pregnancy was unintended and a lack of prenatal care, as well as experience poorer infant outcomes, such as low birth weight; they also have a higher risk depression and other mental health issues, death as a result of homicide, and substance abuse (Alhusen et al., 2015; Campbell et al., 2017; Hill et al., 2016). In fact, regardless of pregnancy status, IPV is associated with substance use in victims, who report engaging in drug use to cope with abuse-related trauma (Pallatino et al., 2021; Phillips et al., 2021; Warshaw et al., 2014). Substance use within the context of a violent relationship can also heighten the severity of IPV, potentially increasing the risk for homicide (Kraanen et al., 2014; Salom et al., 2015). However, research has shown that an estimated 47–90% of pregnant women with SUDs experience IPV, surpassing general population rates (Campbell et al., 2017; Engstrom et al., 2012; Schneider et al., 2009; Velez et al., 2006). Additionally, studies of women in treatment for substance use disorders have found that lifetime physical and emotional abuse surpasses 70%, with 45% reporting pregnancy-related IPV (Velez et al., 2006). Thus, suggesting that pregnant women are at a particularly high risk for IPV-related substance abuse.

Despite the recognition that women may have unique needs in relationship to co-occurring IPV and substance use during pregnancy or the immediate post-partum period, several gaps in the literature remain. First, although there is a burgeoning set of research – derived from studies with both patients and providers – on co-occurring IPV and substance use, such studies have not traditionally included pregnant or immediately post-partum women (e.g., Afifi et al., 2012; Bennett & O'Brien, 2007; Cafferky et al., 2018; Kraanen et al., 2014; McHugo et al., 2005). Thus, it remains unclear as to what is needed to optimize outcomes for pregnant or post-partum women specifically. Second, research suggests that opioid use disorder (OUD) among reproductively aged women, including those who are currently pregnant or immediately post-partum, has risen in the last fifteen years (Haight et al., 2018). However, relatively few studies of IPV and substance use have included OUD (Stone & Rothman, 2019) or sought to understand the intersection of co-occurring IPV and OUD with women who are pregnant or immediately post-partum (Dewey, 2020; Pallatino et al., 2021; Phillips et al., 2021). Studies that seek to understand the complexities of IPV and OUD during pregnancy or the post-partum period are, therefore, warranted. The current study seeks to begin to fill these gaps by highlighting providers' perspectives on the barriers to providing care for pregnant and post-partum women experiencing co-occurring IPV and OUD (Co-IPV/OUD). Such studies are needed to devise ways to comprehensively integrate or improve care for pregnant and post-partum women experiencing IPV and SUDs, but also to improve maternal and infant health outcomes.

Method

The data for this study were collected as a part of a larger exploratory study on ways to improve outcomes for pregnant or post-partum women experiencing Co-IPV/OUD. The aim of the parent study was to understand barriers and facilitators to care and service integration for this population, and to gain insights from both patients and providers about what evidence-based practices might be employed to improve health and safety outcomes for women experiencing Co-IPV/OUD and their children. As a part of this study, we interviewed a range of service providers on their experiences caring for pregnant and post-partum women with Co-IPV/OUD. The current analysis draws on these interviews to broadly explore providers' perspectives on what barriers exist for treating and working with pregnant and post-partum women with Co-IPV/OUD.

Data Collection

Data for this study was collected between 2018 and 2019. Recruitment of providers was facilitated in coordination with a local women's hospital in Southwestern Pennsylvania, which houses a specialized treatment program for pregnant and post-partum women with OUD. The Magee Women's Hospital Pregnancy Recovery Center (PRC) is a comprehensive outpatient program which provides obstetrical, medical, and behavioral health care to prenatal and pregnant women experiencing OUD (Krans et al., 2018). In addition, the PRC utilizes an extensive network of community agencies to provide continuing support services and programming to its patients to assist with a wide range of needs (e.g., IPV, child and family, welfare, etc.). Providers were therefore recruited both from within the hospital and affiliated external agencies using two main approaches. First, flyers were hung in the hospital in the relevant areas (e.g., clinics, offices, lobbies) frequented by providers who serve this population. Flyers contained information about the study and how to contact study staff should providers be interested in participation. Second, snowball sampling was also used to expand the sample. Providers who participated in the study were asked at the end of their interviews to suggest and facilitate contact

with additional providers they felt would have a valuable perspective to share regarding providing care for patients with Co-IPV/OUD.

Providers were eligible for participation in the study if they were working in a service provision setting related to IPV, substance use, prenatal care, criminal justice, welfare, or other contexts (e.g., child protective services, behavioral/mental health) which would bring them into contact with pregnant or post-partum women experiencing Co-IPV/OUD. Our decision to include a wide range of service providers in the study was two-fold. First, past research on service integration for co-occurring IPV and OUD has focused primarily on key informants in mental health, substance use, and maternal and child health (e.g., Mason & O'rinn 2014; Moses et al., 2004; Portnoy et al., 2020). Second, IPV and OUD both carry consequences beyond health-related outcomes. Victims and their families also often are involved in and/or have contact with a wide range of stakeholders from criminal justice, child, youth, and family (CYF) services, and welfare provision, among others. In order to understand the full range of complexities that need to be considered in the design of integrated care for IPV and OUD, our study includes IPV advocates, prenatal providers, substance use providers, harm reduction service providers, addiction medicine specialists, law enforcement, criminal justice, CYF, and welfare services. By including multidisciplinary professionals in the study sample, we seek to create a more holistic framework for researchers to better understand the social, legal, and healthcare-related barriers and facilitators that impact service access, quality, and integration.

All interviews with providers lasted approximately 60 min and were conducted in a location of the providers' choosing, or via telephone. The interview guide broadly explored providers' experiences caring for pregnant and/or immediately post-partum women with Co-IPV/OUD, their perceptions on their ability to connect and engage women with substance use treatment and IPV-related services, service provision barriers and facilitators, practices regarding recording keeping (e.g., client demographics) and evaluation or measurement of outcomes, and suggestions for evidence-based integrated substance use and IPV treatment practices for women with OUD. Providers were also asked to fill out a brief survey assessing their work history, agency size, service field, and socio-demographic characteristics (e.g., gender, race). All providers were compensated $50 for their time. The Institutional Review Board at the University of Pittsburgh approved this protocol.

Analysis

All interviews were audio-recorded, transcribed verbatim by a trained transcriptionist, and uploaded into ATLAS.ti for organization and analysis. We utilized a two-coder iterative approach to analyze the data (Crabtree & Miller, 1999). Analysis focused on global and content coding of broad thematic categories and subcategories across all participants. In the first step, the first author and a qualitatively trained graduate research assistant each independently reviewed the transcripts line-by-line to identify preliminary themes. The coders then met to compare themes and refine each, creating hierarchical categories of themes and subthemes. Definitions were delineated for each major and minor theme to assist in the final coding step. The two coders then independently recoded the transcripts using the codebook and met once more to reconcile any differences if needed. Themes presented in this analysis are those that arose consistently across all participants.

Results

Sample Characteristics

Most participants (N = 49) were female (92%) and white (72%). A majority (44%) had been in their field for over 20 years, with a range of years of service between < 1 year to 40 years and a mean of 17.5 (SD 12.7). Most worked in the field of IPV (25%), "other" (22%), substance use (20%), or prenatal care (20%), and had worked one or more agencies where they had served women with Co-IPV/OUD (78%). The number of pregnant or post-partum women serviced by the participants' agencies or programs ranged from less than 100 to over 1500, with most participants reporting under 100 (32%) or between 100 and 300 (32%) individuals seen per year.

Thematic Overview

The analysis which yielded three main thematic categories[1]: (1) Barriers that make it difficult for pregnant or post-partum women to seek, receive, and successfully engage in care for both IPV and OUD; (2) Barriers that providers encounter

[1] For ease of presentation and logistical flow of the manuscript, the results of the thematic analysis related to barriers to care are presented here as unique themes. However, these challenges are often interrelated and more likely represent a set of difficulties that holistically affect providers' ability to care for pregnant and post-partum women with Co-IPV/OUD on multiple levels. Additionally, as our focus was on the barriers to care specifically for pregnant or post-partum women experiencing IPV and OUD, we have only included those barriers which are associated with the intersection of these experiences (IPV and OUD, and/or IPV or OUD and pregnancy/post-partum). Thus, our list of barriers presented here is not exhaustive. Finally, while we asked providers specifically about OUD, some providers framed their responses within the context of substance abuse more generally – a point we will address in our discussion.

in trying to care for and/or treat pregnant and post-partum women with Co-IPV/OUD; (3) Barriers which present a challenge to providing comprehensive, coordinated care for pregnant or post-partum women with Co-IPV/OUD.

Barriers to Help-Seeking/Engaging in Treatment

Disclosure Participants described the unique challenges related to help-seeking, or engaging in care, that women who are pregnant and/or post-partum and experiencing Co-IPV/OUD may encounter. One such barrier was patients' unwillingness to fully disclose IPV and OUD. Participants recognized that pregnant and post-partum women – like all women – experiencing IPV and OUD were often afraid of being judged and thus, may be reluctant to share these issues with providers. As one participant stated about OUD, "They don't want them [the doctor] to know, like 'My PCP is going to know that I'm prescribed Suboxone.' I think that people think they're going to be stigmatized." Another participant similarly stated about IPV, "So women don't seek care because they're ashamed, they don't want their provider to know that they have injuries, or anything like that." However, participants asserted that stigma and fear were often doubled for patients experiencing Co-IPV/OUD. As one provider stated, "People don't talk about their substance use or intimate partner violence. Both populations feel highly stigmatized. From the victim's perspective, it's the double-whammy to admit, 'not only am I using drugs, I'm also being beaten up by my partner.'" Furthermore, being pregnant or having a child only added an additional layer to the stigma patients with Co-IPV/OUD may encounter. As another provider stated, "There is a lot of stigma around these situations, you have a child with injuries, or mom's [using] Suboxone, you know, it's the "I'm a bad mom" kind of thing." Thus, while disclosure is difficult for all women experiencing IPV and OUD, providers felt that the potential for stigma increased when IPV and OUD were co-occurring, and even more so when women were pregnant or post-partum.

Additionally, participants recognized the role that fear of consequences related to disclosure might have on pregnant or post-partum women's willingness to seek help from providers. Specifically, they felt that many women may be reluctant to disclose IPV or OUD because they feared losing their children as a result. As one provider stated, "With [IPV and OUD], you're more pulling the information from them, because they're not required to give it to you. I think often they're afraid, especially when there's children involved, that they're going to lose their kids." Another similarly stated, "There are women who don't seek care because they don't want CYF involved. Same is true with intimate partner violence, they're ashamed, they don't want CYF involved. So again, that being co-occurring, I think the biggest barrier." Thus, participants recognized that while patients may not fully disclose IPV or OUD for many reasons, pregnancy and/or having children complicated patients' willingness to seek help for these issues.

Barriers to Help Seeking for IPV – Pregnancy Related Participants also described the challenges pregnant and post-partum women with co-occurring OUD face when trying to seek help for abuse. Participants agreed that again, like all women experiencing IPV, pregnant and immediately post-partum women had to be ready and willing to leave their partners. As one participant stated, "If she's not willing – ready and willing to do anything about it, then there's really nothing that we can do. We can't force somebody to leave their relationship." However, participants felt that being pregnant and/or having children with a partner often made it more difficult for women to leave. Some described what they saw as women's reluctance to "break up" the family unit during pregnancy, "A lot of times pregnant women want to hold onto that nuclear family of like mom, dad, baby, and having a normal happy pregnancy that should be something to be celebrated." Another similarly stated, "When you're pregnant, you [are] very embedded in your relationship, and in your family structure, so upping and taking some bold step is not the typical response." Others felt that in some cases women who were pregnant or had children were more reluctant to give up their partner's support (e.g., financial, psychosocial, etc.), "You hear a lot of women say, 'well, I can't do it by myself. As long as he doesn't hit the kids, it's OK.'" Another similarly stated, "Most of the clients that we talk to, when they talk about why they didn't leave, it's almost always 'I couldn't support my kids, I couldn't do anything, I had to go back." Thus, participants felt that women who were pregnant and/or had children often relied more heavily on their partners for support and therefore, faced greater challenges in terms of being able to leave an abusive relationship. As one participant stated:

> A lot of times they return because they feel like they don't have any resources. When they go to leave, they come up against all these barriers and it's hard to establish independence. So, some of the reasons that they stay in a relationship are also the reasons that they return: financial reasons, housing, children, all that sort of thing.

Barriers to Help Seeking for IPV – Substance Use Related Having a substance abuse issue likewise added to the reliance women had on their partners and complicated their ability to leave or seek help. As one participant stated, "Substance abuse is [often] linked to domestic violence,

you're stuck because of your addiction. And they'll say, 'Why don't you just leave?' It's not that easy if you're using together and you have a co-dependent relationship." Another provider similarly stated, "Most drug users want to have a partner. They don't want to do it [by] themselves, so they have a partner they're comfortable with, they don't want to lose that partner, they have a tie to them." Thus, having a substance use issue while pregnant or having children with one's partner only served to increase the degree to which a victim might be reliant on their partner and/or unwilling to leave a potentially abuse situation. One provider summarized:

> [Substance abuse] may affect maybe their motivation to leave the relationship. It plays into it is how dependent they are…on their partner for housing, for childcare, if they're unemployed, is their partner their dealer? All that stuff –it's really intermixed. If they're dependent on their partner for childcare, to get their drugs, alcohol, whatever, they're less likely to leave that situation, in their minds, they have more to lose by leaving.

Barriers to OUD Recovery – IPV Related Participants also endorsed barriers that pregnant and post-partum women may encounter in seeking help for their OUD that were related to IPV. Participants asserted that it was not uncommon for women who are experiencing IPV to engage in substance use as a coping mechanism. As one stated, "There is a correlation between IPV and substance abuse. Sometimes the issue of trauma triggers substance abuse, and when people don't have healthy coping, substance abuse is a way to manage the hurt." Another similarly stated, "While they're in the abusive relationship, substance use can kind of be a coping mechanism before they're able to find other support." Thus, participants felt that substance abuse served as a means of managing the trauma of IPV. Furthermore, engaging in recovery while IPV was ongoing was difficult as it added stress to an already stressful situation. As one participant stated, "It's a vicious cycle – trying to come through something stressful like leaving the situation while having to get rid of the crutch that's helping you to stay numb to it." Likewise, another provider offered:

> A lot of hard work has to go into [addressing your] addiction, planning and organization and being able to attend your sessions, and future planning. Most people who are in active abusive situations are just really trying to survive day by day. They don't have the energy or peace of mind to try to fix something that takes more than one step.

IPV, therefore, complicated women's engagement in recovery and added a layer of complexity to the already challenging process of sobriety.

Abusive partners were also identified as a barrier to help-seeking for OUD. Some participants described the blatant ways abusive partners sought to sabotage women's sobriety. As one participant stated:

> I tell the story all the time, a patient had come in late for her appointment, she was crying, she shimmied down an air conditioner so she could crawl out the window, because he was holding her in the house. There's a lot of sabotaging there in general.

Another offered, "If he's holding her from completing paperwork or getting downtown or doing whatever. I think that's a huge barrier: blatant sabotaging." Other participants described more subtle forms of sabotaging related to recovery. For example, one participant described how partners may use emotional abuse to derail victims' recovery, "Their significant others will tell them that they are a piece of s**t, a junkie, it's just that manipulative cycle where they're just breaking them down. Like it just takes their confidence down to zero." Another described the control partners have over their victims and how it complicates care for OUD, "Just the amount of control that they have over every aspect of their life. It's difficult to have them [the victim] follow up because it's hard to get away even a second to do things without them knowing." However, as with other barriers, participants felt that being pregnant or post-partum added a layer of complexity to the dynamics involved Co-IPV/OUD, making it easier for partners to control their victims and thus, sabotage their ability to seek help and engage in recovery. As one participant stated:

> There are all these layers of complexity that increase [with] IPV. For example, patients have a partner who is upset with them for being on a maintenance medication because they don't understand it and don't agree with it, and that it could increase the risk to the fetus [or] newborn, so they think… there can be a lot of anger with that issue.

Thus, participants felt that a victims' pregnancy status was often used by partners as an excuse to keep them from doing the things they needed to do (e.g., take maintenance medication, attend appointments, etc.) to be successful in recovery. Another participant stated, "They look at it as a way to hold their medications from them, or keep them on a strict plan, or "You're not going to be on this medication while you're pregnant."

Barriers to OUD Recovery – Pregnancy/Post-Partum Related Participants also described issues specifically related to pregnancy or the immediate post-partum period

that presented challenges to engaging in care for OUD recovery. Some participants described this period as generally high-risk for relapse, citing the changes that women go through as precipitating factor, "Women who are pregnant and post-partum are more high-risk for relapse, it can be a lot scarier than for women who aren't pregnant or post-partum." Another participant likewise stated:

> People forget how much a woman's body changes while they're pregnant, physically, emotionally, mentally, everything, there's just so much change, and they can't control that. They're not just dealing with recovery, they're not just dealing with the issues that are occurring in their homes, they're growing a human being inside of them, they can't even control themselves– and even post-partum. All these things work against them.

A third offered, "Detoxing off methadone is not a good recommendation because of the stress in the first year of motherhood. Also, post-partum depression and anxiety, if you have someone who has substance abuse issues– there's a high-risk for relapse post-partum." Thus, participants identified pregnancy and the immediate post-partum period as a particularly vulnerable time for relapse due to the increased stressors of new motherhood and risk for post-partum depression.

Furthermore, participants felt that having the additional stress of IPV during this time only served to compound the stressors of new motherhood and post-partum depression. As one participant stated, "The conception happened, but the violence [is] still occurring. May not be physical assaults, but intimidation, coercion, emotional, psychological. And here are these expectations because oh, now you're dealing with post-partum. It is high risk for relapse." The combination of IPV, post-partum depression, and OUD, therefore, presented a unique set of interrelated challenges for women trying to remain sober. As one participant summarized:

> People that are dealing with addiction and abuse, after they have their baby, they get worse. They tend to do well while they're pregnant because you have someone else in your body. Once you deliver that child – especially dealing with post-partum depression, I think it is easier for them to justify using. Because they have – now they have given birth. I see more relapses after a child is born, opposed to while a client is pregnant.

Barriers to Caring for/Treating Co-IPV/OUD

Screening for IPV or OUD Participants also described challenges they encountered when trying to treat or care for pregnant and/or post-partum women with Co-IPV/OUD. One such barrier was the lack of screening for IPV or OUD across service contexts. For example, one provider stated, "We don't do any screening for substance use. Not only is it not in our protocol, but the way that we approach [it] is if they're coming to us, at least we're helping them in some aspect." Another similarly stated, "We can kind of try and determine based on their actions, even prescribed medication, we can try and poke but as far as any screening, we don't do that." Conversely, others reported a lack of screening for IPV, "I would say I don't usually when I speak to clients, I kind of like let them voluntarily reveal information, but it's [IPV] also not something that I directly ask about. We don't screen for that." Other providers asserted that screening for IPV or OUD depended on the situation, but rarely would they do both at once:

> If I have a child with physical abuse, I don't think I would ask the parent about substance use. I'm much more focused on violence – So I'm much more likely to talk about intimate partner violence for a kid who's there for violence. If the child's there for supervisory neglect that's more related to substance use, I'm more likely to ask about that. It is in the context of why I'm seeing the child.

Thus, one barrier to being able to provide care for this population was a lack of consistent screening for IPV and OUD across different types of service contexts – or rather, that providers tended to only screen routinely for one or the other, but not both.

Discomfort with IPV or OUD Providers' also expressed some discomfort with addressing IPV or OUD when these issues were disclosed. For example, providers whose primary role was in treatment for OUD or other services external to IPV expressed some reservation in discussing IPV with their patients. As one stated, "I like to stay in my own lane. I can only talk to them about the recovery aspect, and then I point them to social work. As soon as they say DV, I'm like, "let's bring the social worker in." Likewise, providers whose primary role was in provision of services related to IPV or other areas external to OUD, also expressed reservations about discussing substance abuse. One stated, "For me, the barriers are like a knowledge deficit, on how to handle that. I know some of the resources but it's not something that I deal with every day, so I don't know them that well." Thus, participants felt that they often lacked the experience, knowledge, or expertise in either IPV or OUD to be able to provide adequate care to patients experiencing both. As one participant stated about IPV, "I think that's a barrier to taking care of your patients, because you don't know what the resources are. There's an educational lapse on our part. I don't feel there was enough education, to be honest with you." Another

similarly stated about substance use, "I'm not trained on how to do that. I mean, I can talk to them briefly. There's [sic] a few things that I am OK with talking about, but I can't say that that's an expertise for me." Participants, therefore, often felt limited in their ability to address IPV and OUD as co-occurring issues. As one participant stated:

> One of the things that challenges us is not necessarily the desire to do it, because we want to do it, it's just the time it takes to appropriately ask the questions and then to match the resources in real time. We are reluctant to ask the questions that we can't address.

Provider Bias Participants also identified providers' own biases about patients experiencing Co-IPV/OUD during pregnancy or the post-partum period as a barrier. As one participant stated, "I feel like there's a lot of judgment towards woman that are in problematic relationships. I think sometimes the barrier [to treatment] could be the people that are taking care of the women." Another similarly stated, "If you see a child with injuries, mom's on Suboxone, there can be a lot of judgement evident in care sometimes, it's a "what a bad mom" kind of thing." Participants recognized, however, that such biases could translate into how providers treated patients. One participant stated, "Sometimes when providers hear that they have a history of use, or that they're pregnant, there's a history of unhealthy relationships, it's almost like it's a red flag that they're not going to take any of these women." Another participant offered:

> Another big barrier is stigma… I worked with a patient, she had used right before delivery, they took custody away and gave it to the significant other who was physically abusive. So, you didn't look at that picture nor did you care – you were just like, "that mom used…" And you didn't look at what was happening.

Thus, provider biases could have implications or negative consequences for patients – including patients' unwillingness to engage in care if they felt discriminated against or treated poorly. As one participant stated, "Some people in this profession – they're judgmental and don't even know they are! And that turns people off. People aren't stupid. You're not gonna see them again." Another provider similarly offered, "People have more stigma towards that population, that might have a client that is on Suboxone and pregnant, or just delivered, the baby's withdrawing. It is a barrier because it makes clients uncomfortable and not want to get treatment." Thus, providers' own biases and the ways in which they approached patients were seen as an additional barrier to providing care to this population.

Barriers to Co-Located/Coordinated Care

Shelter/Treatment Facility Requirements Participants described several barriers to providing co-located or coordinated care for this population; the first issue was shelter/treatment facility requirements for pregnant and post-partum women with Co-IPV/OUD. From a treatment perspective, participants recognized that many programs had stipulations on housing that presented difficulties for pregnant and post-partum women experiencing Co-IPV/OUD. For example, participants acknowledged that many IPV shelters often could not, or would not, accommodate women who were actively using. One participant stated "Most of the shelters won't allow people who are actively abusing to be in shelter. Most of them don't have a separate drug and alcohol rehab program. They're actively using, that's a barrier to finding shelter." Another similarly offered, "If you want access to housing, often there's a requirement that you don't use drugs. That's a barrier to someone facing violence from a partner [who] needs alternative housing, if they're using, that makes that extremely difficult to access." On the other hand, however, inpatient drug treatment facilities that provide transitional housing for women in recovery also were problematic – while many will accept women while they are pregnant, they must find new housing once they have given birth. As one provider stated, "Once they deliver with us, they can't live with us. We have that house, the [maternity care facility] house, but you can't live there unless you're pregnant. Once they have that baby, they're on their own." Another offered:

> Pregnant women are counted as single because they don't yet have a dependent child. They start their treatment in one program, have their child, and have to move into a new program. If they're pregnant with their first child, they don't qualify for any type of inpatient treatment for families. But they become a family and are uprooted again.

Thus, the intersection of pregnancy and/or the post-partum period with IPV and OUD made it particularly challenging for women experiencing these issues concordantly to find stable, long-term housing or shelter – something that women experiencing these issues independently might not encounter.

Barriers to Funding The second challenge to coordinated or co-located care for pregnant and post-partum women with Co-IPV/OUD was a lack of funding to provide additional services and/or expand services to integrate care. For example, one participant stated, "Funding, obviously. I think that we probably could offer more than we do right

now, we could do more." Another similarly stated, "I would love to work in an interdisciplinary setting, where there was everything. You have a psychiatrist and a medical doctor, someone who specifically deals with substance abuse, but financial issues in general are always a barrier." Participants felt, more importantly however, that there was a lack of willingness on the part of funders to invest in these types of care. As one participant stated, "There's so much stigma against this still that money doesn't want to be put there. I guess I feel like it's just a whole way we are as a society like, "why would we put money into that?" Another similarly stated, "So funding in general, the lack of like availability of services, there's just no funding for resources. And like the stigma behind women who are pregnant and in recovery is extremely difficult to overcome." Additionally, participants felt that funding mechanisms, such as Medicaid or private insurance, were not set up to support women with multiple co-occurring issues and/or only covered women when they were pregnant. As one participant stated, "It's really important to get third-party payers (i.e., private insurance, Medicaid) onboard with this… if you ignore the payer side of things, you won't end up with a healthcare system that is optimally useful to women with multiple problems." Another participant likewise offered:

> [The] people that are writing the checks and making the laws, and what healthcare will and won't cover… I think that people don't realize how much money it costs for kids to go in and out of foster care, and moms to go in and out of jail relapsing and this and that. That costs a lot of money. It's sad that it has to go down to the money, but I think it does.

Thus, participants recognized the need to secure funding streams for women experiencing Co-IPV/OUD and in particular, the need to expand coverage for women into the post-partum period.

Barriers to Working Across Agencies The last challenge to coordinating care was related to working across the numerous agencies that provide care for pregnant and post-partum women with Co-IPV/OUD. Participants recognized that in absentia of collocated care, their clients often have more needs than one agency alone can provide for – however, participants cited several difficulties in terms of referring patients to additional services. Some described a lack of information regarding what services existed, "We have a list of resources. But we never have an updated list…[A] barrier is not having a dynamic list with some very helpful information as to insurance, are they open to new clients, and their location." Another stated, "There's no way to know what's out there. If there were only one website or list, we could connect people easily, and not just give them a bunch of numbers but giving the right numbers for their situation." Others described difficulties in terms of successfully connecting with referral agencies, "Sometimes I don't get calls back from places, there's no follow-up, we did all these extra steps. But they didn't follow through with contacting our patient, or never returned my call, or anything like that." Another stated, "And even just calling back. They're probably just as overwhelmed as we are sometimes. So, they're dealing with all these different things, and they just might not return our call for a while." Others still described challenges in terms of timing and availability of services when making referrals. As one participant stated, "No availability. Maybe they'll have a therapist, but the patient won't see a psychiatrist for months. So… yeah, I think lack of availability. Long waits to get them in." Another similarly stated, "Say we wanted to place all these individuals into certain circumstances, there's not always an availability… Everything has to line up perfectly in order for the right thing to happen at the right time." Providers asserted that these challenges and their inability to help women connect with additional services in a timely manner had an impact on patient engagement. As another participant stated, "If it takes a really long time, then they're done – shut off, they're not going to come back, or they're going to feel uncomfortable, or they may throw up their guard again." Another participant similarly stated:

> We make the call, no one answers, or they don't have an appointment for weeks, that sometimes can be discouraging for residents… I think that can be discouraging, if somebody's ready right away to get treatment and help, and then they have to wait.

Thus, our participants identified several logistical challenges related to access and timely coordination of care across agencies to address co-morbidities among survivors of Co-IPV/OUD.

Discussion

We conducted 49 semi-structured interviews with providers across different service fields to understand what exist for caring for pregnant and immediately post-partum women experiencing co-occurring IPV and OUD. Participants reported barriers across multiple contexts of care, including the patient, provider, and system-levels. Women experiencing Co-IPV/OUD have a set of unique needs that may impact their care and outcomes related to pregnancy, IPV, and substance abuse. Providers and systems of care, therefore, may need additional resources to effectively treat this population and improve maternal and child health outcomes. This study has implications for thinking about ways to tailor care for women experiencing co-occurring IPV and substance

abuse disorders, and more specifically for pregnant and post-partum women with Co-IPV/OUD.

We found that pregnant and post-partum women face a kind of "triple jeopardy" when it comes to disclosing their experiences with Co-IPV/OUD to providers – the stigma and fear related to disclosure of IPV or OUD may be compounded not only by the co-occurrence of these two issues, but also by patients' pregnancy status. IPV and OUD are highly stigmatizing experiences and individuals who face these issues often do not disclose out of fear of being judged, labeled, and/or treated poorly in clinical settings (Burgess et al., 2021; Crowe & Murray, 2015; Huhn & Dunn, 2020; Joshi et al., 2021; Kennedy & Prock, 2018). However, women who are pregnant and/or have children often report greater barriers to treatment and cite fear of legal and custody consequences related to their children as a reason why they do not disclose or seek help for IPV and OUD (Burgess et al., 2021; Campbell et al., 2021; Hasselle et al., 2020; Hughes et al., 2011; Huhn & Dunn, 2020; Joshi et al., 2021; Kennedy & Prock, 2018; Phillips et al., 2021; Rhodes et al., 2010). Thus, it is not surprising that providers would report stigma-related barriers to disclosure as a challenge to treating pregnant and post-partum women experiencing Co-IPV/OUD. However, most of the research on stigma related to IPV and OUD has focused on only one issue or the other (i.e., only addressed stigma in IPV or OUD), with very few studies examining the complexities of stigma that occur when these issues are co-occurring (Joshi et al., 2021; Stone et al., 2021) and/or in populations of pregnant and/or immediately post-partum women (Joshi et al., 2021; Phillips et al., 2021). Much, therefore, remains unknown as to how pregnancy and/or the immediate post-partum period complicates help-seeking for women with Co-IPV/OUD, including help-seeking for needs beyond substance use, maternal and child health, and safety-related outcomes. Future studies should seek to understand ways to minimize disclosure related barriers and stigma for this population and ensure women feel empowered to seek help for both their IPV and OUD. Additionally, these findings suggest that programs that offer intervention for IPV and OUD may need a more multidisciplinary framework, or intervention approaches that seek collaborations across service contexts, and which help address the needs of women more comprehensively. Thus, this study points to the need to work across service contexts more holistically, and more specifically, to involve non-traditional service providers (e.g., members of the socio-judicial system, such as CYF or lawyers) in the process and/or to develop more medical-legal partnerships to improve outcomes (Josway & Chang, 2021; Phillips et al., 2021; Phillips & Warshaw, 2020).

We also found that both pregnancy status and substance use dependency may complicate women's ability to seek help for IPV. Specifically, women may be reluctant to leave an abusive partner when they are pregnant or have a child because they do not wish to "break up the family" or feel as though they cannot survive without the financial, housing, childcare, or other forms of support their partners provide. Thus, our findings support some of the extant literature which shown that women with children may be more likely to delay help seeking for IPV out of fear of losing what little support they have (Hughes et al., 2011; Meyer, 2016; Pallatino et al., 2021; Phillips et al., 2021; Rhodes et al., 2010). We also found, however, that substance abuse issues only serve to increase women's dependency on abusive partners and can further complicate their ability to seek help for IPV (Hasselle et al., 2020; Pallatino et al., 2021; Phillips et al., 2021; Phillips & Warshaw, 2020). Thus, women who are pregnant and/or post-partum and who are also OUD may encounter a greater degree of barriers when seeking help for IPV than women who do not have children or who are not substance use dependent; and their reliance on their partners for a complex matrix of support (e.g., financial, childcare, drug use, etc.) may leave them vulnerable to more severe and/or prolonged forms of abuse. Our findings, therefore, support the need for more programs which can provide wrap around services and/or a holistic set of support mechanisms for pregnant and post-partum women experiencing Co-IPV/OUD to help maximize their ability to seek help for IPV.

Relatedly, we also found that this population may also face greater challenges to their sobriety due to IPV and their pregnancy status. The role abusive partners play in their victims' substance use has been documented elsewhere and others have likewise found that abusers may seek to keep their victim in active addiction and/or sabotage recovery as a means of maintaining control (Macy et al., 2013; Pallatino et al., 2021; Phillips et al., 2021; Phillips & Warshaw, 2020; U.S. Department of Health and Human Services, 2020). Our findings, therefore, support the literature on IPV and substance use which suggests that partners may play a significant role in treatment outcomes, and that providers should be screening patients about the partners' involvement in both their substance use patterns and treatment decision-making (Warshaw et al., 2014). Our participants also, however, felt that substance use may serve as a coping strategy for women experiencing IPV and that the pregnancy and post-partum periods are high risk for relapse (Forray et al., 2015; Pallatino et al., 2021); thus, suggesting that women may *also* be using substances as a means of coping with the unique stressors related to new motherhood (El-Bassel et al., 2005; Hughes et al., 2011; Pallatino et al., 2021; Phillips et al., 2021; Warshaw et al., 2014; White & Chen, 2002). This suggests that the compounding issues of IPV and pregnancy-related stressors, such as post-partum depression, are a significant challenge to recovery for women with substance abuse disorders. Future studies should seek to include pregnant and post-partum victims' perspectives on substance

abuse coercion and the role that partners play in their substance use patterns. Such studies can assist in developing approaches to care that allow providers to attend to victim safety, while also ensuring access to treatment for substance abuse. Additionally, the intersections of post-partum depression, substance use, and intimate partner violence also needs to be studied further.

We also found several barriers that may prevent patients from receiving optimal care. Participants reported a lack systematic screening across treatment contexts for both IPV and OUD and expressed some discomfort in addressing these issues due to a lack of training or knowledge in one area of the other. Again, research shows that despite the knowledge that IPV and substance use disorders, such as OUD, are highly correlated, screening for both is rare across healthcare contexts (Bennett et al., 2016; Mason & O'rinn, 2014; Weaver et al., 2015). A recent systematic literature review conducted by Weaver et al., (2015) also found that very few effective or validated measures for screening co-occurring IPV and SUDs exist. Furthermore, the same review showed that issues such as a lack of adequate staff training and access to referrals can further impede providers' ability to screen conjointly for IPV and SUDs. Our study, therefore, supports the need for integrated, cross-disciplinary trainings or other educational interventions that can be applied across various healthcare contexts and settings, and which equip providers of different backgrounds with the knowledge they need to address Co-IPV/OUD and related comorbidities and accesses to essential needs (Macy & Goodbourn, 2012). Given, however, the high level of needs of this population, especially those who are pregnant or post-partum, our findings also suggest that coordinated care models, or those which utilize a multi-disciplinary team approach to deliver patient centered care may be most effective; thus, finding ways to encourage, empower, and incentivize providers to work across service provision silos is important and efforts should be made to help providers with additional screening and establishing the necessary linkages and referrals to further care, resources, and community supports (Burgess et al., 2021; Crowe & Murray, 2015; Humphreys et al., 2005). Such approaches may also serve to help reduce some of the provider bias against pregnant and post-partum women with Co-IPV/OUD reported in this study as well (Burgess et al., 2021; Crowe & Murray, 2015; Joshi et al., 2021).

Finally, our participants also reported barriers to providing coordinated care for pregnant and post-partum women with Co-IPV/OUD. Logistical and financial issues were both cited as barriers to coordinating care for this population. Others studies have likewise found that women with Co-IPV/OUD often face difficulties in terms of securing space in treatment facilities due to housing stipulations (Stone et al., 2021). For example, a study by Stone et al., (2021) found that women experiencing Co-IPV/OUD reported a lack integrated services for those with both needs and that it was especially difficult for patients with children to receive in-patient care. Given, as well, that our participants cited a need for coverage for women experiencing these issues that extends beyond pregnancy, our study suggests that women in the immediate post-partum period need to be better supported in their recovery from IPV and OUD; and that funding should be allocated to support agencies in providing post-partum services for this population (Weaver et al., 2015). Additionally, (Joshi et al., 2021). Our study supports the literature which shows that while co-located care would be ideal, finding ways to improve coordinated care, at minimum, could improve outcomes for this population and maximize patient engagement in care (Mason & O'rinn, 2014; Stone & Rothman, 2019; Weaver et al., 2015). Thus, our study suggests that efforts at integrating care for IPV and OUD are needed (Mason & O'rinn, 2014; Stone et al., 2021), as well as are initiatives which support agencies' ability to work across different service contexts need to be prioritized. Such efforts are important to reducing the burden of care placed on any given agency or service, as well as help to minimize some of the challenges agencies face in terms of referring patients with competing demands to additional services.

Limitations

This study has several limitations which are important to address. First, the study is focused specifically on barriers and facilitators to care for pregnant and post-partum women with Co-IPV/OUD and while our providers often framed their responses to our questions in terms of substance abuse more broadly, our findings may not be relevant to populations of women with other substance use disorders (e.g., alcohol, tobacco, etc.). This study was also conducted in a single county in coordination with one hospital that provided care for the study population. Thus, our findings may be isolated to this region and the various legal, social, and political influences specific to our region. Additionally, our sampling strategy and number of key informants also does not allow us to make comparisons between categories of participants. There may be differences in perspectives between IPV advocates, substance use providers, socio-judicial participants, CYF, etc. that we were not able to capture. We also chose to stop subject recruitment at 49 key informants. The addition of more informants—particularly those with positions or roles that had less representation in our sample—could have elicited new or different perspectives. Finally, the population of pregnant and post-partum women experiencing Co-IPV/OUD that is served primarily by the participating hospital where recruitment took place and the external agencies represented in this study represents a homogenous group of women who are predominately white; thus, our findings may

not be representative of providers' experiences with women of color or other populations.

Conclusion

Our study sought to understand what barriers exist to caring for pregnant and post-partum women experiencing Co-IPV/OUD from a diverse set of professional working across service contexts. Our participants noted challenges to providing comprehensive, coordinated care for this population across various levels and contexts of care. Our findings suggest that improving outcomes related to maternal and child health, IPV, and substance use in this population will require a more holistic approach – one which treats pregnant and post-partum women experiencing Co-IPV/OUD as whole people, and which seeks to integrate care across service domains and address the complex set of needs of this population. Furthermore, systems of care likewise need to be supported in providing this level of care. Future research should focus on continuing to include pregnant and post-partum women in research aimed at developing effective intervention strategies for women experiencing Co-IPV/OUD, and in the design of education, training, intervention, and other mechanisms for providers and systems of care that seek to improve outcomes around these issues.

Declarations

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Conflict of Interest None of the authors have a conflict of interest.

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