# Substance Use Coercion:
# Practitioner Perspectives of Women Accessing Domestic Violence Refuges and Therapeutic Communities in Western Australia

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## Abstract

Substance use coercion is a form of intimate partner violence and coercive control, in which the abuser weaponised drugs or the victim-survivor's drug use to exert power and control. Previous research in the USA has documented this form of abuse. However, in Australia the role of drugs in patterns of control are seldom recognised and the unique experiences and risk factors that women who use drugs face are largely ignored. Rather the role of drugs in intimate partner violence is often understood as an accelerant to the perpetration of physical abuse. Women who use drugs may face a number of barriers to seeking support for intimate partner violence, such a lack of worker expertise and a lack of integrated services. This research sought to identify how substance use coercion is manifesting for women who are accessing domestic violence refuges and alcohol and other drug therapeutic communities by conducting semi-structured interviews with workers in these services. Feminist theory and Narcofeminism underpinned the lens of the research due to intimate partner violence and coercive control being rooted in gendered power imbalances, and the experiences of women who use drugs being emphasised. Biderman's Chart of Coercion assisted to identify how illicit drugs are used coercively based on the methods outlined in the chart. Social Constructivism influenced the development of research and interview questions. The findings provided four themes to describe the tactics of substance use coercion being experienced, barriers victim-survivor's face in accessing support services, and suggestions to improve service response. This research was limited in that it did not interview women with lived experience due to the limited time to conduct the research. The broad focus on illicit drugs means trends associated with specific drugs or drug types could be missed. Despite these limitations, this research aimed to address the lack of research on substance use coercion in the Australian context. This research positions itself as a foundation for future research on substance use coercion in Australia to build upon.

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Date: 28 October 2024

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## Introduction

Intimate partner violence refers to the use of behaviours towards a current or former intimate partner (married, unmarried and living together, dating relationships) that cause physical, sexual or psychological harm (Australian Institute of Health and Welfare, 2024a). One in four Australian women have experienced intimate partner violence since the age of 15 (AIHW, 2024a). Often underlying intimate partner violence is coercive control. Coercive control describes the pattern of behaviours that aim to exert power and control over the intimate partner, depriving the victim of their autonomy, liberty, and self-worth (AIHW, 2024b). Trauma expert Judith L. Herman wrote in her seminal book Trauma and Recovery "The methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma." (1992, p. 112). There are a number of specific types of coercive control, and substance use coercion can be understood as a form of coercive control.

Substance use coercion may be understood as a form of coercive control, in which an abusive partner may exploit alcohol and other drugs (AOD) in order to exert power and control over the victim-survivor (Humphreys et al., 2024). This can involve introducing an intimate partner to drug use, and/or facilitating the progression from drug use to drug dependence, controlling other aspects of their drug use, sabotaging attempts at recovery, and using the victim-survivor's drug use to undermine their credibility (Phillips et al., 2020; Warshaw et al., 2014). Certain behaviours of abusive partners who use drugs have also been identified as being part of substance use coercion. For example, the abusive partner may use their own drug use to excuse the violence they have perpetrated (Humphreys et al., 2024). Drug intoxication and withdrawal may also be weaponised to gain compliance from the victim-survivor who may attempt to appease the abusive partner and prevent an escalation in their behaviour (Humphreys et al., 2024). However, this form of abuse and coercion has not been widely recognised or researched.

Illicit drugs are not often understood as being part of a pattern of control in intimate partner violence. Rather, illicit drug use and dependence is frequently associated with the perpetration of physical abuse and understood as a coping mechanism following abuse (AIHW, 2024c; Morgan & Gannoni, 2020). However, it is important to acknowledge the known links

between experiences of trauma and drug use. Trauma experiences at a young age and current experiences of physical violence are risk factors for drug use and transitioning to injection drug use (IDU) (NDARC, 2010). Moreover, women who inject drugs have disclosed experiences of childhood abuse, neglect, and foster care placements (Kitson & O'Byrne, 2021). Not only has sexual abuse been identified as a risk factor for drug use generally, with one study finding 49% of women who used drugs reported ever experiencing sexual abuse (Valencia et al., 2020), it is especially pronounced in people engaging in IDU and an earlier initiation into IDU (NDARC, 2010).

In addition to trauma being linked to future drug use, those who use drugs may experience increased levels of violence. In one study 71% of women who used drugs reported having experienced "at least one incident of serious physical injury by a male partner" (Valencia et al., 2020, p. 4). Illicit drug involvement in incidents of violence has been associated with higher odds of injury, and drug use is more likely to be present in intimate partner violence (IPV) and family violence (FV) than in other forms of violence (Coomber et al., 2019). However, it should be noted that 'victim' and 'perpetrator' was not specified and the study focused on incidents of physical violence, and as a result does not capture patterns of control surrounding drug use and IPV (Coomber et al., 2019). Moreover, drugs were grouped into broad categories of "stimulants" and "depressants", which may impact the interpretation of results. By using broad categories any context and potential trends surrounding drug use and violence may be missed. For example, people who use benzodiazepines and/or opioids may experience intense withdrawal symptoms (Brett & Murnion, 2015; Darke et al., 2024); people who regularly use methamphetamine may experience paranoia or psychosis (Glasner-Edwards & Mooney, 2014); GHB is a sedative and has been used to facilitate sexual assault (Bursadò & Jones, 2015). Moreover, between July 2019 and June 2020 in Australia 19% of domestic homicide victims "had illicit drugs or non-therapeutic levels of pharmaceuticals in their system" (Serpell et al., 2022, p. 8).

Women who inject drugs face unique risk factors for coercive control. Women are more likely than men to be injected by an intimate partner at initiation into IDU (NDARC, 2010). Women who continue to be injected by their partner may be more dependent on them, placing them at greater risk of IPV (NDARC, 2010). Additionally, physical and psychological IPV is

associated with a higher likelihood of unsafe drug using practices such as needle/syringe sharing, increasing their risk of contracting blood-borne viruses and other infections (Stoicescu et al., 2018). However, despite these risks being known, substance use coercion remains largely unacknowledged and under researched, particularly in Australia.

This thesis focuses on women's experiences of substance use coercion in intimate partner violence and the use of illicit drugs specifically. Furthermore, it focuses on the aspects of substance use coercion that involve victim-survivor illicit drug use, such as those identified by Warshaw et al. (2014), rather than aspects related to the abuser using their own drug use to extend power and control as identified by Humphreys et al. (2024).

The International Network of People Who Use Drugs language guide provides alternatives to language that could reinforce drug-related stigma (Madden & Henderson, 2020). When discussing drug use and people who use drugs the guide informs the language used when by suggesting terminology that is strengths-based and respectful (Madden & Henderson, 2020). For example, the guide suggests a person-centred approach to language first and foremost, and not defining the person by their drug use; avoiding victimising or sensationalist language, such as describing someone as "suffering from addiction"; choosing empowering language that emphasises the person's agency and choice; and avoiding slang and jargon (Madden & Henderson, 2020). As the advice of people who have lived experience of drug use should be acknowledged and valued (Madden & Henderson, 2020), this guide informs the language used throughout this thesis.

In regard to language used when discussing IPV and gender-based violence, each person has different preferences for how they and their lived experience is described. The term "victim" may be associated with passivity, weakness, powerlessness, and vulnerability, which some women may reject, whereas "survivor" has been imbued with ideas of strength and recovery (Thompson, 2000). However, for others "victim" has also been associated with innocence and not being at fault for the violence they had been subjected to (Thompson, 2000). Taking this and the understanding that identification with either term is personal to the individual into consideration, the term "victim-survivor" will be used throughout when referring to women who have experienced substance use coercion as it accounts for both identities.

# Literature review

## Illicit drugs and coercion

The lack of understanding of substance use coercion in research impacts how it is addressed in policy and practice and how women access support. This literature review will explore the ways that substance use coercion can manifest, and examine the research on women's experiences of stigma and service barriers which may prevent access to support. It will then outline the current policy landscape relating to IPV and illicit drug use in Australia to highlight existing knowledge and gaps in literature.

Research demonstrates the reality of substance use coercion for women and how it can manifest. A survey conducted through an American domestic violence hotline gathered data on substance use coercion (Warshaw et al., 2014). It was found that among 3,025 callers 27% reported being pressured or forced to use drugs by an intimate partner, and 24.4% said they had been afraid to call police due to their partner telling them they would not be believed and would be arrested for their drug use. Furthermore, 37.5% said their partner threatened to report their drug use to prevent child custody, obtaining a job, benefits or protective orders (Warshaw et al., 2014). 15.2% of respondents stated they had sought help for their drug use recently, and of those respondents 60.1% said their partner attempted to prevent or discourage this (Warshaw et al., 2014). Quantitative research points to the occurrence and prevalence of substance use coercion yet it lacks the nuance that can be gathered from qualitative research.

### Access and initiation

Substance use coercion can involve introducing an intimate partner to illicit drug use, and/or facilitating the progression from drug use to drug dependence. In her book Women of Substances journalist Jenny Valentish (2017) travelled Australia to investigate women's experiences of alcohol and other drug use. In this book she described the role of men introducing girls and women to drugs, acknowledging the power imbalance and reliance on the male partner that can be established in these scenarios (Valentish, 2017). Moreover, Valentish (2017) interviewed Dr Jennifer Johnston from the University Centre for Rural Health, Lismore, who said "The girls start using meth because these guys have good access to it. Then the girls become

dependent on the meth and reliant on the guy. The relationship turns sour. There's often a lot of domestic violence, or they owe the guy – or his friends – sexual favours" (p.109).

Expanding on the work by Warshaw et al. (2014), and providing rich insight to the experience of substance use coercion, Copes et al. (2020) conducted qualitative research on methamphetamine use and coercive control in rural Alabama. Although a small sample size and restricted to a specific geographic region, significant insights from victim-survivors and perpetrators of drug-related coercive control were gathered, highlighting how participants understand and explain their experiences. Abusive partners may control the victim-survivor's access to drugs, such as some male partners controlling how much of the drug their female partners use, when and where they use, the route of administration, and who they use with (Copes et al., 2020). Men explained their attempts to limit their partner's use in order to "protect" them from the negative effects of meth and to reduce the possibility their partner would have sex with other men (Copes et al., 2022). However, some men may seek to increase their female partners dosage as well, and this has been interpreted as a tactic to make them more dependent on both the drug and the partner who obtains it (Copes et al., 2022). This control over dosage may increase the risk of overdose as women may be misled about the amount they have been administered and their tolerance to the drug (Phillips et al., 2020)

Abusive partners may exert control over an intimate partner through controlling the route of administration, such as whether the drug is snorted, smoked or injected. A woman described how her male partner used physical violence to force her into injecting methamphetamine with larger gauge needles rather than smoke it: "I got locked in the bathroom, he hit me over the head with a flashlight until I did one" (Copes et al., 2020, p. 202). Abusers forcing their partners to use drugs with unsafe paraphernalia has also been reported, with implications for the victim-survivor's health also being reported (Phillips et al., 2020). If the victim-survivor is being forced to re-use a syringe this increases their risk of skin infection, abscess, and septicaemia (Marks et al., 2024). Furthermore, physical and psychological IPV is associated with a higher likelihood of needle and syringe sharing (Stoicescu et al., 2018), and if abusers are forcing their partners to share syringes, or the women are last in line for drug injecting equipment (Valentish, 2017), this can increase their risk of contracting a blood-borne virus such as Hepatitis C or HIV (AIVL, 2020).

Who uses the drug first may be controlled and enforced by an abusive partner, and this is especially true for women who use drugs intravenously and rely on their partner to prepare drugs and inject them. Women are more likely than men to be injected by an intimate partner at their initiation into intravenous drug use, and women who continue to be injected by their intimate partner may be more dependent on them, placing them at greater risk of IPV (NDARC, 2010). Women have disclosed their experiences with male partners self-injecting and becoming intoxicated before injecting her, which could lead to "indirect" physical injury, such as veins being missed (Wright et al., 2007). This could then lead to confrontations, which placed women at risk of violence: "it caused a lot of arguments and I ended up probably getting slapped and being told to wait and basically 'cos I couldn't do it myself, I had no choice" (Wright et al., 2007, p. 420). Elaborating on this, women have identified that violence is pervasive in drug economies, environments, and social relationships, and these environments tend to be controlled by men, reinforcing gendered power imbalances (Harris et al., 2024).

**Forced drug use and related activities**

Victim-survivors are subjected to forced drug use and being drugged in order to "keep them awake, induce paranoia, increase their sexual compliance, or impair their memory" (Phillips et al., 2020, p. 8). To illustrate, a woman explained how her male partners threats of violence led to her using drugs with him: "I was afraid of getting beat up. It was more of the fear of, if I didn't do what he says then something bad gonna happen to me or something to the kids" (Copes et al., 2020, p. 205). That ever-present threat and fear of violence can lead women to use drugs in order to dull those feelings and cope with violence (Kunins et al., 2007). Similarly in another study a worker stated "They can just get high and zone out and then maybe it doesn't matter if they're beat" (Gezinski et al., 2021, p. 116). Furthermore, in a qualitative study investigating the experiences of substance use coercion among women who were postpartum, women described being forced or pressured to use as a condition of their relationship, with some partners threatening to leave the relationship if the woman stayed sober (Fusco et al., 2024). Being drugged by an intimate partner was also described as a method of sabotaging the victim-survivor's AOD recovery (Fusco et al., 2024).

Beliefs about sex, drug use, and control have been described in some studies outside of Australia. Attempting to exert control over drug use may be tied to perceptions that injecting a drug with a partner increases intimacy, therefore men described wanting to prevent their partner from using drugs with other men (Copes et al., 2022). Additionally, women may share a syringe with their partner in order to demonstrate trust and promote intimacy (Valentish, 2017). Methamphetamine being perceived as a sex drug, particularly by men, led to expectations of sex while using, and it is these perceptions that had the potential to amplify paranoia about romantic partners being intimate with other men while intoxicated (Copes et al., 2022). These beliefs could lead to controlling and violent behaviour. Women have described experiences of being pressured into sex when they did not want it or in ways they did not want, sexual assault while unconscious from intoxication, and their drug use being used as justification for sexually abusive behaviour (Copes et al., 2022; Warshaw et al., 2014). An American survey on IPV and sexual violence found that of the women who reported AOD facilitated sexual assault (administered a substance without their knowledge), 43% of offenders were identified as intimate partners (Black et al., 2011). Moreover, some men who used methamphetamine held beliefs that women deserve to be physically or sexually assaulted if they resist sexual advances while using methamphetamine (Watt et al., 2017). Control associated with drug use and sex can also extend into sex work. Women who use drugs have disclosed experiences of being used for sexual and/or monetary gain by men they trusted (Kitson & O'Byrne, 2021). For instance, some women are encouraged or forced by their partner into exchanging sex for drugs, or into sex work to obtain money to purchase drugs (Macy et al., 2013). One woman explained how her partner forced her to "sell herself" to get money to buy drugs and it made her self-esteem "real low" (Macy et al., 2013, p. 892). Despite wanting their partners to engage in sex work to obtain drugs the male partners would also then berate their partner for engaging in these activities and use it as justification for physical violence (Macy et al., 2013).

**Drugs as punishment and apology**

Abusive partners may withhold drugs to punish or coerce into compliance, particularly as this may force their victim into withdrawal. For instance, a woman in one study said that her partner "wouldn't give me the dope if I didn't listen to him" (Abdul-Kabir et al., 2014, p. 314). Withdrawal symptoms vary for each drug but there are added withdrawal risks for certain types

of drugs which could require medical management to safely detox, such as with benzodiazepines (Brett & Murnion, 2015). The anticipation of withdrawal symptoms can cause distress, enabling the abuser to enforce demands and gain the victims compliance. This withholding of drugs may also work to demonstrate the abuser's power over the victim-survivor.

Gifting drugs following incidents of violence is another tactic abusive partners may use. For example, gifting drugs as an apology for violence was described by a woman who disclosed her partner would provide her with alcohol after beating her (Edwards et al., 2017). In another study that interviewed AOD treatment practitioners it was stated: "if the partner continues to feed [drugs to] the client, that helps them stay in control ... after they abuse them, then they'll get them high, and say it's okay, I love you. And, in her mind, she'll be thinking ... he really loves me; he didn't mean to hit me" (Kunins et al., 2007, p. 253).

## Stigma and other barriers

### Stigma and gender-role violation

Societal stigma directed at drug use and people who use drugs can prevent women who are using illicit drugs and experiencing IPV from accessing help, or it can reduce the quality of care they receive. Goffman (1963) defined stigma as the possession of an attribute that is "deeply discrediting", and they go from being a "whole and usual person" to a "tainted and discounted one" (p. 10). Goffman (1963) also introduced the concept of the "discredited", those whose stigmatised attribute is known, and the "discreditable" whose stigmatised attribute is being concealed. These concepts are applicable to both IPV and AOD use and its intersections.

Being a victim-survivor of IPV is a stigmatised identity and the Intimate Partner Violence Stigmatization Model assists to describe this stigma by describing 3 components: cultural stigma, anticipated stigma, and the internalisation of stigma (Overstreet & Quinn, 2013). Cultural stigma refers to societal beliefs such as victim-blaming attitudes and stereotypes about IPV and what a victim looks like; anticipated stigma is associated with concerns about how support networks will respond to disclosures of abuse; and the internalisation of stigma describes the extent the individual believes the stigma applies to them, manifesting as self-blame and shame, and

decreasing self-efficacy in seeking support (Overstreet & Quinn, 2013). These components of stigma may also be experienced by women who use drugs.

IPV victim-blaming is directed toward women deemed to be violating gender role expectations (Overstreet & Quinn, 2013) and research demonstrates that drug use is regarded as a transgression of the behaviour expectations placed on women. For example, IPV victim-survivor "alcohol abuse" is associated with higher levels of victim-blaming and self-blame (Sáez et al., 2020), and although the focus of this thesis is illicit drug use rather than alcohol and prescription pills these sentiments may be applicable to women engaging in illicit drug use as well. Furthermore, women who use drugs face more moral judgment than men do due to gendered expectations of women being "the moral guardians and reproductive agents of society" (Chang., 2020, p. 275). Stigma is associated with both injection drug use and "failing" as a woman, with some women who used drugs attributing their experiences of harassment and name-calling to perceptions that they were not capable of performing expected gender roles (Kitson & O'Byrne, 2021). Moreover, Australian FDV expert Cathy Humphreys wrote that women who are drug affected are not perceived as an "ideal victim, nor an ideal woman" (2023, para. 13).

**Isolation**

Stigma that is associated with drug use has an impact on women's capacity to seek help if they experience abuse, and abusive partners exploit these stigmatising attitudes to exert control. Abusive partners may hinder the victim's relationship with family and friends by telling, or threatening to tell, family and friends about the victim's drug use to undermine their credibility and prevent access to support, contributing to the victim-survivor's isolation (Phillips et al., 2020). To illustrate, in a Thai study about the tactics used by women who use drugs to resist violence it was said "Sometimes, I wanted to leave him, but I also had no one and nowhere to go. I could not go back to my family. He was a bad guy but I felt like he knew me more than my family" (p. 208). The abusive partner may sabotage the woman's relationship with people who do not use drugs, which also worked to sabotage recovery efforts (Fusco et al., 2024). For instance, women described their partner coming home intoxicated and causing a scene when they had friends over, or their partner complaining about their friends who did not use drugs to the

point that women would attempt to appease him by no longer seeing those friends (Fusco et al., 2024). Moreover, a woman in another study said "Drugs led us to believe that we were just bad people and that we deserved to be beaten by men because we were doing something bad" (Edwards et al., 2017, p. 79); this self-blame and shame points to the internalisation of stigma.

The abusive partners exploitation of stigma can also be used to impede their victim from seeking formal supports as well. In the American hotline survey 24.4% of respondents said they had been afraid to call police for help because their abusive partner told them they would not be believed or would be arrested due to their drug use (Warshaw et al., 2014). Abusive partners are aware that women who use drugs will be less likely to seek out support or report assaults, and this demonstrates how the criminalisation of drugs and policing can exacerbate gender-based violence (Harris et al., 2024). For example, one woman stated "The fact that you're doing something that's illegal and are less likely to want to go to the police, that makes you an ideal target" (Harris et al., 2024, p. 4). This reluctance to report to police is discussed in the following section.

**Negative experiences with formal supports**

As identified above, women who use drugs and experience substance use coercion may be reluctant to report abusee to the police. Although abusive partners exploit stigmatising attitudes and exaggerate the negative response the victim-survivor could receive, these women have genuine concerns about these potential responses. These concerns have been demonstrated in Australian and international research. For example, women who use drugs are among those who have received poor police responses following sexual violence (Women's Safety and Justice Taskforce, 2022, p. 154). A submission to Queensland's Hear Her Voice taskforce stated "Women involved in illegal drugs are often considered sluts willing to fuck anything for drug money, so when they claim they have been assaulted or raped their claims are dismissed" (Women's Safety and Justice Taskforce, 2022, p. 80). Additionally, women may be reluctant to seek help from police due to having witnessed police violence toward family members or fellow community members (Kitson & O'Byrne, 2021). Again, this demonstrates how the criminalisation and policing of drugs exacerbates gender-based violence, as women may experience stigma and discrimination in mainstream society with formal supports.

Women may be reluctant to seek assistance from health care services as well. Women who injected drugs have reported healthcare workers would go "from being personable to being cold" when their drug use became known (Kitson & O'Byrne, 2021, p. 345), consistent with the idea of becoming the "discredited" once the stigmatising attribute becomes known (Goffman, 1963). Among people who use illicit drugs in Australia, women are more likely to report experiencing stigma when accessing healthcare services, with 75% of 232 women reporting negative experiences with health care workers due to their injection drug use (Brener et al., 2024; Sutherland et al., 2024). In order to avoid negative experiences with health care workers women may avoid or put-off engaging with these services or won't attend follow-up appointments, downplay their need for pain medication, won't disclose their drug use, or seek out alternative health care services (Brener et al., 2024). This is especially concerning for women who use drugs and are experiencing IPV as they may not be receiving adequate treatment following violence or testing and treatment for blood-borne viruses.

**FDV and AOD service barriers**

Women who use drugs face other barriers when seeking support for IPV. Studies consistently highlight a lack of expertise about drugs in FDV services, as well as the strict enforcement of sobriety requirements. These sobriety requirements in FDV accommodation services mean women are turned away or are discharged from services for continued drug use, which means women may be returning to unsafe situations (Phillips et al., 2020). Over a 6-month period 79 out of 347 women in New Zealand refuges with AOD and/or mental health issues had their service withdrawn for reasons such as alcohol or other drug consumption and drug dealing (Hager, 2007), again, potentially returning to unsafe situations. Many FDV services may not be well equipped to respond to the drug-related needs of victim-survivors, and AOD services may not be equipped to respond to FDV-related needs due to limitations in funding and resources (Phillips et al., 2020). A UK study exploring barriers women experiencing IPV and substance use issues faced identified that professionals lacked awareness of the intersections between IPV and AOD (Fox, 2020). Similarly, the survey conducted by Hager (2007) revealed that another reason women were moved out of the refuge service was that staff felt they did not have the skills or expertise to work with them. Supporting this finding, interviewees in Fox (2020) stated

that AOD and IPV services were not integrated, presenting a barrier to some women who may not have the ability to leave their house whenever they want to.

For women who use drugs and experience gender-based violence and oppression, the link between drugs and gender is clear. However, similar to service barriers, in drug user activist movements this interconnection goes unacknowledged, and feminist organisations may view drug use as a reason to withhold support (Dennis et al., 2023). Narcofeminist activist Maria Plotko illustrated this, stating "women inside the drug user movement started to speak about specific women's issues and this was not understood by the men in this community" and "the issues of women who use drugs among the feminist movement are not discussed" (Bessonova et al., 2023, p. 748).

## Australian understanding and policy

### AOD and FDV services

Within Australian organisations and policy substance use coercion is largely unrecognised. From an online search ("Drugs women's refuges", "drugs women's shelters", "drugs domestic violence", "drugs coercive control", "drugs intimate partner violence", "substance use coercion Australia") substance use coercion is scarcely acknowledged by Australian FDV and AOD organisations, however in the state of Victoria some organisations have made efforts to raise awareness. For example, a webinar held in 2019 by AOD treatment organisation Turning Point was described as exploring substance use coercion and how drugs coexist with patterns of control in IPV; a Victorian AOD service provider conference was also held (Herd et al., 2019). Gippsland Family Violence Alliance produced resources about substance use coercion, one acknowledging the lack of research on the phenomenon in Australia (GFVA, 2023). LaTrobe Community Health Service (2023) also released an infographic describing substance use coercion and its manifestations. It is encouraging that there have been developments in this area, however it is not enough for a few services in one Australian state to address the reality women are facing across Australia.

### Policy and legislation

*Table 1. Australian national and state/territory policies*

| STATE / TERRITORY / NATIONAL | GOVERNMENT POLICY | SUBSTANCE USE COERCION MENTIONED? |
|---|---|---|
| National | National Principles to Address Coercive Control in Family and Domestic Violence | YES<br>Page 13 |
| National | National Plan to End Violence Against Women 2022-2032 | NO |
| Western Australia | Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020-2030 | NO |
| Victoria | Free From Violence: Victoria's Strategy to Prevent Family Violence and All Forms of Violence Against Women | NO |
| New South Wales | NSW Domestic and Family Violence Plan: 2022-2027 | NO |
| Queensland | Domestic and Family Violence Prevention Strategy 2016-2026 | NO |
| Northern Territory | NT's Domestic, Family and Sexual Violence Reduction Framework 2018-2028 | NO |
| Tasmania | Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022-2027 | NO |
| Victoria | Ending Family Violence: Victoria's Plan for Change | NO |
| South Australia | Committed to Safety: A Framework for addressing domestic, family and sexual violence in South Australia (ended June 2022) | NO |
| Australian Capital Territory | ACT Domestic and Family Violence Risk Assessment and Management Framework: Supporting an Integrated Domestic and Family Violence Service System | NO |

In Australia's domestic violence policy documents (see table 1), substance use coercion is described in only one: the National Principles to Address Coercive Control in Family and

Domestic Violence (Attorney General's Department, 2023, p. 13). The National Plan to End Violence Against Women and Children 2022-2032 does not recognise substance use coercion (Department of Social Services, 2022). Instead it refers to substance use in the context of child abuse reports indicating violence occurred more often when parents have AOD or mental health issues; acknowledging the prevalence of victim-blaming attitudes toward drug affected women; perpetrator interventions being incorporated with AOD services; and intentions for health and community services to be equipped with the skills to respond to gender-based violence and the interplay between FDV, AOD and mental health (Department of Social Services, 2022).

Not one state or territory FDV policy mentions substance use coercion, and AOD use is typically recognised as a contributing factor in the perpetration of violence, a risk resulting from experiences of family and domestic violence related trauma, or an area to enhance service provider collaboration, but not as being part of a pattern of control (Communities & Justice, 2022; Department of Territory Families, Housing & Communities, 2018; Queensland Government, 2021; Department of Communities, 2020). Moreover, Tasmania's Action Plan was described as drawing from the voices of victim-survivors but does not mention "substance use", "drugs", or even "alcohol" once, which could indicate a lack of representation of women who have used drugs and experienced IPV (Safe From Violence Tasmania, 2022). WA's consultation outcomes report on Legislative Responses to Coercive Control chapter 4.3 acknowledged the experiences of coercive control by specific groups, however did not acknowledge the risk and unique experiences of women who use drugs (Department of Justice, 2023). Similarly, chapter 5.1 discussed the barriers to support seeking in specific groups, again women who use drugs and their unique risks and experiences were left out (Department of Justice, 2023). Encouragingly, Victoria's family violence plan discussed creating specialist family violence advisers in major mental health and AOD services to ensure practitioners are better equipped to identify and respond to FDV (Government of Victoria, 2020), but what this looks like and whether knowledge surrounding substance use coercion is part of this is unclear. Moreover, Queensland's Hear Her Voice report one acknowledged that some victim-survivors are forced into criminal behaviour such as drug dealing, and drugs were recognised as an element of coercive control used by some perpetrators, but "substance use coercion" as its own form of abuse was not stated specifically (Women's Safety and Justice Taskforce, 2021).

New South Wales coercive control legislation came into effect in July 2024, an Australian first. In this legislation, although it mentions harm being caused to the current or former intimate partner if they do not comply with demands, behaviour that shames, degrades or humiliates, and depriving the person of their liberty and unreasonably regulating day-to-day activities, the examples provided of how these behaviours may manifest are minimal and do not include how drugs can be exploited to achieve this (Crimes Legislation Amendment (Coercive Control) Act 2022 NSW, s. 54F). If awareness of substance use coercion is lacking it may not be recognised in legal matters, leaving women who use drugs and experienced substance use coercion unprotected by the law.

Other states and territories are aiming to introduce criminalise coercive control, or are amending existing family and domestic violence legislation to recognise elements of coercive control. Queensland and South Australia are introducing standalone coercive control laws. Both states legislation provides examples of coercive control, such as coercing sexual activity, degrading, humiliating and punishing, use of threats, controlling ability to make choices in regard to their body, etc (Criminal Law (Coercive Control and Affirmative Consent) and Other Legislation Amendment Bill 2023; Criminal Law Consolidation (Coercive Control) Amendment Bill 2024). Some of these behaviours can be associated with substance use coercion, but the potential role of drugs in these behaviours are not explicitly acknowledged in the examples provided.

The Northern Territory made amendments to its existing FDV legislation, providing numerous examples of coercive control, including behaviours that can be seen in substance use coercion such as threats to disclose sensitive information and coercion to relinquish control over assets and income (Domestic and Family Violence Act 2007 (NT)). It also acknowledges there may be cases where both parties are committing acts of domestic violence, such as for their own protection, and in these cases the person most in need of protection should be identified (Domestic and Family Violence Act 2007, s. 4 (k)). However, despite the numerous examples provided, none of these examples specifically recognise the role of drugs.

Existing family violence legislation in Tasmania, the Australian Capital Territory, and Victoria describe acts of coercive control to varying degrees (Family Violence Act 2016 (ACT); Family Violence Act 2004 (TAS); Family Violence Protection Act 2008 (VIC)), including some that might be observed in instances of substance use coercion. Once again, none of the examples included the role of drugs and how drugs can be employed in coercive control and family and domestic violence.

There is currently no standalone coercive control legislation in place in Western Australia, and a phased approach to criminalisation is being undertaken, beginning with reform to the Restraining Orders Act 1997, and increased education and training for police and relevant stakeholders (Government of Western Australia, 2023).

With the role of drugs in IPV receiving brief mention in policies, typically from a view of perpetration and coping mechanisms, and FDV legislation not recognising or providing examples of drugs in coercive control perpetration, patterns of drug-related control are ignored at the highest level. Policies and legislation influence responses at the ground-level and with a lack of acknowledgement across policies it is made clear that there is a gap in awareness, and possibly concern, for women who are using drugs and at-risk of coercive control.

**Research**

Nearly all of the research or other sources relating to the role of drugs in coercive control discussed in this literature review were located in the United States of America. Other research that did not look specifically at substance use coercion but examined the intersections of FDV and drug use, or findings were consistent with methods of substance use coercion, were located in the United Kingdom, Spain, New Zealand, South Africa, and Thailand. The Australian research that investigated the role of drugs in family and domestic violence typically focused on drugs impacting on the perpetration of physical violence, rather than drugs being part of a pattern of control. Two reports was based in Queensland, Australia, (Women's Safety & Justice Taskforce, 2022; Women's Safety & Justice Taskforce, 2021) and one book explored women's experiences and journeys into drug dependence in Australia (Valentish, 2017).

Existing research carried out in Australia on substance use coercion has not been identified, demonstrating a gap in Australian knowledge on substance use coercion and a need for further Australian research, particularly as services, drug markets, trends, and laws differ in each country. However, Professor Cathy Humphreys from the University of Melbourne is one expert who has written about the issue, and in a letter directed to the National Consultation on Coercive Control recommended substance use coercion be acknowledged (Humphreys, 2022; Humphreys, 2023). Moreover, the KODY program in Victoria, which focuses on an all-family and integrated approach to AOD use and FDV, is being evaluated by researchers at the University of Melbourne, aiming to improve policy and services for families impacted by both issues (KODY Research Team, 2023). Acknowledging the work of the KODY (Kids First [Caring Dads] and Odyssey House) research team in calling attention to substance use coercion and its impact on families, especially children, it should be noted that this thesis differs in that the experiences of women victim-survivors is the focus, with no investigation into the impact on children.

# Methodology

## Theoretical Framework

### Social Constructivism & Feminist Theory

Social Constructivism posits that meaning is derived from our interaction with others and through the social, historical and cultural norms in which the person lives and works (Creswell & Poth, 2016). Social Constructivism influences this research by prioritising the use of broad questions, which is useful for gathering practitioner perspectives on their workplace interactions with service users, and allows them to "construct" the meaning of the experience that has been formed through those interactions (Creswell & Poth, 2016). Further, there is a focus on the context of participant experience (Creswell & Poth, 2016), which is relevant to the research being undertaken as the context and environments of crisis accommodation and treatment services will impact participant experiences with victim-survivors and how they construct these experiences.

Due to the gendered nature of the research Feminist theory influences the approach and interpretation of data in this research. Feminist theory highlights gender domination in a patriarchal society (Creswell & Poth, 2018), and IPV and coercive control are typically understood as a gendered issue "rooted in historically unequal power relations that view women and girls as subordinate to men and boys" (Department of Social Services, 2022, p. 32). In qualitative research feminist theory encourages the study of unequal power relations and how this can impact on women (Creswell & Poth, 2018). This understanding of gendered power relations in IPV and feminist theory enables the control surrounding drug use in intimate partner relationships to be revealed. Furthermore, the transformational aspect that can be found in feminist research is fitting for the topic under research given the aim of highlighting the experiences of women who use drugs that have been coloured by prejudiced viewpoints or rendered invisible (Creswell & Poth, 2018). An intersectional feminist theory argues that women's experiences are influenced by both their gender and other social categories (Lutz et al., 2011), and in research this allows complexities in women's experiences to be understood and analysed (Collins & Bilge, 2016). Moreover, having the awareness that multiple branches of identity and division possessed by an individual and community can influence each other assists

us to understand social inequality, power, and the lived experiences of individuals (Collins & Bilge, 2016). This is pertinent to this thesis, given the focus of the intersections of gender and drug use.

Narcofeminism, a term first coined in 2018 by women in Eastern Europe and Central Asia, also points out that gender-based oppression overlaps with oppression based on drug use (Dennis et al., 2023). Furthermore, it highlights that the issues faced by women who use drugs are indeed feminist issues, despite women who use drugs typically being excluded from mainstream feminist discourse and women's issues often being ignored in drug activism (Dennis et al., 2023). Additionally, this perspective encourages a more nuanced understanding of the various social, cultural and political forces that drug use occurs in, challenging the simplistic notions of drug use that persist (Dennis et al., 2023). Narcofeminist approaches have the potential to contribute to "drug policies that prioritise care and community over punishment and control" (Dennis et al., 2023, p. 945), which is the hope of this research. Although Narcofeminism rejects the sole focus on harm and pathology dominant in the existing literature on women's drug use (Dennis et al., 2023), as this research potentially adds to, this perspective remains imperative to the research being undertaken. This lens of Narcofeminism is imperative due to its concern with issues facing women who use drugs, which have been rendered invisible in both mainstream feminist discourses and drug activism (Dennis et al., 2023), and this thesis aims to bring light to substance use coercion as experienced by women. Although the researcher does not have lived experience of illicit drug use and dependence but does have experience in the harm reduction space and has witnessed drug dependence and drug-related harm in their relationships, the essence of Narcofeminism is present in this research.

## Biderman's Chart of Coercion

Biderman's Chat of Coercion has previously been used to describe the tactics of family and domestic violence. Evan Stark, forensic social worker and researcher who documented coercive tactics used in domestic violence and coined the term "coercive control", referred to the use of coercion against prisoners of war during the Korean War (Stark, 2007; Wiener, 2024). Stark (2007) wrote that psychologists Camella Serum and Margaret Singer identified that the tactics used by perpetrators of domestic violence were the same or similar to those documented

during the Korean War. Moreover, trauma expert and psychiatrist Judith Herman described Biderman's Chart in relation to gendered violence in two of her books (Herman, 1992; Herman, 2023). Herman (2023) elaborated on some of the coercive methods, such as describing how the alternation of rewards within a schedule of punishment not only instil the fear of death but also "gratitude for permission to live" (p. 31). Herman wrote that providing occasional indulgences to the victim-survivor works to undermine psychological resistance: "The hope of a meal, a bath, a kind word, or some other ordinary creature comfort can become compelling to a person long enough deprived" (1992, p.114). Adding to the description of degradation, Herman (2023, p. 31) wrote that this may involve forcing the victim-survivor to do things they find "humiliating and disgusting". She also acknowledged that drugs may be used and offered to debilitate and induce altered states in the victim-survivor, breaking down their sense of identity and bodily integrity (Herman, 1992; Herman, 2023). Jess Hill (2019) continued this use of Biderman's Chart to illustrate the process of coercive control in her book See What You Made Me Do. Excerpts from Hill's book were included in the NSW Joint Select Committee on Coercive Control (NSW Parliament, 2021).

In 1957 social scientist Albert Biderman published the report Communist Attempts to Elicit False Confessions from Air Force Prisoners of War. This report examined the tactics of coercion that American prisoners of war were subjected to while imprisoned by Communist Chinese forces during the Korean War, identifying 8 tactics that aimed to elicit confessions and compliance (Biderman, 1957). The Chart was also included in Amnesty International's 1973 Report on Torture. The methods of coercion that Biderman identified are outlined in table 2.

*Table 2. Biderman's Chart of Coercion*

| Tactics of coercion | Description of tactics and their aim |
|---|---|
| Isolation | aimed to cut the prisoner off from social support, promote dependence on the interrogator, and reduce their ability to resist |
| Threats | used to create fear and anxiety, and could include threats of physical violence or death against the prisoner or their loved ones, and the use of vague threats |

| | |
|---|---|
| Enforcing trivial demands | the enforcement of minute rules to foster complete compliance |
| Demonstrating omnipotence | the interrogator being confrontational, demonstrating complete control over the prisoner's fate, aiming for the prisoner to come to the understanding that resistance was ultimately futile |
| Degradation | the use of insults and taunts, unhygienic surroundings and prevention of hygiene, denial of privacy, and demeaning punishments, in order to reduce the prisoner to "animal level" concerns and to demonstrate that complying with interrogator demands would be less detrimental to their self-esteem than resistance |
| Inducing debility and exhaustion | reduced the prisoners will to resist by exhausting their mind and body, such as through over-working, sleep deprivation, semi-starvation, and prolonged interrogation |
| Monopolisation of perception | aimed at eradicating information that competed with the interrogators, fixing the prisoners attention to their current situation and exhausting actions inconsistent with compliance. This was established with barren environments and monotonous food in the case of POWs, however may present differently in scenarios of IPV; essentially, the abusers beliefs become the only truth that must be complied with |
| Occasional indulgences | hindered the prisoner's adjustment to harsh treatment and provided motivation for compliance, such as rewards for partial compliance, favours, and promises |

# Methods

## Recruiting participants

Purposive convenience sampling was undertaken for this research. This means that recruitment efforts were directed towards workers who likely had exposure to service users who experienced substance use coercion, and were then selected from those who responded to the research advertisement (Braun & Clarke, 2013). To expand on this, recruitment was conducted

through advertisement to organisations operating FDV refuges or AOD therapeutic communities in the Perth metropolitan and Peel region of Western Australia. The aim being to recruit practitioners who worked directly with women in these services.

Women's domestic violence refuges are crisis services, which were first established in Australia in the 1970s (Arrow, 2024), providing safe accommodation to women and children who are escaping family and domestic violence. Therapeutic Communities (TC's) are an alcohol and other drug treatment setting, which are based on the idea of "community as method" and informs the approaches taken (De Leon & Unterrainer, 2020). The underlying beliefs of therapeutic community and "community as method" is that the individual engages with the community and utilises the tools available within the community to achieve change and establishes expectations of participating in the community (De Leon & Unterrainer, 2020). In this model values are interwoven into the therapeutic community, such as accountability, honesty, and community involvement, which assists in recovery efforts (De Leon & Unterrainer, 2020). Moreover, the therapeutic community strives to look at the "whole person" rather than focusing purely on their drug use and dependence (De Leon & Unterrainer, 2020). The setting of a therapeutic community also plays a role in breaking the bond that the individual has to the drug, promoting a drug-free life (De Leon & Unterrainer, 2020).

Six organisations were contacted by phone call to briefly explain the research being conducted and ascertain an appropriate email address to send the research advertisement. The research advertisement was sent to the email address provided, which included a QR code that directed respondents to an online EOI form. In the email it was requested that the advertisement be disseminated to organisation staff who worked in refuge services or therapeutic communities. Of the six organisations contacted, three did not provide a response to follow-up emails and phone calls, and three provided a response agreeing to disseminate the research advertisement to staff. Respondents were contacted by the researcher and an interview date, time and location was organised. From the three organisations that agreed to assist, seven people made contact regarding the research, however two did not respond to follow-up emails, and one person advised their case load was too large to participate.

## Interviews

Participants were able to provide a preference for the location of interview, such as whether it was via an online meeting, in-person at their workplace, or in-person at a community centre or library. Participant information forms (appendix A) and consent forms (appendix B) were emailed to respondents, outlining the purpose of the study, what it involves, privacy, potential risks, and contact information for the researcher and the ECU Ethics Committee.

Four people participated in individual semi-structured interviews, and these interviews ranged from 20-minutes to 45-minutes long. Interview questions included introductory questions related to the participants organisational role and how long they had worked in that role, the substance use coercion tactics they had identified in referral and assessment or heard from service, what they perceived as barriers to service provision, and their suggestions to improve service provision to these victim-survivors (see appendix C).

Some participants described previous roles they had worked in, in addition to their current role. These work roles included managers, co-ordinators, advocates, and support workers. Some participants had experience in both FDV and AOD sectors, whereas others had only worked in one of these sectors. Some participants were relatively new to their work, while others had worked in the field for 10 years or longer. One participant described having lived experience of family and domestic violence and drugs.

Pseudonyms have been used to protect the identity of participants and the organisations they work for. Participants are described as either a domestic violence worker or a therapeutic community worker. See list of participants with pseudonyms:

Siobhan, domestic violence worker
Saoirse, domestic violence worker
Sloane, domestic violence worker
Shannon, therapeutic community worker

## Analysis

Braun and Clarke's method of thematic analysis was utilised for the data analysis process in order to develop themes within the participant interviews. In reflexive thematic analysis it is understood that all research is influenced, and this influence can come from the researcher who brings with them their own values, assumptions, biases, histories, and politics, and this should be regarded as a useful research tool (Braun & Clarke, 2013). According to thematic analysis themes are produced by the researcher through both the data and the theoretical assumptions, skills and resources the researcher possesses (Braun & Clarke, 2019).

Rather than provide a summary of the data, thematic analysis aims to make sense of and interpret the data using those skills and resources possessed by the researcher, promoting reflective engagement with the data (Braun & Clarke, 2013). Through this engagement themes are produced by the researcher (Braun & Clarke, 2013). There are 6-steps to thematic analysis: (1) familiarising with the data, (2) coding, (3) generating initial themes, (4) developing and reviewing themes, (5) refining, defining and naming themes, and (6) writing up and contextualising the data (Braun & Clarke, 2013).

To familiarise with the data, the researcher listened to the interview recordings twice, ensured the transcripts reflected the content of audio-recordings. The transcripts were printed and read multiple times, and through this familiarisation with the data codes were able to be produced. Statements were highlighted by the researcher and preliminary codes and notes were written for these statements. Both deductive coding (directed by existing theories and concepts) and inductive coding (directed by data content) were utilised in analysis (Trainor & Bundon, 2021). From the coding process themes were then developed. Themes must have a shared meaning and a "central organising concept" (Braun & Clarke, 2013). To clarify, codes describe one idea, and themes are made up of multiple codes relating to a central concept that conveys meaning relevant to the research questions (Braun & Clarke, 2013). The researcher created a table on a Word document to assist with the organisation of codes and themes. The themes were reviewed and altered when necessary to ensure there was a unifying concept that also relayed meaning rather than a summary of the data. Statements from participants were selected to illustrate those themes and sub-themes, which provide insight and meaning to the research questions. Some quotes were edited in minor ways to "tidy" them up in order to read cohesively;

there were no major edits that changed the meaning of these statements. Once themes had been developed the process of "writing up" the findings and providing further context to the data was undertaken, which involved relating the data to existing literature as well.

## Researcher positionality

Acknowledging the researcher's position is a form of reflexivity, which can refer to the researchers' attempt to neutralise the impact of their own subjective perspectives on the phenomenon under study, or instead to acknowledge that subjectivity and the influence it may have throughout the research process (Olmos-Vega et al., 2023). As discussed above, thematic analysis acknowledges that the researcher's experiences and skills influence the research being undertaken and cannot be set aside, rather it can be understood as a tool at the researcher's disposal (Braun & Clarke, 2013). Further, the researcher's status as an insider or outsider in relation to the topic under study can impact how research is conducted, analysed and communicated, and how the researcher engages with the research participants (Shaw et al., 2019). This is particularly important to consider when undertaking research on sensitive topics and research relating to vulnerable groups of people due to the power imbalances that potentially exist between the researcher and population being researched (Shaw et al., 2019). Futher, transformative feminist theory urges the researcher to be conscious of their own positions and how this can impact their interpretation of a woman and her experiences (Creswell & Poth, 2018), which is also consistent with thematic analysis.

The author of this research worked in a Needle and Syringe Exchange Program (NSEP) for 3.5 years, worked in a women's refuge for 2.5 years, and currently works in the co-ordinated response service, which is a domestic violence service based in police stations responding to high-risk domestic and family violence reports. It is the experiences and interactions in these roles that led to an interest in substance use coercion and motivated the author to undertake research. This prior understanding has the potential to impact on the research being undertaken, its methods, approaches, and interpretations. Moreover, the sample consisted of workers in FDV and AOD services and as such, the authors experience in these fields could impact interactions with participants during interviews.

The researcher is a white-Australian woman with a university degree and as such may experience social privilege that some women who use drugs may not experience. However, the author acknowledges their own lived experience of intimate partner violence and the lived experience of their family and friends, and also the women they have engaged with in their work. Furthermore, the author has witnessed drug use, dependence, and drug-related harm through their romantic, platonic, and familial relationships. The authors experience in the harm reduction sector also means significant time has been spent with people who use drugs, providing support and information on topics and issues relevant to those service users. These experiences impact the authors perspectives and therefore the research being undertaken, and as such the author has made efforts to approach the topic of substance use coercion and women's drug use with care and sensitivity.

**Ethical considerations**

The research undertaken was submitted to the Edith Cowan Human Research Ethics Committee and approved before the recruitment process commenced. The submission to the Ethics Committee involved careful consideration of any potential risks to participants, mitigating these risks, and ensuring informed consent was obtained. Examples of this was planning for the possibility a participant experienced distress during an interview and mitigating these risks. This was achieved by asking participants to consider this risk, providing information on where to get support if they do experience distress, and advising they can pause or end the interview at any time. Further, the confidentiality of participants, and also their service users was considered. Research participants were given pseudonyms and are referred to as either a domestic violence worker or therapeutic community worker in order to protect the identity of the participants and the organisations they work for. Due to this research asking for participant observations and experience working with vulnerable service users, participants were reminded of their obligations surrounding confidentiality of their service users.

## Findings

The perspectives of people working in domestic violence and drug sectors provide insights into the forms of substance use coercion women were experiencing, the barriers to supporting women who have experienced substance use coercion, and how responses could be improved for those women. The findings focus on four themes, which are outlined in table 2.

*Table 2. Themes and sub-themes*

| Theme | Sub-themes |
|---|---|
| Establishing & Maintaining Connection/Control | Drug use as bonding activity |
| | Drugs inhibiting decision making |
| | Using drugs to "keep the peace" |
| | Sabotaging recovery attempts |
| | Luring back to relationship with drugs |
| Controlling Drug Use & Associated Activities | Forced drug use and drugging |
| | Drugs used to facilitate sexual assault and coercion |
| | Withholding drugs to exert control |
| | Dose being controlled |
| Awareness, Attitudes & Consciousness-raising | Opportunity to speak about experiences of IPV and drug use |
| | Judgmental attitudes |
| | Lack of awareness of substance use coercion |
| | Shame and stigma impede support-seeking behaviour |
| | Stigma impedes provision of support to victim-survivors |
| Inadequate Services | Lack of integrated services |
| | Lack of knowledge about existing integrated services |
| | Co-occurring issues are difficult to address |
| | Refuge environments are challenging |
| | Strict policy & service criteria |

## Establishing and maintaining connection/control

Establishing and maintaining connection between the abusive partner and the victim-survivor, and by extension control over them was identified in interviews with participants. This presented in a number of ways, for instance women may be pressured or coerced by their partner into using drugs by encouraging it as an activity to be enjoyed together, a way to foster connection. For example, one participant highlighted methamphetamine specifically as a substance that abusive partners may encourage and coerce to use due to its connection to sex:

> "the massive thing about using like, meth for example, is it's great sex, right? So, there's probably that coercion to be like, 'well, let's just go have a fun time'" (Saoirse, domestic violence worker).

Additionally, one research participant, Sloane, mentioned that isolation from family and friends could operate as part of the coercion into using drugs. This isolation compounds the victim-survivor's dependence on the abusive partner as they become their main source of emotional connection and, perhaps their source of drugs as well.

Participants identified that abusive partners may attempt to sabotage women's recovery attempts in order to maintain the unequal power dynamic and control over them, and this could include offering or gifting drugs:

> "the women seem to break away from the perpetrator and try and get support around their addiction and stuff, um, but then it seems like the perpetrator pulls them back into that web of all the drugs" […] "And offering the drugs just to keep them with them" (Siobhan, domestic violence worker).

> "for example, the victim survivor then chooses to like, you know, go on a journey of recovery and not use anymore, there is that sense of loss of control and um, you know for them they're probably feeling like 'oh well she thinks she's better than me'. And then that dynamic sort of crumbles because maybe she's like, 'oh, actually I shouldn't be being treated like this' because she's not under the influence, she has more clarity. So, I think

> when there is that power imbalance in terms of using then maybe... there's intent there to, like, keep them using." (Saoirse, domestic violence worker).

This use of drugs to inhibit the victim-survivor's awareness and decision-making ability is another method of extending this power and control in the relationship that participants described:

> "keep them incapacitated and, you know, in their control." (Sloane, domestic violence worker).

> "really just inhibiting their decision making" […] "like, contributing to making you do something that I want you to do" (Shannon, therapeutic community worker).

> "Even just manipulating the dose, or what you think you're getting, or even that person may be unconscious or, you know, kind of too far gone a point where they can make an informed decision" (Shannon, therapeutic community worker).

Interestingly, participants noted that women may use drugs for safety, such as to keep the peace with their abusive partner, maintain that relationship and connection with them, or even to assist them to leave the relationship:

> "women who obviously use to keep themselves safe, um, just to be in that same sort of awareness and capacity as their perpetrator" (Saoirse, domestic violence worker).

> "the perpetrator's using drugs, so they just go into that, same as what the perpetrators doing, like to keep everything just running smoothly so it doesn't escalate" (Siobhan, domestic violence worker).

> "we've had someone recently who used drugs, all of the drugs she had, to build courage to leave. So, it's not always negative" (Saoirse, domestic violence worker).

## Controlling drug use and associated activities

The control abusive partners exert over access to drugs and the regulation of other aspects of the victim-survivors use of drugs was reported by participants, with multiple different methods of control described. To illustrate, multiple participants described working with women who disclosed being drugged by their abusive partner:

> "a lot of women say that they're, um, given drugs without their permission, so that could be through injection or through like, liquids in their drinks or anything like that" (Saoirse, domestic violence worker).

> "some of them have actually, like, didn't even know, they might have put it in their drink or whatever. Some of them don't know at all" (Siobhan, domestic violence worker).

This places women at increased risk of sexual assault, whether drugs are being used to incapacitate and facilitate sexual assault or women are being forced into sexual acts in order to obtain drugs for themselves or for their partner. This sexual aspect of substance use coercion was identified by all interview participants:

> "she wasn't aware that something was placed in her drink. She woke up, she was, um, obviously naked and felt like she may have been sexually assaulted but wasn't sure" (Saoirse, domestic violence worker).

> "sometimes I've found with some of the women I work with, it goes into further stuff like… sexual… like, yeah" (Siobhan, domestic violence worker).

> "It can also, it seems to be… quite sexual as well, sometimes" (Sloane, domestic violence worker).

> "I think also um, consent, it would be a huge risk, as in lack thereof" (Shannon, therapeutic community worker).

> "it can be, you know, women doing things that they may not want to be doing to receive drugs, to get drugs, because of drugs" (Shannon, therapeutic community worker).

Rather than drugging the victim-survivor without their knowledge, some abusers may force or pressure women to use drugs, and this may be achieved through threats or through physical force:

> "I want to say like 50% of women that come through and say that at one point in their relationships they were forced or felt pressured to use substances" (Saoirse, domestic violence worker).

> "A lot of it is very pushed onto the women at times, so obviously they get addicted, and then it just goes from there" (Siobhan, domestic violence worker).

> "threatening, I don't know, harm to themselves, pets, family members" […] "threats of harm to self and others would be it, would be a huge way" (Shannon, therapeutic community worker).

> "In some instances, they have been, um…Forcibly injected or, um, even bound" (Sloane, domestic violence worker).

On the contrary to forced use or drugging an intimate partner, abusers may even withhold substances from their partner or control the dosage of the drug:

> "that could either be withholding drug and alcohol. It could be giving drug and alcohol" (Shannon, therapeutic community worker).

> "Even just manipulating the dose, or what you think you're getting" (Shannon, therapeutic community worker).

Some of the risks related to these forms of substance use coercion were acknowledged by one participant. This included unsafe drug using practices and unsafe sex practices, which then increases the risk of contracting blood-borne viruses.

### Awareness, attitudes & consciousness-raising

The awareness, knowledge, and attitudes possessed by both victim-survivors and practitioners were identified by participants as potential barriers to either victim-survivors seeking support or the provision of support by workers. Some victim-survivor's may not be aware that their partners control surrounding drug use is indeed a form of abuse, and it was pondered whether women may be reluctant to speak about their experiences of drug-related control and IPV, and whether this could explain a broader lack of awareness in the FDV and AOD fields:

> "The women, I've found, struggle because they love this man but they don't see it as like, that he's doing harm to them in a sense" (Siobhan, domestic violence worker).

> "some women might hold back on some of their experiences around that coercion and maybe that's why there's not that much information out there, because there's a lot of shame and stuff probably attached to those things" (Saoirse, domestic violence worker).

Underpinning this sense of shame are the negative attitudes some workers, and the broader community, possess toward drug use:

> "I think they just feel that they're not gonna be believed, is the biggest one I get. I think their perception is that we're just gonna look at them and go 'nah, you're a drug user', you know, 'you brought it on yourself' […] and then being just perceived as a junkie, and having no validation of their struggles" (Sloane, domestic violence worker).

It was acknowledged that these attitudes may be due to some workers having limited education or experience about drugs and drug use:

> “maybe they've chosen, like, one pathway of studying and they haven't really addressed the AOD stuff yet, or maybe it's not as significant in their studies, you know, if you were doing specific training. Um, but yeah, absolutely. I've seen some pretty close minded, judgmental comments or attitudes, ways of working with those clients” (Saoirse, domestic violence worker).

Moreover, a focus on victim-survivors who are expected to jump through hoops to prove themselves as worthy of support and perpetrators not being held to account to the same extent was also described:

> “what I certainly see here is that our women, you know, they're going to the DCP [Child Protection] meetings, they're in rehab, they're trying. They're doing all these things, they're here with their kids. What's he [the perpetrator] doing?” (Shannon, therapeutic community worker).

However, research participant Shannon also emphasised that, in her experience, service users have not often described negative experiences with services, stating:

> “you hear the odd kind of thing, comments. Certain services, you know, having had horrible experiences, treated poorly. So yeah, you do hear it but I don't hear it a lot” (Shannon, therapeutic community worker).

Providing women with the opportunity to talk about their experiences, bringing to light the abuse that was intertwined with drug use, and workers being curious and allowing women to express this can be helpful:

> “if I feel the client's comfortable enough, will ask the question because I like to learn as well and I always say to them 'I don't understand because I've never used, so can you explain' […] they're knowing you're not being judgmental, you're just asking questions, you're curious” (Siobhan, domestic violence worker).

> "we've had a really, overwhelmingly beautiful and positive response to even just talking about FDV in like a psychoeducational manner. Our residents have really responded so so positively to that because it is such a veil dropping experience and they, like, the ability to relate in a community setting with other women who understand it" […] "we experience a lot of willingness from women who want to explore these parts of their story" (Shannon, therapeutic community worker).

However, the existence of services that do actively acknowledge and honour the intersections of drug use and IPV may not be well known:

> "I think overwhelmingly what I hear is that they have no idea that these sorts of services exist" (Shannon, therapeutic community worker).

Raising awareness and education on substance use coercion at a community level was also discussed by participants, and providing information regarding services and legal rights to victim-survivors through increased outreach programs was suggested.

### Inadequate services

Service policy, criteria, and environments may impede support seeking behaviours and the capacity of workers to provide adequate support to victim-survivors of substance use coercion. It was acknowledged that some refuges persist with zero-tolerance alcohol and other drug policies, and services may have strict criteria that women may not meet:

> "a lot of refuges still, or some of them are still in that very much like, 'if you've got AOD you can't come into refuge'" (Saoirse, domestic violence worker).

> "There just always seems to be so many boxes that you have to be in in order to get the help" (Shannon, therapeutic community worker).

This means that women are missing out on accessing the safety and support that refuges or other services can provide, or service may be withdrawn when the woman's drug use becomes known, therefore these victim-survivors may remain in or return to unsafe situations.
Co-occurring AOD, mental health, and IPV present another challenge in receiving supports:

> "The challenges are also their mental health. Um… You know, due to them using as well. Um, their mental health can be pretty bad. Um, their pattern of behaviour it's very up and down." […] "What we have found, there's a lot of psychosis there from the drugs, the trauma, the PTSD. Um… Yeah, it's a very difficult one to navigate and it is case by case. On a whole it makes our job here a little bit more complex" (Sloane, domestic violence worker).

> "what we're seeing as a trend, um we're seeing a lot more complexities, like mental health is just becoming so complex" (Shannon, therapeutic community worker).

> "the most challenging thing is just that there's co-occurring needs, and sometimes it's difficult to work out which came first. Umm, not that that matters, like, in terms of like supporting them and things like that" (Saoirse, domestic violence worker).

For women with co-occurring needs such as AOD and mental health issues, on top of having experienced IPV, receiving support from services can be difficult due to services often being siloed:

> "when you try and access mental health services they won't have a bar of it if there's AOD involved, and then if you try to go to AOD they kind of want you to stabilise your mental health first" (Saoirse, domestic violence worker).

> "we deal with domestic violence here, but we understand women come, a lot of other complex issues like drug related issues, and um, drug and alcohol and mental health" (Siobhan, domestic violence worker).

As a result of this, attempts to prioritise service user needs are made:

> "So, it's about identifying which one they want to prioritise, and you can sort of address that first, but sometimes that can be difficult" (Saoirse, refuge worker).

Women may have different priorities and motivations than the service provider. For example, they may not want to or be ready to address their drug use, and their priorities may change day-by-day. Moreover, due to communal living arrangements and services being required to consider all service-users who reside in refuge accommodation the individual's priorities cannot always be tended to:

> "it depends on where the woman is at at the time, whether she really wants to do it or if she's just doing it, you know, to be in a safe place and have a roof over her head so that's a challenge as well" (Siobhan, domestic violence worker).

> "And whilst some days, you know, the trauma is at forefront of the woman's mind and that's what's causing them a lot of, like, heartache and pain. Then other days maybe the cravings are like, the thing" (Saoirse, domestic violence worker).

> "obviously we want to be client-centred and follow the clients priorities and all those but sometimes that can be really hard when there's conflicting things going on in the house" (Saoirse, domestic violence worker).

Participants who worked in domestic violence services described how their service attempted to provide support for women with mental health and drug use, and what they believed services needed to improve service provision:

> "I think we need extra supports… to help the women get through it all" […] "we do the best we can, but it would be really good to have that, just drug and alcohol with them, with workers that understood the coercive control in the drug and alcohol use, because

I'm not sure how much, um, drug and alcohol services understand all of that" (Siobhan, domestic violence worker).

Additionally, participants from the domestic violence service described their in-house AOD/mental health support workers who women could be referred to in order to receive free counselling sessions, and these workers could also provide information and training to other staff on AOD and mental health issues:

"They know all the extra bits that we don't" (Siobhan, domestic violence worker).

Participants also mentioned that an AOD counsellor attended the refuge service one day a week, which emphasised the importance of collaboration between FDV and AOD services.

The environment of refuge services can be a challenge when accessing supports. Once accepted into refuge accommodation it can be an overwhelming experience for women, particularly when there is drug use involved, and conflict can arise with other service users:

"come into an environment where you don't know anyone, and you're with other women in this service and different workers and, you know, that's a challenge, and then trying to build up that rapport. And especially when they go into withdrawal because who can you trust? Who do you believe, you know? You're out of your comfort zone that you've just come from" (Siobhan, domestic violence worker).

"if someone is, you know, trying to remain abstinent and they're on their recovery journey, but then someone else is also in a similar situation, they only have their own different triggers and that can sort of raise conflict" (Saoirse, domestic violence worker).

"if there was someone that was heavily using meth and we had someone that was recovering from meth that would not be an appropriate intake. So... Yeah, that again is another negative and challenge that these women face" (Saoirse, domestic violence worker).

The necessity of ensuring victim-survivors feel safe and empowered was highlighted:

> "establishing safety in every sense of the word […] there are a lot of things that we have to do to make it a therapeutic community, but a lot of those things in itself provide safety and structure" (Shannon, therapeutic community worker).

> "we espouse a lot of values, but a lot of those values are about personal responsibility and accountability […] I think that empowerment really stems from that" (Shannon, therapeutic community worker).

The issue of accommodation for women, particularly once they leave the service, was also described, highlighting how it is often the victim-survivor who must leave the home:

> "There needs to be more places for women to go, women and children to go, um... yeah. Accommodation, as we all know, is always the thing" (Shannon, therapeutic community worker).

> "Therapeutic communities are already a long-term treatment option, but we made ours longer because we have women and children here and again, we don't wanna exit women into homelessness, so we kind of gave everyone more breathing space to complete the program" (Shannon, therapeutic community worker).

All workers in domestic violence described challenges in working with victim-survivors who used drugs. These challenges were related to the complexities of trauma, drug use, and mental health on top of the experience of IPV and the challenges of refuge environments. Whereas research participant Shannon, the therapeutic community worker, stated that she did not find it challenging to work with women who had co-occurring drug use and IPV. This could be interpreted as the nature and focus of the work, with domestic violence refuges being dedicated to addressing family and domestic violence, and are not designed to cater to drug use issues, whereas therapeutic communities are dedicated to addressing AOD concerns but not IPV.

From the insights gathered in the findings, links can be made to Biderman's Chart of Coercion (see table 3). As discussed above, the chart consists of 8 methods of coercion: demonstrating omnipotence, threats, induced debility and exhaustion, monopolisation of perception, occasional indulgences, degradation, isolation, and enforcing trivial demands (Biderman, 1957). All of the methods of coercion outlined by Biderman were identified in the findings, which demonstrates that drugs do indeed play a role in the coercive control and abuse experienced by some women.

*Table 3. Biderman's Chart of Coercion connection to themes*

| Methods of coercion | Examples of coding including pseudonyms | Themes |
|---|---|---|
| Isolation | "the women seem to break away from the perpetrator and try and get support around their addiction and stuff, um, but then it seems like the perpetrator pulls them back into that web of all the drugs" (Siobhan, domestic violence worker)<br><br>Code – Luring back into the relationship<br>Code – Sabotaging recovery attempts | Establishing and maintaining connection/control |
| Threats | "threatening, I don't know, harm to themselves, pets, family members" […] "threats of harm to self and others would be it, would be a huge way" (Shannon, therapeutic community worker) | Controlling drug use and associated activities |

| | | |
|---|---|---|
| | Code – Threats of harm to force drug use | |
| Enforcing trivial demands | "that could either be withholding drug and alcohol. It could be giving drug and alcohol" (Shannon, therapeutic community worker)<br><br>Code – Intimate partner withholds drugs | Controlling drug use and associated activities |
| Demonstrating omnipotence | "In some instances, they have been, um…Forcibly injected or, um, even bound" (Sloane, domestic violence worker)<br><br>Code – Forced drug use<br>Code – Forced injection | Controlling drug use and associated activities |
| Degradation | "it can be, you know, women doing things that they may not want to be doing to receive drugs, to get drugs, because of drugs" (Shannon, therapeutic community worker)<br><br>Code – Coercion into unwanted acts for drugs<br>Code – Coercion into unwanted acts while intoxicated | Controlling drug use and associated activities |
| Induced debility and exhaustion | "she wasn't aware that something was placed in her drink. She woke up, she was, um, obviously naked and felt like she may have been sexually assaulted but wasn't sure" (Saoirse, domestic violence worker) | Controlling drug use and associated activities |

| | | |
|---|---|---|
| | Code – Drugs as a tool to facilitate sexual assault<br>Code – Drugged by intimate partner<br>Code – Impaired memory and consciousness due to being drugged | |
| Monopolisation of perception | "for example, the victim survivor then chooses to like, you know, go on a journey of recovery and not use anymore, there is that sense of loss of control and um, you know for them they're probably feeling like 'oh well she thinks she's better than me'. And then that dynamic sort of crumbles because maybe she's like, 'oh, actually I shouldn't be being treated like this' because she's not under the influence, she has more clarity. So, I think when there is that power imbalance in terms of using then maybe... there's intent there to, like, keep them using" (Saoirse, domestic violence worker)<br><br>Code – Perpetrator loses control when partner stops using drugs<br>Code – Sabotaging recovery to maintain relationship and control | Establishing and maintaining connection/control |

| | | |
|---|---|---|
| Occasional indulgences | "And offering the drugs and, and just to keep them with them" (Siobhan, domestic violence worker)<br><br>Code – Drugs to lure back to relationship | Establishing and maintaining connection/control |

## Discussion

Through this research insights were gathered from practitioners in domestic violence refuge and AOD therapeutic community settings. Methods of substance use coercion being experienced by women, the barriers to accessing services and the capacity of services to provide support, and what practitioners believed is needed to better assist victim-survivors was described.

Interesting to note in the findings is how abusive partners used drugs to establish and maintain their connection with victim-survivors, and therefore control over them as well. Participants described abusive partners using drugs as a bonding experience with the victim-survivor, an action that helps to build intimacy. The use of drugs as fostering intimacy between partners has been identified by people with lived experience of drug use previously (Copes et al., 2022; Valentish, 2017). This can be interpreted as coercion through occasional indulgences due to the positive connotations being attached to the action. This works to keep the victim-survivor in the relationship and believing the abusive partner does indeed care for them despite the abuse, which has been described in previous research (Kunins et al., 2007). Furthermore, abusive partners luring the victim-survivor back into the relationship and back into drug use, such as by offering drugs, is another way that coercion through occasional indulgences is demonstrated. Occasional indulgences can be alternated with punishments, which may manifest as other forms of coercion described in this thesis.

Abuser behaviours and tactics of coercion that sabotaged the victim-survivors recovery was described in the findings and is consistent with findings from the hotline survey conducted in the USA and other prior research (Fusco et al., 2024; Phillips et al., 2020; Warshaw et al., 2014). These behaviours are also linked to what Biderman (1956) termed monopolisation of

perception, in which access to external information that could contradict the abuser is prevented. By accessing treatment or other support services victim-survivors may encounter those "veil dropping" moments that were described by one research participant. Those "veil dropping" moments refer to having clarity about their past or present experiences. These moments of clarity and access to external information and supports have the potential to weaken the abuser's power and control over the victim-survivor. Therefore, the abusive partner may take actions that impede the victim-survivor's recovery and access to services so that their worldview maintains supremacy. Preventing or sabotaging recovery also reinforces the isolation of the victim-survivor, as communication and support from external sources is prevented.

Within the theme of controlling drug use abusers forcing their intimate partner to use drugs through physical force or threats, and/or drugging without the partners knowledge, was identified by participants, which supports findings from previous research (Copes et al., 2022; Black et al., 2013; Phillips et al., 2020; Warshaw et al., 2014). Part of this research and data analysis was the use of Biderman's Chart to identify methods of coercion and how tactics of substance use coercion are applicable to those methods outlined in Biderman's Chart. For instance, forced drug use and being drugged without knowledge aligns with inducing debility and exhaustion due to the effects drugs can produce. Forced drug use and drugging can also be an example of demonstrating omnipotence, due to the use of physical force and violence, which works to communicate to the victim-survivor the futility of resisting the abusive partners demands. Although Biderman (1956) and Herman (1992) acknowledge that physical violence is not necessary for instilling fear and compliance, it may be used to enforce fear and compliance, as in cases of forcing drug use for example.

Sex and drug use appear to play a role in the perpetration of substance use coercion. This link between substance use coercion and sex was identified by all four participants, particularly in regard to methamphetamine, and this has been identified in previous research as well (Copes et al., 2022; Phillips et al., 2020). Moreover, research has pointed to the beliefs some men hold that women who use drugs are deserving of physical and sexual violence when they resist men's sexual desires (Watt et al., 2017), or that they are lying about not wanting sex while intoxicated (Copes et al., 2022). Whether drugs are employed to facilitate sexual assault or women are

coerced into sex acts when intoxicated or to obtain access to drugs, victim-survivors may find these acts, or the coercion and violence, "humiliating and disgusting" (Herman, 2023, p……) and damaging to their self-esteem. This points to the coercive method of degradation that was described in Biderman's Chart. The use of drugs to facilitate sexual assault or gain sexual compliance is also an example of inducing debility and exhaustion due to the effects produced by drugs, such as impaired memory, loss of consciousness, and impaired judgment, and has been described in research previously (Black et al., 2011; Phillips et al., 2020). Additionally, the use of sexual violence works to demonstrate the futility of resistance and the power the abusive partner has over the victim-survivor, which is consistent with the method of demonstrating omnipotence.

The withholding of substances and the control of dosage described by one research participant has been described in research conducted in the USA (Abdul-Kabir et al., 2014; Copes et al., 2022; Phillips et al., 2020). These tactics are indicative of enforcing trivial demands, as withholding a drug and inducing withdrawal symptoms help the abuser to gain compliance from the victim-survivor. Further, by controlling the dose of the drug the abusive partner is enforcing a demand, that is whether the victim-survivor consumes more or less of the drug. Another method of coercion that withholding drugs or controlling dose aligns with is inducing debility and exhaustion. Due to the effects of drugs varying depending on the amount consumed and also the withdrawal symptoms for drugs, this aids the abusive partner in exerting control over the victim-survivor. Additionally, this control over whether the victim-survivor can access the drug, whether they will go into a stress inducing withdrawal, or will be given a large and potentially lethal dose, demonstrates the abusive partners omnipotence. That is, it shows that the abusive partner wields power over the victim-survivors life and wellbeing, and the futility of resisting their demands.

The attitudes and knowledge that practitioners and victim-survivors do or do not possess could impact access to support. For instance, a lack of knowledge around substance use coercion could reduce the capacity of victim-survivors or practitioners to identify harm and coercion being inflicted. As Linda Lovelace, who was coerced into sex work and pornography, said "It started in such small ways that I didn't see the pattern until much later" (cited in Herman, 1992, p. 117). A lack of knowledge about the intersections of IPV and drug use among practitioners in

each respective field has been highlighted in research in the USA (Phillips et al., 2020) and New Zealand (Hager, 2007). This is significant because important aspects of a victim-survivors experiences and the perpetrators pattern of abuse remain unrecognised if practitioners are unaware of substance use coercion.

Feelings of shame associated with IPV and drug use may be a factor in a victim-survivors reluctance to speak about their experiences, and seek out and engage with support services. This shame can have its roots in the internalisation of stigma toward drug use and from the degrading acts the abusive partner has subjected them to. These feelings of shame and lowered self-esteem have been pointed out by women with lived experience (Edwards et al., 2017; Macy et al., 2013), and it is this shame that can contribute to the isolation of the victim-survivor. Further, this shame and stigma ties in with Goffman's ideas of the "discreditable" (attribute of stigma is concealed) and the "discredited" (attribute of stigma is known) (1963). Women may attempt to hide their own drug use to avoid judgment and stigma from services or others, which can be understood as a method of "impression management" (Goffman, 1963). This can extend to concealing their experiences of coerced drug use as well. Efforts to conceal these experiences may be carried out because once their drug use is revealed they become the "discredited". Abusive partners may exploit the stigma associated with drug use and threaten to disclose the victim-survivor's drug use to family, friends, police, and services (Warshaw et al., 2014; Phillips et al., 2020). Instilling fear in victim-survivors that they and their disclosures of abuse are not credible can compound their isolation. Providing more settings for victim-survivors of substance use coercion to express and understand their experiences, particularly with peers, could be one way to address this sense of shame, lack of understanding, and isolation. Research participant Shannon described how women in their service responded positively to being able to speak about their experience of IPV and drug use with other women who understood, and how this could be a "veil dropping" experiencing for them.

The barriers to support that victim-survivors face, or that services face when attempting to support them, were described by research participants. A lack of integrated services is a significant barrier victim-survivors face, and has been noted in research from the UK (Fox, 2020). The findings in this thesis expand on this, with participants describing the strict criteria of

services. For example, some refuges may not want to accept women into the service if they are known to use drugs, which means these victim-survivors may be remaining in, or returning to, unsafe situations. Furthermore, women experiencing co-occurring issues like mental health and AOD may not meet strict service criteria where support is directed at just one of those issues. Participants felt that more supports were required to better support women experiencing the complex interplay of drug use and IPV. For example, having workers within organisations who have expertise in AOD and/or IPV available to provide support to victim-survivors and other staff. Awareness raising campaigns could also be useful for educating both victim-survivors and workers in relevant sectors (family and domestic violence, child protection, and alcohol and other drugs) to improve knowledge about this form of abuse. Not only is there a lack of integrated AOD and FDV services, but for the few services that are integrated there may be a lack of awareness that they exist, as described by one research participant. This demonstrates the need for more integrated services to recognise and respond to the intersections of IPV and AOD. Further, there is a need to better promote those services that do exist and their referral pathways in order to reach more victim-survivors.

The research findings emphasised that victim-survivor priorities and motivations may clash with those of the service provider, and that refuge environments can be challenging for victim-survivors. Increased outreach services were suggested as a way to reach those victim-survivors who may not be ready to leave the abusive relationship. This was also pointed out in a UK study, explaining that women may not be ready to leave or able to leave the house for multiple appointments at different services (Fox, 2020). Outreach services could be beneficial for women who do not respond well to refuge environments and whose priorities are not consistent with a refuge service. Outreach services could be useful for women who continue using drugs, as this would mean victim-survivors are in contact with a service who can check-in, provide support and safety planning, reducing their isolation. In regard to AOD specific services, research has indicated that AOD services dedicated to women's experiences and needs are highly sought after (Harris et al., 2024).

Of note is how refuge workers identified more challenges in working with women who used drugs and experienced substance use coercion, than the therapeutic community worker. This

indicates that workplace and service environments impact how participants construct the challenges experienced with service users. To illustrate, the therapeutic community is dedicated to drug use and is set-up for working with people who use drugs rather than addressing IPV. Whereas refuge services are dedicated to responding to family and domestic violence, not to address women's drug-related needs, and practitioners may be working within strict policies and guidelines. Despite these challenges, participants described the ways that they and their services tried to support these victim-survivors. This included some FDV organisations having dedicated in-house AOD/mental health workers, collaboration between AOD and FDV services, and workers being able to access AOD or FDV related training to upskill. Moreover, workers described being comfortable to either ask victim-survivors questions or to challenge their colleagues' stigmatising attitudes toward victim-survivor drug use.

It can also be helpful to discuss what was not identified in the findings but has been reported in previous research to inform future Australian research on the subject. For example, abuser control over the route of administration of drugs, verbal abuse associated with drug use, using victim-survivor drug use as justification for violence, dictating who uses the drug first, and using drugs in a cycle of punishment and apology was not described by participants. However, this is likely due to the sample consisting of workers who may not have direct lived-experience of substance use coercion. It is possible that these, or other methods of substance use coercion, could be identifiable in future research consisting of a sample of women with lived experience of substance use coercion.

## Limitations

This research focused on the understandings FDV and AOD practitioners have of substance use coercion through their interaction with service users. It looked specifically at intimate partner violence, typically heterosexual relationships, and the use of illicit drugs broadly rather than a specific drug; alcohol was not a focus. This research enabled significant perspectives and observations to be gathered on this under-researched phenomenon in the Australian context. However, limitations must be acknowledged.

The lack of lived experience perspectives is a major limitation of this research. Due to the short time frame for data collection recruitment focused on workers and their observations rather than women with direct lived experience of substance use coercion. Although there is a potential that the participants could have lived experience of intimate partner violence, substance use, and substance use coercion, the questions asked were based on their observations and understanding in their professional roles. It is vital that future research on substance use coercion in Australia gather insights from those who have directly experienced substance use coercion and amplify these voices in order to better inform education and service response.

This study did not focus on one particular drug, only illicit drugs. This focus on illicit drugs broadly may mean that potential patterns and trends associated with specific drugs or drug types may not be identifiable. Future research could examine coercive control in relation to methamphetamine, for example, as meth was highlighted by participants as being the drug they often observed in cases of substance use coercion.

## Conclusion

This research gathered the observations and knowledge that domestic violence refuge and AOD therapeutic community workers have of substance use coercion through their interactions with service users, using thematic analysis to develop themes. Biderman's Chart of Coercion was used as part of the analytical process, helping to identify methods of coercion in regard to substance use. All aspects of Biderman's Chart were identifiable in the methods and tactics of substance use coercion that participants described. This strengthens our understanding of drugs being used in patterns of coercion and abuse.

Victim-survivor use of drugs to provide a sense of safety and feelings of courage to either keep the peace, be on the same level of awareness as the abusive partner, or to help them escape the relationship was an interesting component that arose in the findings. This pushes back on pervasive ideas that all drug use is "bad" and counter-productive. It also points to drug use acting as a protective function for some victim-survivors in scenarios of abuse and coercion.

The drug most often associated with substance use coercion was methamphetamine, which could be due to the current illicit drug market in Western Australia and methamphetamine being

more readily accessible than other drugs, or its association with sex. Future Australian research could explore methamphetamine and substance use coercion further.

This thesis also argued that women who use drugs face unique experiences of intimate partner violence and its associated risks, which should be recognised more. Especially as the policing and criminalisation of drugs contributes to this violence as they may experience drug-related stigma and discrimination in mainstream society, while also being subjected to gender-based violence in male-dominant drug markets.

With no Australian research on the role of drugs in coercive control identified at this time, this research adds a crucial missing element to existing drug research and family and domestic violence research. It also positions itself as a foundation for future research on substance use coercion in Australia. Furthermore, it adds to the existing and growing body of research on substance use coercion and the role of drugs in coercive control internationally.

It is imperative that substance use coercion become more widely recognised, and services be improved or created to better support women to break the cycle of violence and enable them to live with autonomy and dignity.

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# Appendices

## Appendix A. Participant information form

Chief Investigator: Dr Colleen Carlon
School of Arts and Humanities
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: 9780 7658
Email: c.m.carlon@ecu.edu.au

# Participant Information Letter

**Project title:**
Substance Use Coercion: Practitioner Perspectives of Women Accessing Domestic Violence Refuges and Therapeutic Communities in Western Australia

**Approval Number:** 2024-05445-CARLON

**Chief Investigator:** Dr Colleen Carlon

**Student Investigator:** Sheridan Robbins

**An invitation to participate in research**

You are invited to participate in a project titled Substance Use Coercion: Practitioner Perspectives of Women Accessing Domestic Violence Refuges and Therapeutic Communities in Western Australia. This project seeks to gather practitioner understandings and experiences of clients' substance use coercion that are encountered in the practitioners' work. You are being asked to take part in this project because you are employed at a family & domestic violence refuge service or women's only therapeutic community and have interacted with clients who have experienced substance use coercion.

This research project is being undertaken as part of the requirements of an Honours degree at Edith Cowan University.

Please read this information carefully. Ask questions about anything that you do not understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative or friend.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read;

- Consent to take part in the research project;
- Consent to be involved in the research described;
- Consent to the use of your personal information as described.

**What is this project about?**

This project aims to understand worker persepctives of women's experiences of substance use coercion in their intimate partner relationships. Substance use coercion refers to the coercive tactics associated with a victim-survivors drug use that a perpetrator may use to exert control and power over them. This research project aims to assist the enhancement of recognition and acknowledgment of substance use coercion in Australia's domestic violence and alcohol and other drug sectors, to ideally improve service responses for women experiencing substance use coercion.

**What does my participation involve?**

Your participation in this research project will involve a one-on-one interview with the student investigator. Interview questions will be open-ended and will be audio-recorded for transcribing to ensure the researcher is able to effectively analyse interview data. Interviews will last between 30 minutes and 1 hour.

**Do I have to take part in this research project?**

Your participation in this research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any time. However, once data has been collected withdrawal will not be possible. If you do decide to take part, you will be given this Participant Information Letter and Consent form to sign and you will be given a copy of the information letter to keep. Your decision to take part, or to take part and later withdraw, will not affect your relationship with the research team and Edith Cowan University.

**Your privacy**

By signing the consent form, you consent to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. You will be de-identified by

providing pseudonyms and the organisation/service you work for will not be named e.g. “Mary*, who worked at a refuge service in Perth, stated…”. Audio-recordings of the interview will be stored in ECU’s secure systems that only the research team will have access.
Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

It is important to acknowledge that the student investigator, Sheridan Robbins, is employed at a family and domestic violence refuge and in an alcohol and other drug service. Please be aware Sheridan is one of the researchers and will be directly involved in the data collection and analysis.

Please be aware that your role in the domestic violence and/or alcohol and other drug sectors may be recognisable, even when de-identified, when published in the public domain. Please be aware of this during the interview. Please consider any likely impacts this could have on your personal and professional standing, the professional standing of your organisation as well as on your familial, social, and professional networks.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except where requested for specific reasons, and then you will be asked to provide written consent.
In accordance with relevant Australian and/or Western Australian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this letter if you would like to access your information.

All data collected will be kept in accordance with ECU’s Data Management Policy. Electronic data will be stored on a secure Microsoft SharePoint site provisioned by ECU’s IT Services and physical records will be stored as required in ECU’s Records Management Policy. The data will be retained for a minimum of 7 years after date of research publication and then destroyed if appropriate at the end of the retention period (section 14.6.5 WAUSDA guidelines). Data will be

*de-identified* when stored and at the end of the retention period, the data will be destroyed, if appropriate under the State Records Act.

**Possible Benefits**

This research may not provide benefit to you personally but it may provide benefits for women who have experienced substance use coercion and access services in the future, and may be beneficial for workers in domestic violence and alcohol and other drug services by enhancing knowledge.

**Possible Risks and Risk Management Plan**

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. If you become upset or worried as a result of your participation in the research project please seek the advice of your GP or relevant health professional. You may also wish to contact:
Lifeline: 13 11 14
13YARN: 13 92 76
Alcohol and Drug Support Service: (08) 9442 5000
Beyond Blue: 1300 224 636, online chat service at www.beyondblue.org.au
1800Respect

**What happens when this research study stops?**

We will advise you of the outcomes via email. We also intend to publish our results in research journals and present them at research conferences locally, nationally and internationally. Your name or any other identifying information will not be included in any of the publications or presentations.

**Has this research been approved?**

This research project has received the approval of Edith Cowan University's Human Research Ethics Committee, in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2023)*. The approval number is 2024-05445-CARLON.

**Contacts**

If you would like to discuss any aspect of this project, please contact the following people.


| **Chief Investigator** | **Student Investigator** |
|---|---|
| Dr Colleen Carlon | Sheridan Robbins |
| Lecturer – School of Arts and Humanities | Bachelor of Arts Honours student |
| Edith Cowan University | Edith Cowan University |
| P: 9780 7658 | E: srobbin1@our.ecu.edu.au |
| E: c.m.carlon@ecu.edu.au | |


If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:


**Independent Person**

Research Ethics Advisor

Edith Cowan University

P: 6304 2423

E: research.ethics@ecu.edu.au


If you wish to participate in this research, please sign the Consent Form and return to srobbin1@our.ecu.edu.au

Sincerely,

**Sheridan Robbins**

Student Investigator

## Appendix B. Participant consent form

Chief Investigator: Dr Colleen Carlon
School of Arts and Humanities
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: 9780 7658
Email: c.m.carlon@ecu.edu.au

Student Investigator: Sheridan Robbins
Bachelor of Arts Honours student
Email: srobbin1@our.ecu.edu.au

# Participant Consent Form

**Project title:** Substance Use Coercion: Practitioner Perspectives of Women Accessing Domestic Violence Refuges and Therapeutic Communities in Western Australia

**Approval Number:** 2024-05445-CARLON

**Chief Investigator:** Dr Colleen Carlon

**Student Investigator:** Sheridan Robbins

I, _____ have read the Participant Information Letter or someone has read it to me in a language that I understand. By signing this consent form, I acknowledge that I:

- have been provided with a copy of the Participant Information Letter, explaining the research study
- have read and understood the information provided
- have been given the opportunity to ask questions and have had questions answered to my satisfaction
- can contact the research team if I have any additional questions
- understand that participation in the research project will involve:
    - a one-on-one interview lasting up to 1 hour, which will be audio-recorded for transcribing
- understand that the information provided will be kept confidential, and that my identity and the organization that I work for will not be disclosed without consent

- understand that I am free to withdraw from further participation at any time, without explanation or penalty
- freely agree to participate in the project
- the data and/or samples collected for the purposes of this research project may be used in further approved research projects provided my name and any other identifying information is removed

*I agree to have my conversations audiotaped*

*Yes* ☐ *No* ☐

Participant name: _____

Signature: _____ Date _____

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Approval to conduct this research has been provided by the Edith Cowan University's Human Research Ethics Committee, approval number 2024-05445-CARLON, in accordance with its ethics review and approval procedures.

## Appendix C. Research interview guide

Before interview

- Interviewer introduces self
- Brief overview of the research project
- Potential for distress: explain what will happen, supports available
- Explain the right to skip questions, pause or end interview
- Confidentiality of service users: remind participants to not use names or identifying details of their clients
- Remind of audio-recording, anonymity & use of pseudonyms
- Consent form

Interview

Introductory questions

- How would you describe your job position and role?
- How long have you worked in this role?
- What is your current understanding of "substance use coercion"?

Client experiences

- What is your understanding of the role of illicit drugs in control and violence experienced by women you have worked with? E.g. through reading referrals or hearing disclosures from clients
- What have women told you about the methods perpetrators have used to coerce them into using drugs?
- Do you think there is intent from perpetrators to get the women dependent on drugs?
- Is there a particular drug you see this coercion with more than others?

Challenges & barriers

- What do you find challenging about working with these clients?

- What is your understanding of the challenges these women face when accessing support services?
- What are your views of staff attitudes towards illicit drug use and clients who use drugs and how it impacts the provision of support?
- What is your perception of the support and training provided from your workplace in regard to drug use, IPV and its intersections?

Improving support & responses

- What do you believe is needed to improve the support provided to women experiencing control related to their drug use?

Conclusion

- Are there any other comments you would like to add or anything else you want to talk about?

<u>End of interview</u>

- Advise of the dissemination of research results
- Remind participants of supports available in case of distress
- Thank participant for their time