April 2023

CRIME VICTIMS' INSTITUTE

COLLEGE OF CRIMINAL JUSTICE
SAM HOUSTON STATE UNIVERSITY

Executive Director: Mary M. Breaux, Ph.D.

Rural Residents Experiencing Co-Occurring Intimate Partner Violence and Substance Use Disorder: Recommendations for Service Providers

Rebecca Stone, Ph.D.
Scarlett R. Crossman, B.S.

Introduction

In recent years, rural communities in the United States have seen an increase in rates of substance use disorder (SUD) and drug-related crime, injuries, and deaths (Chen et al., 2021; Florence et al., 2021). While the impact of the opioid epidemic has certainly been felt across the urban-rural spectrum, opioid-related mortality increased more in rural than in urban areas. Between 1999 and 2016, the age-adjusted opioid-related mortality rate increased by 682% in micropolitan nonmetro counties and 721% in noncore nonmetro counties (Rigg et al. 2018). Fentanyl, an extremely powerful synthetic opioid, has been found throughout the drug supply and is driving much of the drug-related overdoses and deaths (CDC, 2022). At the same time, rural communities are also witnessing a rapid increase in methamphetamine use (NIDA, 2021), sustained high levels of harmful alcohol use (Friesen et al., 2021), and polysubstance use like mixing stimulants and depressants (Bunting et al., 2020; Ellis et al., 2021), which carries a high risk of overdose.

There is a well-known bidirectional relationship between substance use and intimate partner violence (e.g., Cafferky et al., 2018; Devries et al., 2014; Foran & O'Leary, 2008; Stone & Rothman, 2019), such that alcohol and drug use may precede abuse by an intimate partner and that experiencing IPV is related to subsequent drug use. Survivors of IPV may cope with physical and emotional injury through substance use or develop a dependence on a substance prescribed to treat a specific IPV-related condition (Bennett & O'Brien, 2007; Schumacher & Holt, 2012; Warshaw et al., 2014). Survivors may also experience symptoms of post-traumatic stress, which is associated with increased substance use (Rivera et al., 2015).

IPV and SUD are intertwined and addressing their co-occurrence in rural communities should be a priority for health and justice agencies. In this report, we provide a review of the literature on partner violence and substance use in rural communities, particularly in Texas and similar contexts. We then outline the specific challenges for rural survivors and service providers and make recommendations to improve access and close gaps in services.

Rural Substance Use

Across the country, access to quality health services, mental health services, and substance use are top priorities for rural stakeholders (Bolin et al., 2015). However, there is great diversity in and between rural communities and they each have unique combinations of challenges and resources, especially when it comes to substance use. In the northeast region of the U.S., overdose deaths are driven by opioids, particularly the synthetic opioid fentanyl (Center on Rural Addiction, 2023). Rates of opioid overdose deaths are also high in West Virginia, Maryland, and Ohio. In other rural areas in the midwestern (e.g., Ohio, Illinois, Indiana) and southwestern U.S. (e.g., Louisiana, west Texas, Nevada) methamphetamine-related arrests and overdose deaths are rapidly increasing (Velázquez & Remrey, 2022). Some rural areas are experiencing epidemics of polysubstance use, like the co-use of opioids and stimulants. Polysubstance use trends are shaped by differences in the availability of certain drugs and may also be influenced by lack of healthcare coverage or treatment availability in rural areas as people attempt to self-treat psychiatric or physical illnesses and past trauma (Ellis et al., 2021).

Rates of substance use disorders and substance use-related injuries and deaths in rural communities are shaped by many factors at the societal, interpersonal, and individual levels. At the societal level, rates of substance use are shaped by economic inequality and deprivation, population decline, and limited health resources (Ciccarone, 2019; Dasgupta et al., 2018; Monnat, 2018; Monnat, 2019, Woolf & Shoomaker, 2019; Zoorob & Salemi, 2017). For example, counties with high levels of manufacturing employment losses, population decline, community health problems, residential mobility, and disadvantage have seen higher rates of overdose deaths (Feldmeyer et al., 2022), and the relationship between economic distress and drug mortality rates is stronger in rural areas (Monnat, 2019). Employment losses and economic distress can also contribute to interpersonal-level predictors of substance use, like family stress and conflict (Keyes et al., 2014). Overall poverty rates are higher in rural areas (16.6%) than in urban areas (13.9%), and poverty rates are particularly high among rural Black, non-Hispanic and Hispanic populations (Economic Research Service, 2022).

At the individual level, a recent study found that women make up a greater proportion of people who use drugs in rural areas than in urban areas (Ellis et al., 2021). Rural populations with opioid use disorder were also younger, more likely to rely on their social networks for income, lack healthcare coverage, and have a high school education or less. Polysubstance use was highest among young adults, those with co-morbid psychiatric issues, and lack of healthcare coverage (Ellis et al., 2021). Importantly, while isolation is a risk factor for substance use (e.g., Ingram et al., 2020), the social networks of people who use drugs often feature overlapping "confidant" and "co-use" relationships – that is, the same people that they rely on for social support are the people with whom they use drugs. These "multiplex" ties are associated with higher polysubstance use (Gauthier et al., 2022).

Rural Intimate Partner Violence

It is difficult to measure the exact prevalence of intimate partner violence. Relying on law enforcement data can underestimate the true prevalence because only about half of all incidents are reported to the police (Morgan & Truman, 2019). Keeping this in mind, the Texas Department of Public Safety *Crime in Texas 2021* report shows that the annual number of family violence incidents in Texas continues to climb, increasing by 9% from 2019 to 2020, and by 8% from 2020 to 2021. The Texas population increased by approximately 2% in the same time period (USA Facts, 2022), suggesting that the increase in the number of incidents is not simply due to population growth. In 2021, 22.6% of all recorded family violence incidents occurred within marital relationships, with the largest proportion of these (17.1%) committed against wives, ex-wives, or common-law wives. 35.7% of all family violence incidents involved a victim categorized as "Other Female Family Member". The age groups with the highest number of victims are the 20-24, 25-29, and 30-34 year old groups. Of offenders whose sex was known, 72.9% were male and they were most likely to be in the 25-29 and 30-34 year old age groups. Areas with the smallest populations (Under 2,500 Population) had the lowest clearance rate for family violence crimes (37.1%) (Texas Department of Public Safety, 2021).

While women in urban, suburban, and rural areas may experience statistically similar rates of IPV, there are important distinctions in their experiences. For example, rural women are more likely than their suburban or urban counterparts to experience violence when separating from or divorcing their spouses (Rennison et al., 2013). Women in rural areas experience more incidents of severe physical violence and begin to experience violence earlier in a relationship as compared to urban women (Logan et al. 2003; Websdale & Johnson, 1998; Peek-Asa et al., 2011). Rates of intimate stalking (Logan et al., 2006) and intimate partner homicide also appear to be higher in rural areas (Edwards, 2015). Key features of rural life, like geographic and social isolation, traditional gender roles and patriarchal attitudes, and economic hardship in rural communities all contribute to women's experiences of IPV and their strategies for response (Riddell et al, 2009). Many rural communities espouse traditional conservative beliefs in which a man is the head of the household and the wife plays a subordinate role, which can result in tolerant attitudes towards IPV or belief that IPV is a private matter (Annan, 2008; Dudgeon & Evanson, 2014; Riddell et al., 2009). Such attitudes may contribute to victim-blaming, like asserting that the victim 'must have done something to deserve it' (Eastman et al., 2007). There may also be a reluctance to confront issues of IPV as a community out of fear that highlighting it may contribute to perceptions of rural residents as "backward, dumb, and violent hillbillies" (Sandberg, 2013), further contributing to the marginalization of rural communities and survivors.

Low population density and great geographic area means that survivors in rural communities may live far from service providers. The mean distance traveled to the nearest IPV resource is three times greater for rural residents than for urban residents , and rural IPV services offer fewer on-site shelter services and must stretch slimmer resources over a greater geographic area (Peek-Asa et al., 2011). In addition to geographic isolation, rural residents experiencing IPV may also face an absence of employment and housing options, limited or no public transportation, and stigmatizing attitudes about IPV (Lanier & Maume , 2009; Logan et al. , 2001; Van Hightower & Gorton, 2002). Even if programs are accessible, they may not have the capacity to serve their communities. Rural residents are more likely to perceive that providers are busy because demand for services outstrips the supply of providers and to identify the need for service expansion (Logan et al., 2004). A study of urban and rural IPV service providers found that they were more likely than urban service providers to report that their agencies were understaffed and under - resourced, and that their clients had multiple concurrent issues that could not be treated by their agencies (Eastman & Bunch 2007 ; Eastman et al., 2007).

How are IPV and Substance Use Connected?

There is a long-established relationship between alcohol use and IPV (Foran & O'Leary, 2008; Devries et al., 2013; Wilson et al., 2014). There is also evidence of a relationship between other types of substance use and IPV perpetration and victimization, though these relationships vary by type of substance, its pharmacological effects, and other contextual factors, including the timing of substance use and IPV – that is, whether the substance use precedes or follows IPV perpetration or victimization. For example, some studies find significant relationships between IPV and stimulants like cocaine and methamphetamine (Gilbert et al., 2012), whereas the evidence of a relationship between IPV and cannabis use is much more mixed (e.g., Smith et al., 2014; Testa & Brown, 2015). Between 31% and 67% of women in SUD treatment settings report experiencing IPV during the past year, and 47% to 90% report experiencing IPV in their lifetime (Rivera et al., 2015).

Both intoxication and withdrawal can preempt IPV perpetration (Gilchrist et al., 2019). Additionally, abusive partners may exercise control by introducing their partners to drugs, forcing or coercing their partners to use, using drug history as a threat (e.g., threatening with arrest, deportation, or loss of child custody), and sabotaging treatment and recovery efforts (Warshaw et al., 2014). Studies highlight the physical and social isolation of women in abusive relationships, which results in low social support, and a desire to demonstrate 'respectability' by keeping their partnership intact (El-Bassel et al., 2001; Illangasekare et al., 2014; Rajah, 2006). Women also explained how substance use increased violence, paranoia, and jealousy in the relationship, as well as heightened conflict during periods of withdrawal, if women were unable to procure more drugs, in arguments over sharing of drugs, and when women sought treatment (Andrews et al., 2011; Gilbert et al., 2001). These findings suggest that the period immediately before and at initiation of treatment may represent heightened risk of violence.

Challenges for Rural Residents Experiencing IPV and SUD

Geographic Isolation and Transportation

One of the greatest challenges for rural residents experiencing IPV and SUD is geographic isolation, which means that they may live far away from resources like grocery stores, medical facilities, and treatment providers, as well as from informal sources of social support like family members and neighbors. In this sense, geographic isolation and social isolation are intertwined, and this relationship was emphasized during the COVID-19 pandemic. A recent rapid review of the literature revealed that, worldwide, geographic and social isolation are associated with an increased risk of IPV (Mojahed et al., 2021). A study based in rural Vermont found that participants reported geographic isolation and lack of transportation as major barriers to leaving abusive relationships and seeking treatment (Stone et al., 2021). Participants in this study reported that their abusers controlled access to vehicles and weather-appropriate clothing, keeping them isolated at home, and that neighbors, towns, and SUD treatment facilities were not within walking distance. Where public transportation existed, it ran infrequently and at inconvenient times.

Social Isolation and Stigma in Small Communities

There is a tendency to romanticize close-knit rural communities where 'everybody knows everybody' and there is always a neighbor to lend a helping hand. At the same time, rural residents are also known to value self-reliance and to distrust outsiders, which has been documented as a barrier to help-seeking (e.g., Fischer et al., 2016; Keller et al., 2020; Snell-Rood et al., 2017; Starcher et al., 2017). While communities may indeed be generally helpful and supportive, this does not always translate into meaningful assistance in situations of IPV. Residents of rural communities may still be reluctant to intervene in "private" problems like IPV and SUD (Banyard et al., 2019). For example, young adults in rural communities explained that "people aren't likely to get involved" in dating violence or domestic violence issues and that people are "willing to help with like community issues … but when it comes to like individuals, [or] personal problems, they won't [help]" (Banyard et al., 2019: 344). This is particularly difficult when the person experiencing IPV may have a reputation as someone involved in substance use, because both IPV and SUD are highly stigmatized (e.g., Earnshaw, 2020; Kennedy & Prock, 2018; Murray et al., 2018; Zwick et al., 2020). Community members may be least likely to help someone they perceive has "brought it on themselves" (Banyard et al., 2019: 345) or who are blamed for their circumstances.

Access to SUD Treatment

Though access to SUD treatment in rural areas has increased in recent decades, availability still falls short of the demand. This is particularly true for women, who face unique barriers to comprehensive care. Women are less likely than men to seek treatment for SUD, for reasons including fear of stigma, violent intimate partners, and lack of childcare (Andrews et al., 2011; Stone, 2015). Programs specifically tailored to women's needs have higher retention or lower drop-out rates, are effective in reducing substance use, and are more successful in reducing barriers to care (Grella, 2008; Campbell & Alexander, 2005; Hser et al., 2011; Ashley et al., 2003). However, facilities providing women's services like trauma-related care, intimate partner violence support, childcare, and housing assistance were all more likely to be found in urban locations than in nonmetropolitan counties (Terplan et al., 2015), indicating that rural women are likely severely underserved.

Medication-assisted treatment (MAT) is the "gold standard" approach for treating opioid use disorder, specifically, and typically involves the use of medications like methadone, buprenorphine, or naltrexone (e.g., Wakeman et al., 2020). However, rural residents face significant challenges in accessing MAT. A recent systematic review of rural-specific barriers to MAT identified common barriers including: a lack of clinics and providers in rural areas, travel hardship when seeking care from distant providers, and provider stigma toward people with SUDs (Lister et al., 2019). The number of medication treatment clinics per 10,000 residents remains significantly lower in rural areas versus urban areas (Grimm, 2020; Hirchak & Murphy, 2017).

A study in Washington state (Kvamme et al., 2013) found that isolated rural areas had the lowest provider-to-population ratios and that physicians who could prescribe buprenorphine were more likely to be primary care providers (versus some other specialty). Psychiatrists also made up a large proportion of buprenorphine-waived providers but were more likely to be located in more densely-populated areas. Primary care providers in public "safety net" settings like health clinics may be the most accessible MAT entry point for rural residents, especially now that the waiver requirement has been removed (SAMHSA, 2023). However, the low number of treatment providers in rural areas may mean that people in abusive relationships where both parties are receiving SUD treatment may find themselves using the same provider, which could increase the likelihood of dangerous encounters.

Access to IPV Services

Rural survivors already face a lack of IPV service providers, and this is especially true for survivors who are seeking IPV service providers with knowledge of SUD and recovery. Service providers in rural areas often face difficulty recruiting and retaining skilled staff and experience high staff turnover rates (Faller et al., 2021). The mismatch between provider resources and community need contributes to staff overwork and burnout (Faller et al., 2021), with fewer opportunities for professional support and continuing education (Cook-Craig et al., 2010). Rural IPV agencies struggle to compete for grant funding against peer organizations in areas with higher populations (Cook-Craig et al., 2010) and may have fewer options for inter-agency collaborations with, for example, mental health and substance use treatment providers (Van Deinse et al., 2019).

A review of 43 service guidelines and training manuals for community-based IPV and sexual assault coalitions commented on advocacy services for IPV survivors who have substance abuse problems. The review highlighted the tension between the importance of serving all survivors, and the recognition that addressing substance use problems is beyond the scope of what most agencies could offer and that such survivors may put staff and other clients at risk (Macy et al., 2009). For example, shelter staff have expressed concern that children in the shelter will witness substance use or find drug paraphernalia (Rothman et al., 2018). Shelter staff also frequently express the need for specialized training. A survey of 205 victim service providers from a variety of organizations in a rural state found that 49% of respondents felt that new victim service providers needed specialized knowledge about trauma symptoms and 25% identified a need for training about substance abuse (Desrosiers et al., 2017).

IPV service providers may also have conflicting perspectives on their role in responding to a client's substance use. A survey of IPV shelter staff in Rhode Island found a variety of policies and practices when responding to clients with SUDs (Rothman et al., 2018). For example, shelters differed in whether they screened for SUDs at shelter intake, whether shelter residents must be "dry" or "sober" to stay there, and whether they kept Narcan (naloxone, an overdose-reversing drug) on their premises. Some programs had specifically trained staff to administer Narcan, while others were opposed to keeping Narcan on hand and training staff to administer it because they did not see themselves as medical professionals and worried about their liability.

Finally, rural residents face great challenges in accessing IPV services that can accommodate their language and cultural needs. There is a lack of research on the experiences and needs of rural survivors who are members of minoritized races and ethnicities, speak languages other than English, or are not U.S. citizens (National Advisory Committee on Rural Health and Human Services, 2015). Formal IPV services in the U.S. have their roots in the second-wave feminist movement which centered the experiences of White, middle-class, heterosexual women and largely relied on law enforcement responses to gendered violence (Mehrotra et al., 2016; Macy et al., 2010; Richie et al., 2021). This history is visible in the present, where immigrant survivors and survivors of color continue to face racism, xenophobia, language barriers, and deportation threats (Levine & Peffer, 2012; Reina et al., 2014; Vidales, 2010; Wachter et al., 2019). The Texas Family Violence Council (TFCV, 2021) has identified the need to expand service accessibility for Spanish-speaking survivors, as well as increasing the number of service providers who can support survivors speaking Urdu, Arabic, Chinese, Vietnamese, and French. Limited service capacities and ineligibility for services due to legal immigration status hinder access to traditional IPV services in Texas (Wachter et al., 2022).

Recommendations

Expanding Service Access in Rural Areas

The problems of providing reliable, timely, and convenient public transportation to rural communities persist and are unlikely to be resolved in the near future. Service innovations may help to close this gap. For example, expansion of 'microtransit' or other shared-use mobility options (for example, Godvarthy et al., 2019; Rodier & Podolsky, 2017) may be appropriate, though implementation of such services is likely to intersect with related issues of internet/phone service as well as stigma and discrimination toward people with SUD. An alternative would be to expand the integrated home visitation to bring services directly to those who need them or extending service reach by bringing resources (including staff) to community locations like local grocery stores and pharmacies (for example, Lowrie et al., 2019) that are more likely to be accessible by limited rural bus service or within reasonable walking distance. Outreach materials could be provided to local businesses; ideally, service providers may consider a rotating schedule where staff cycle through different community locations on different days of the week.

Partnerships with local primary care providers are key, as these can be important sites for connection to both SUD treatment options and IPV service referrals. Family physicians are a key point of contact with rural residents for screening and intervention for IPV and SUD. They are more likely to be accessible to rural residents than specialist services, which may serve much larger geographic areas and thus require significant travel for care. Major medical organizations recommend IPV screening by family physicians (e.g., U.S. Preventive Services Task Force, 2019), but some evidence suggests that rural physicians may not practice routine screening due to limited visit time, lack of training, limited services to offer clients or doubts about their effectiveness, and concern that screening for IPV would damage the doctor-patient relationship (McCall-Hosenfeld et al., 2014). This highlights an important frustration for both clients and providers: the perceived pointlessness of screening and disclosing problems when there are no services or solutions to offer. One way to expand service availability is to increase the number of family physicians who are able to prescribe MAT. While psychiatrists make up a larger proportion of approved buprenorphine prescribers than family physicians, they are much less likely to practice in rural areas (Wingrove et al., 2016). Now that the waiver requirement has been dropped, we are hopeful that more rural family physicians will take an active role in responding to SUD and preventing overdoses in their communities.

The COVID-19 pandemic presented an opportunity to implement long-recommended teleservices like phone and video check-ins and online support groups. However, the limitations imposed by poor telecommunications infrastructure and the expense of internet/phone service and internet-ready devices limited the reach of these services, suggesting that – for now, at least – teleservices may be a useful addition to service offerings but cannot fully replace in-person services. To maximize the potential of teleservices to reduce barriers to healthcare for rural populations, we must invest in telecommunication infrastructure and consider innovative approaches to expanding broadband internet access. For example, in Vermont, some areas are exploring communications union districts (CUDs), which are organizations of two or more towns that join together to build fiber-optic communication infrastructure to deliver internet services (State of Vermont DPS, n.d.), typically in areas with population densities below what is typically seen as profitable for private internet service providers. Additionally, states may be able to make use of federal funds to expand broadband internet access in rural areas (Landen, 2021).

Beyond the logistics of improving access to telehealth, there are also client safety issues to consider. Teleservices may help to protect the privacy of service users, but providers must be cognizant of clients who share a living space and may not be able to share safely in a video conference. In these situations, in-person office or home visits may be preferable. Providers should defer to the clients' preference as to what is comfortable and most useful for them, with reasonable safety precautions to protect all parties. Service providers should also prioritize the safety, privacy, and dignity of their clients. Where possible, clinic waiting areas should be relatively private and not require service users to line up outside the building. Take-home medication dosing privileges would help to ameliorate both geographic and social barriers to care by reducing the frequency of in-person office visits.

Constraining IPV and SUD Workforces

Numerous experts have called for cross-training of IPV and SUD providers on topics regarding the nature of the other issue and the overlap between the two issues, screening and referral practices, and responding to disclosures of IPV or SUD (Bennett & Bland, 2008; Edwardsen et al., 2011; Macy & Goodbourn, 2012; Zweig et al., 2002). However, there are a number of challenges associated with cross-training IPV advocates and SUD recovery counselors. For example, IPV and SUD services are built on different approaches, which has led to distinctly different methods of service and treatment delivery in each sector (Bennett & O'Brien, 2007; Macy & Goodbourn, 2012; Zweig et al., 2002). Whereas IPV services have used empowerment models, SUD treatment historically has utilized a medical model of addiction, which holds that addiction is a chronic disease, and emphasizes medical and behavioral treatments (Humphreys, 2005). Providers also cite a lack of resources including staff and funding to develop new policies and deal with more complex treatment models, time to restructure services, and cross-training materials and educators (Humphreys, 2005; Macy & Goodbourn, 2012). The outcome is that IPV advocates and SUD treatment providers have varied levels of knowledge, training, and skills related to the other topic.

Peer recovery coaching is a type of support service for individuals with SUD that is philosophically aligned with IPV advocacy. Recovery coaches are individuals with their own experience of SUD and recovery who are trained to provide informational, emotional, and practical support to peers with SUD (Eddie et al., 2019). The recovery coach model emphasizes multiple paths to recovery and the need for long-term support through resource provision, and by connecting peers to needed housing, employment, harm reduction, and other resources (White & Evans, 2013). Recovery coaches may be paid employees or volunteers, and may be based in traditional clinical settings, faith-based organizations, recovery community centers, other health and social service organizations, or working as ad hoc lay volunteers (Bassuk et al., 2016).

The alignment between the peer recovery coach model and the IPV advocacy model makes collaboration between advocates and recovery coaches particularly attractive for addressing the complex needs of rural survivors. For example, Stone and colleagues (2022) worked with community partners to develop a one-day cross-training event for community-based IPV advocates and peer recovery coaches. In addition to improved knowledge about the topics and confidence in working with clients experiencing IPV and/or SUD, participants also built valuable connections and strengthened local networks of people doing this work in rural communities. As a result of this cross-training, there is a growing number of IPV advocates in Vermont who are cross-training as peer recovery coaches. IPV experts are also increasingly involved in local and statewide taskforces that are responding to the opioid and polysubstance crises.

Addressing the Housing Crisis

Intimate partner violence is a leading cause of women's homelessness (Daoud et al., 2016; Pavao et al., 2007), yet there are few clear solutions to meeting the need for housing. The Texas Council on Family Violence notes that in 2019, almost half of the survivors seeking shelter were denied due to lack of space. While this number decreased to 39% in 2021, this still indicates that shelter availability falls drastically short of the demand (TCFV, 2021). The same report identifies housing as the most critical need for IPV survivors, a need exacerbated by high housing costs and high numbers of evictions (TCFV, 2021). When turned away from a shelter, survivors may resort to living in motels or cars, or returning to their abuser (Gezinski & Gonzalez-Pons, 2021). Survivors with substance use disorders, criminal records, or poor credit histories face additional barriers to securing housing (Kofman et al., 2018).

Existing research on IPV and housing services has largely focused on emergency shelters and not on long-term housing solutions (Yakubovich et al., 2021). A recent review noted the lack of research on interventions to address IPV survivors' housing needs (Klein et al., 2021). The authors found some support for rapid rehousing and flexible funding approaches. Rapid rehousing is a 'Housing First' model in which obtaining stable housing is a first step toward providing support for other issues. This model aims to help survivors quickly exit emergency shelters or homelessness and secure permanent housing (Padgett et al., 2016; Sullivan & Olsen, 2016). Flexible funding approaches allow service providers to use dedicated program funds to help pay overdue rent, car repair bulls, and utility deposits (Sullivan et al., 2016). A study based in Utah supported the Housing First model with built-in supportive services, but also found that existing policies requiring 12 months of continuous and chronic homelessness created a barrier for survivors and that there is a lack of IPV service providers to meet the demand for services (Gezinski & Gonazalez-Pons, 2021). Given the need for more research on housing interventions and the need for funding, it may be possible to form research-practitioner partnerships to secure grants that might provide program funding and evaluation research. The outcomes of this research may then be used to spur greater investment in housing interventions for survivors.

Conclusion

Many rural U.S. communities are grappling with deadly and quickly-evolving drug crises. These crises intersect with intimate partner violence in complex ways, creating gaps in services for multiply-marginalized survivors. To close these gaps, we must not only understand the relationship between substance use and partner violence, but also understand the way that rural contexts shape this relationship and the options available for those seeking safety and recovery. While some solutions must happen at the structural level and may be high-cost, like increasing housing availability and expanding broadband internet access, others are relatively low-cost – for example, improving collaborative partnerships between IPV advocacy organizations and substance use treatment providers, cross-training the IPV and treatment/recovery workforces, and working to increase access to MAT through family medicine practitioners. Researcher-community partnerships may help to facilitate some of these interventions by securing pilot program funding and evaluating outcomes to provide evidence of effectiveness. Through these cross-sector and interdisciplinary efforts, we can create context-specific and innovative solutions that will save lives and build stronger communities.

Rebecca Stone, Ph.D., MPH, is an Assistant Professor in the Department of Sociology & Criminal Justice at Suffolk University. Dr. Stone is an interdisciplinary scholar in the areas of criminal justice and public health, with a focus on justice-involved women. She has developed expertise in community-engaged qualitative research methods, including in-depth interviewing, focus groups, and field observations. For more information about her research, teaching, and public engagement activities, please see rebeccajstone.com.

Scarlett R. Crossman, B.S., is a graduate student at Suffolk University working toward dual Masters degrees in Mental Health Counseling and Crime and Justice Studies. She holds an undergraduate degree in Criminal Justice from Lasell University. Her research interests include mental health, intimate partner violence, substance use, and the criminalization of mental illness.

@cvi_shsu

References

Andrews, C. M., Cao, D., Marsh, J. C., & Shin, H.-C. (2011). The impact of comprehensive services in substance abuse treatment for women with a history of intimate partner violence. Violence Against Women, 17(5), 550–567. https://doi.org/10.1177/1077801211407289

Annan, S. L. (2008). Intimate Partner Violence in Rural Environments. Annual Review of Nursing Research, 26(1), 85–113. https://doi.org/10.1891/0739-6686.26.1.85

Ashley, O. S., Marsden, M. E., & Brady, T. M. (2003). Effectiveness Of Substance Abuse Treatment Programming For Women: A Review. The American Journal of Drug and Alcohol Abuse, 29(1), 19–53. https://doi.org/10.1081/ADA-120018838

Banyard, V. L., Edwards, K. M., Moschella, E. A., & Seavey, K. M. (2019). "Everybody's Really Close-Knit": Disconnections Between Helping Victims of Intimate Partner Violence and More General Helping in Rural Communities. Violence Against Women, 25(3), 337–358. https://doi.org/10.1177/1077801218768714

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review. Journal of Substance Abuse Treatment, 63, 1–9. https://doi.org/10.1016/j.jsat.2016.01.003

Bennett, L., & Bland, P. (n.d.). Substance Use and Intimate Partner Violence. Applied Research Forum, National Online Resource Center on Violence Against Women. Retrieved February 13, 2023, from https://andvsa.org/wp-content/uploads/2009/12/sa-and-ipv-bennett-and-bland-vawnet_ii1.pdf

Bennett, L., & O'Brien, P. (2007). Effects of coordinated services for drug-abusing women who are victims of intimate partner violence. Violence Against Women, 13(4), 395–411. https://doi.org/10.1177/1077801207299189

Bolin, J. N., Bellamy, G. R., Ferdinand, A. O., Vuong, A. M., Kash, B. A., Schulze, A., & Helduser, J. W. (2015). Rural Healthy People 2020: New Decade, Same Challenges. The Journal of Rural Health, 31(3), 326–333. https://doi.org/10.1111/jrh.12116

Bunting, A. M., Oser, C., Staton, M., & Knudsen, H. (2020). Polysubstance Use Patterns among Justice-Involved Individuals Who Use Opioids. Substance Use & Misuse, 55(13), 2165–2174. https://doi.org/10.1080/10826084.2020.1795683

Cafferky, B. M., Mendez, M., Anderson, J. R., & Stith, S. M. (2018). Substance use and intimate partner violence: A meta-analytic review. Psychology of Violence, 8(1), 110–131. https://doi.org/10.1037/vio0000074

Campbell, C. I., & Alexander, J. A. (2005). Health Services for Women in Outpatient Substance Abuse Treatment: Women's Services in Substance Abuse Treatment. Health Services Research, 40(3), 781–810. https://doi.org/10.1111/j.1475-6773.2005.00385.x

Center on Rural Addiction. (2023). 2020 Rural Opioid Overdose Morality (Data Brief). University of Vermont. https://www.uvmcora.org/wp-content/uploads/2023/01/UVM-CORA-2020-Rural-Opioid-Overdose-Mortality-Data-Brief-January-2023.pdf

Centers for Disease Control and Prevention (CDC). (2022). Now Is the Time to Stop Drug Overdose Deaths. https://www.cdc.gov/drugoverdose/featured-topics/overdose-prevention-campaigns.html

Chen, Q., Sterner, G., Segel, J., & Feng, Z. (2022). Trends in opioid-related crime incidents and comparison with opioid overdose outcomes in the United States. International Journal of Drug Policy, 101, 103555. https://doi.org/10.1016/j.drugpo.2021.103555

Ciccarone, D. (2019). The triple wave epidemic: Supply and demand drivers of the US opioid overdose crisis. International Journal of Drug Policy, 71, 183–188. https://doi.org/10.1016/j.drugpo.2019.01.010

Cook-Craig, P. G., Lane, K. G., & Siebold, W. L. (2010). Building the Capacity of States to Ensure Inclusion of Rural Communities in State and Local Primary Violence Prevention Planning. Journal of Family Social Work, 13(4), 326–342. https://doi.org/10.1080/10522158.2010.492498

Daoud, N., Matheson, F. I., Pedersen, C., Hamilton-Wright, S., Minh, A., Zhang, J., & O'Campo, P. (2016). Pathways and trajectories linking housing instability and poor health among low-income women experiencing intimate partner violence (IPV): Toward a conceptual framework. Women & Health, 56(2), 208–225. https://doi.org/10.1080/03630242.2015.1086465

Dasgupta, N., Beletsky, L., & Ciccarone, D. (2018). Opioid Crisis: No Easy Fix to Its Social and Economic Determinants. American Journal of Public Health, 108(2), 182–186. https://doi.org/10.2105/AJPH.2017.304187

Desrosiers, P., Sullivan, D., Lay, C., & Dickinson, T. (2017). Victim assistance service providers' training needs assessment. Professional Development: The International Journal of Continuing Social Work Education, 20(1), 14–25.

Devries, K. M., Child, J. C., Bacchus, L. J., Mak, J., Falder, G., Graham, K., Watts, C., & Heise, L. (2014). Intimate partner violence victimization and alcohol consumption in women: A systematic review and meta-analysis: IPV and alcohol. Addiction, 109(3), 379–391. https://doi.org/10.1111/add.12393

Dudgeon, A., & Evanson, T. A. (2014). Intimate partner violence in rural U.S. areas: What every nurse should know. The American Journal of Nursing, 114(5), 26–35; quiz 36, 48. https://doi.org/10.1097/01.NAJ.0000446771.02202.35

Earnshaw, V. A. (2020). Stigma and substance use disorders: A clinical, research, and advocacy agenda. American Psychologist, 75(9), 1300.

Eastman, B. J., & Bunch, S. G. (2007). Providing Services to Survivors of Domestic Violence: A Comparison of Rural and Urban Service Provider Perceptions. Journal of Interpersonal Violence, 22(4), 465–473. https://doi.org/10.1177/0886260506296989

Eastman, B. J., Bunch, S. G., Williams, A. H., & Carawan, L. W. (2007). Exploring the Perceptions of Domestic Violence Service Providers in Rural Localities. Violence Against Women, 13(7), 700–716. https://doi.org/10.1177/1077801207302047

Economic Research Service< U.S. Department of Agriculture. (2022). Rural Poverty & Well-Being. https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being.aspx

Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoeppner, B., Weinstein, C., & Kelly, J. F. (2019). Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching. Frontiers in Psychology, 10, 1052. https://doi.org/10.3389/fpsyg.2019.01052

Edwards, K. M. (2015). Intimate Partner Violence and the Rural–Urban–Suburban Divide: Myth or Reality? A Critical Review of the Literature. Trauma, Violence, & Abuse, 16(3), 359–373. https://doi.org/10.1177/1524838014557289

Edwardsen, E. A., Dichter, M. E., Walsh, P., & Cerulli, C. (2011). Instructional Curriculum Improves Medical Staff Knowledge and Efficacy for Patients Experiencing Intimate Partner Violence. Military Medicine, 176(11), 1260–1264. https://doi.org/10.7205/MILMED-D-11-00258

Ellis, M. S., Kasper, Z. A., & Cicero, T. J. (2021). Polysubstance use trends and variability among individuals with opioid use disorder in rural versus urban settings. Preventive Medicine, 152, 106729. https://doi.org/10.1016/j.ypmed.2021.106729

Faller, Y. N., Wuerch, M. A., Hampton, M. R., Barton, S., Fraehlich, C., Juschka, D., Milford, K., Moffitt, P., Ursel, J., & Zederayko, A. (2021). A Web of Disheartenment With Hope on the Horizon: Intimate Partner Violence in Rural and Northern Communities. Journal of Interpersonal Violence, 36(9–10), 4058–4083. https://doi.org/10.1177/0886260518789141

Feldmeyer, B., Cullen, F. T., Sun, D., Kulig, T. C., Chouhy, C., & Zidar, M. (2022). The Community Determinants of Death: Comparing the Macro-Level Predictors of Overdose, Homicide, and Suicide Deaths, 2000 to 2015. Socius: Sociological Research for a Dynamic World, 8, 237802312211003. https://doi.org/10.1177/23780231221100392

Fischer, E. P., McSweeney, J. C., Wright, P., Cheney, A., Curran, G. M., Henderson, K., & Fortney, J. C. (2016). Overcoming Barriers to Sustained Engagement in Mental Health Care: Perspectives of Rural Veterans and Providers: Overcoming Barriers to Mental Health Care. The Journal of Rural Health, 32(4), 429–438. https://doi.org/10.1111/jrh.12203

Florence, C., Luo, F., & Rice, K. (2021). The economic burden of opioid use disorder and fatal opioid overdose in the United States, 2017. Drug and Alcohol Dependence, 218, 108350. https://doi.org/10.1016/j.drugalcdep.2020.108350

Foran, H. M., & O'Leary, K. D. (2008). Alcohol and intimate partner violence: A meta-analytic review. Clinical Psychology Review, 28(7), 1222–1234. https://doi.org/10.1016/j.cpr.2008.05.001

Friesen, E. L., Bailey, J., Hyett, S., Sedighi, S., de Snoo, M. L., Williams, K., Barry, R., Erickson, A., Foroutan, F., Selby, P., Rosella, L., & Kurdyak, P. (2022). Hazardous alcohol use and alcohol-related harm in rural and remote communities: A scoping review. The Lancet Public Health, 7(2), e177–e187. https://doi.org/10.1016/S2468-2667(21)00159-6

Gauthier, G. R., Markowski, K., Smith, J. A., Harcey, S., & Johnston, B. (2022). Co-use among confidants: An examination of polysubstance use and personal relationships in southeastern Nebraska. Addictive Behaviors, 124, 107116. https://doi.org/10.1016/j.addbeh.2021.107116

Gezinski, L. B., & Gonzalez-Pons, K. M. (2021). Unlocking the Door to Safety and Stability: Housing Barriers for Survivors of Intimate Partner Violence. Journal of Interpersonal Violence, 36(17–18), 8338–8357. https://doi.org/10.1177/0886260519851792

Gilbert, L., El-Bassel, N., Chang, M., Wu, E., & Roy, L. (2012). Substance use and partner violence among urban women seeking emergency care. Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 26(2), 226–235. https://doi.org/10.1037/a0025869

Gilbert, L., El-Bassel, N., Rajah, V., Foleno, A., & Frye, V. (2001). Linking drug-related activities with experiences of partner violence: A focus group study of women in methadone treatment. Violence and Victims, 16(5), 517–536.

Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L. M., & Gadd, D. (2019). The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. International Journal of Drug Policy, 65, 8–23. https://doi.org/10.1016/j.drugpo.2018.12.009

Godvarthy, R., Hough, J., Libberton, S., & Koff, R. (2019). Opportunities for State DOTs (and others) to Encouraged Shared-Use Mobility Practices in Rural Areas. Small Urban and Rural Center on Mobility, Upper Great Plains Transportation Institute, North Dakota State University. http://onlinepubs.trb.org/onlinepubs/nchrp/2065/Task76Report.pdf

Grella, C. E. (2008). From Generic to Gender-Responsive Treatment: Changes in Social Policies, Treatment Services, and Outcomes of Women in Substance Abuse Treatment. Journal of Psychoactive Drugs, 40(sup5), 327–343. https://doi.org/10.1080/02791072.2008.10400661

Grimm, C. A. (2020). Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder (OEI-12-17-00240). U.S. Department of Health and Human Services, Office of Inspector General. https://oig.hhs.gov/oei/reports/oei-12-17-00240.pdf
Hirchak, K. A., & Murphy, S. M. (2017). Assessing Differences in the Availability of Opioid Addiction Therapy Options: Rural Versus Urban and American Indian Reservation Versus Nonreservation: Assessing Differences in the Availability of OAT. The Journal of Rural Health, 33(1), 102–109. https://doi.org/10.1111/jrh.12178
Hser, Y.-I., Evans, E., Huang, D., & Messina, N. (2011). Long-term outcomes among drug-dependent mothers treated in women-only versus mixed-gender programs. Journal of Substance Abuse Treatment, 41(2), 115–123. https://doi.org/10.1016/j.jsat.2011.02.004
Humphreys, C. (2005). Domestic Violence and Substance Use: Tackling Complexity. British Journal of Social Work, 35(8), 1303–1320. https://doi.org/10.1093/bjsw/bch212
Illangasekare, S. L., Burke, J. G., Chander, G., & Gielen, A. C. (2014). Depression and Social Support Among Women Living with the Substance Abuse, Violence, and HIV/AIDS Syndemic: A Qualitative Exploration. Women's Health Issues, 24(5), 551–557. https://doi.org/10.1016/j.whi.2014.05.004
Keller, E. M., & Owens, G. P. (2020). Traditional rural values and posttraumatic stress among rural and urban undergraduates. PLOS ONE, 15(8), e0237578. https://doi.org/10.1371/journal.pone.0237578
Kennedy, A. C., & Prock, K. A. (2018). "I Still Feel Like I Am Not Normal": A Review of the Role of Stigma and Stigmatization Among Female Survivors of Child Sexual Abuse, Sexual Assault, and Intimate Partner Violence. Trauma, Violence, & Abuse, 19(5), 512–527. https://doi.org/10.1177/1524838016673601
Keyes, K. M., Cerdá, M., Brady, J. E., Havens, J. R., & Galea, S. (2014). Understanding the Rural–Urban Differences in Nonmedical Prescription Opioid Use and Abuse in the United States. American Journal of Public Health, 104(2), e52–e59. https://doi.org/10.2105/AJPH.2013.301709
Klein, L. B., Chesworth, B. R., Howland-Myers, J. R., Rizo, C. F., & Macy, R. J. (2021). Housing Interventions for Intimate Partner Violence Survivors: A Systematic Review. Trauma, Violence, & Abuse, 22(2), 249–264. https://doi.org/10.1177/1524838019836284
Kofman, L., & Marcus, S. (2018). 2017 Safe Housing Needs Assessment: Results Overview. National Alliance for Safe Housing. https://www.safehousingta.org/wp-content/uploads/2018/10/Safe-Housing-Needs-Assessment-published-10-2018.pdf
Kvamme, E., Catlin, M., Banta-Green, C., Roll, J., & Rosenblatt, R. (2013). Who prescribes buprenorphine for rural patients? The impact of specialty, location and practice type in Washington State. Journal of Substance Abuse Treatment, 44(3), 355–360. https://doi.org/10.1016/j.jsat.2012.07.006
Landen, X. (2021, April 7). Vermont leaders say federal money for broadband could help close "digital divide." VTDigger. https://vtdigger.org/2021/04/07/vermont-leaders-say-federal-money-for-broadband-could-help-close-digital-divide/
Lanier, C., & Maume, M. O. (2009). Intimate Partner Violence and Social Isolation Across the Rural/Urban Divide. Violence Against Women, 15(11), 1311–1330. https://doi.org/10.1177/1077801209346711
Levine, H., & Peffer, S. (2012). Quiet Casualties: An Analysis of U Non-Immigrant Status of Undocumented Immigrant Victims of Intimate Partner Violence. International Journal of Public Administration, 35(9), 634–642. https://doi.org/10.1080/01900692.2012.661191
Lister, J. J., Weaver, A., Ellis, J. D., Himle, J. A., & Ledgerwood, D. M. (2019). A systematic review of rural-specific barriers to medication treatment for opioid use disorder in the United States. The American Journal of Drug and Alcohol Abuse, 1–16. https://doi.org/10.1080/00952990.2019.1694536
Logan, T. K., Cole, J., Shannon, L., & Walker, R. (2006). Partner stalking: How women respond, cope, and survive. Springer Publ.
Logan, T. K., Walker, R., Cole, J., Ratliff, S., & Leukefeld, C. (2003). Qualitative Differences Among Rural and Urban Intimate Violence Victimization Experiences and Consequences: A Pilot Study. Journal of Family Violence, 18(2), 83–92. https://doi.org/10.1023/A:1022837114205
Logan, T. K., Walker, R., & Leukefeld, C. G. (2001). Rural, Urban Influenced, and Urban Differences Among Domestic Violence Arrestees. Journal of Interpersonal Violence, 16(3), 266–283. https://doi.org/10.1177/088626001016003006
Logan, T., Stevenson, E., Evans, L., & Leukefeld, C. (2004). Rural and Urban Women's Perceptions of Barriers to Health, Mental Health, and Criminal Justice Services: Implications for Victim Services. Violence and Victims, 19(1), 37–62. https://doi.org/10.1891/vivi.19.1.37.33234
Lowrie, F., Gibson, L., Towle, I., & Lowrie, R. (2019). A descriptive study of a novel pharmacist led health outreach service for those experiencing homelessness. International Journal of Pharmacy Practice, 27(4), 355–361. https://doi.org/10.1111/ijpp.12520
Macy, R. J., Giattina, M. C., Parish, S. L., & Crosby, C. (2010). Domestic Violence and Sexual Assault Services: Historical Concerns and Contemporary Challenges. Journal of Interpersonal Violence, 25(1), 3–32. https://doi.org/10.1177/0886260508329128
Macy, R. J., Giattina, M., Sangster, T. H., Crosby, C., & Montijo, N. J. (2009). Domestic violence and sexual assault services: Inside the black box. Aggression and Violent Behavior, 14(5), 359–373. https://doi.org/10.1016/j.avb.2009.06.002
Macy, R. J., & Goodbourn, M. (2012). Promoting Successful Collaborations Between Domestic Violence and Substance Abuse Treatment Service Sectors: A Review of the Literature. Trauma, Violence, & Abuse, 13(4), 234–251. https://doi.org/10.1177/1524838012455874
McCall-Hosenfeld, J. S., Weisman, C. S., Perry, A. N., Hillemeier, M. M., & Chuang, C. H. (2014). " I Just Keep My Antennae Out ": How Rural Primary Care Physicians Respond to Intimate Partner Violence. Journal of Interpersonal Violence, 29(14), 2670–2694. https://doi.org/10.1177/0886260513517299
Mehrotra, G. R., Kimball, E., & Wahab, S. (2016). The Braid That Binds Us: The Impact of Neoliberalism, Criminalization, and Professionalization on Domestic Violence Work. Affilia, 31(2), 153–163. https://doi.org/10.1177/0886109916643871
Mojahed, A., Brym, S., Hense, H., Grafe, B., Helfferich, C., Lindert, J., & Garthus-Niegel, S. (2021). Rapid Review on the Associations of Social and Geographical Isolation and Intimate Partner Violence: Implications for the Ongoing COVID-19 Pandemic. Frontiers in Psychiatry, 12, 578150. https://doi.org/10.3389/fpsyt.2021.578150
Monnat, S. M. (2018). Factors Associated With County-Level Differences in U.S. Drug-Related Mortality Rates. American Journal of Preventive Medicine, 54(5), 611–619. https://doi.org/10.1016/j.amepre.2018.01.040
Monnat, S. M. (2019). The contributions of socioeconomic and opioid supply factors to U.S. drug mortality rates: Urban-rural and within-rural differences. Journal of Rural Studies, 68, 319–335. https://doi.org/10.1016/j.jrurstud.2018.12.004
Murray, C. E., Crowe, A., & Overstreet, N. M. (2018). Sources and Components of Stigma Experienced by Survivors of Intimate Partner Violence. Journal of Interpersonal Violence, 33(3), 515–536. https://doi.org/10.1177/0886260515609565
National Advisory Committee on Rural Health and Human Services. (2015). Intimate Partner Violence in Rural America. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2015-partner-violence.pdf
National Institute on Drug Abuse (NIDA). (2021). Methamphetamine-involved overdose deaths nearly tripled between 2015 to 2019, NIH study finds. https://nida.nih.gov/news-events/news-releases/2021/09/methamphetamine-involved-overdose-deaths-nearly-tripled-between-2015-to-2019-nih-study-finds
Padgett, D., Henwood, B. F., & Tsemberis, S. J. (2016). Housing first: Ending homelessness, transforming systems, and changing lives. Oxford University Press.
Pavao, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). Intimate Partner Violence and Housing Instability. American Journal of Preventive Medicine, 32(2), 143–146. https://doi.org/10.1016/j.amepre.2006.10.008
Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural Disparity in Domestic Violence Prevalence and Access to Resources. Journal of Women's Health, 20(11), 1743–1749. https://doi.org/10.1089/jwh.2011.2891
Rajah, V. (2006). Respecting Boundaries. The British Journal of Criminology, 46(5), 837–858. https://doi.org/10.1093/bjc/azl003
Reina, A. S., Lohman, B. J., & Maldonado, M. M. (2014). "He Said They'd Deport Me": Factors Influencing Domestic Violence Help-Seeking Practices Among Latina Immigrants. Journal of Interpersonal Violence, 29(4), 593–615. https://doi.org/10.1177/0886260513505214
Rennison, C. M., DeKeseredy, W. S., & Dragiewicz, M. (2013). Intimate Relationship Status Variations in Violence Against Women: Urban, Suburban, and Rural Differences. Violence Against Women, 19(11), 1312–1330. https://doi.org/10.1177/1077801213514487
Richie, B. E., Kanuha, V. K., & Martensen, K. M. (2021). Colluding With and Resisting the State: Organizing Against Gender Violence in the U.S. Feminist Criminology, 16(3), 247–265. https://doi.org/10.1177/1557085120987607
Riddell, T., Ford-Gilboe, M., & Leipert, B. (2008). Strategies Used by Rural Women to Stop, Avoid or Escape From Intimate Partner Violence. 30(1–2), 134–159. https://doi.org/DOI: 10.1080/07399330802523774
Rigg, K. K., Monnat, S. M., & Chavez, M. N. (2018). Opioid-related mortality in rural America: Geographic heterogeneity and intervention strategies. International Journal of Drug Policy, 57, 119–129. https://doi.org/10.1016/j.drugpo.2018.04.011
Rivera, E. A., Phillips, H., Warshaw, C., Lyon, E., Bland, P., & Kaewken, O. (2015). An applied research paper on the relationship between intimate partner violence and substance use. National Center on Domestic Violence, Trauma & Mental Health. http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/09/IPV-SAB-Final202.29.1620NO20LOGO-1.pdf
Rodier, C., & Podolsky, L. (2017). Opportunities for Shared-Use Mobility Services in Rural Disadvantaged Communities in California's San Joaquin Valley: Existing Conditions and Conceptual Program Development. National Center for Sustainable Transportation. https://rosap.ntl.bts.gov/view/dot/34234

Rothman, E. F., Stone, R., & Bagley, S. M. (2018). Rhode Island Domestic Violence Shelter Policies, Practices, and Experiences Pertaining to Survivors With Opioid Use Disorder: Results of a Qualitative Study. Substance Abuse: Research and Treatment, 12, 1–7. https://doi.org/10.1177/1178221818812895
Sandberg, L. (2013). Backward, Dumb, and Violent Hillbillies? Rural Geographies and Intersectional Studies on Intimate Partner Violence. 28(4), 350–365. https://doi.org/10.1177/0886109913504153
Schumacher, J. A., & Holt, D. J. (2012). Domestic violence shelter residents' substance abuse treatment needs and options. Aggression and Violent Behavior, 17(3), 188–197. https://doi.org/10.1016/j.avb.2012.01.002
Smith, P. H., Homish, G. G., Collins, R. L., Giovino, G. A., White, H. R., & Leonard, K. E. (2014). Couples' marijuana use is inversely related to their intimate partner violence over the first 9 years of marriage. Psychology of Addictive Behaviors, 28(3), 734–742. https://doi.org/10.1037/a0037302
Snell-Rood, C., Hauenstein, E., Leukefeld, C., Feltner, F., Marcum, A., & Schoenberg, N. (2017). Mental health treatment seeking patterns and preferences of Appalachian women with depression. American Journal of Orthopsychiatry, 87(3), 233–241. https://doi.org/10.1037/ort0000193
Starcher, R. W., Geurin, L., Shannon, L., & Whitley, A. (2017). Assessing the Likelihood of Seeking Health Care in Rural Kentucky: Applying the Barriers to Help Seeking Scale to Appalachian and Non-Appalachian Undergraduates. Journal of Appalachian Studies, 23(2), 239–258. https://doi.org/10.5406/jappastud.23.2.0239
State of Vermont Department of Public Service (DPS). (n.d.). Vermont Communications Union Districts. https://publicservice.vermont.gov/content/vermont-communications-union-districts
Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. Health & Justice, 3(1). https://doi.org/10.1186/s40352-015-0015-5
Stone, R., Campbell, J. K., Halim, N., Kinney, D., & Rothman, E. F. (2022). Design and Pilot Evaluation of a Cross-Training Curriculum for Intimate Partner Violence Advocates and Peer Recovery Coaches. Victims & Offenders, 1–21. https://doi.org/10.1080/15564886.2022.2026544
Stone, R., Campbell, J. K., Kinney, D., & Rothman, E. F. (2021). "He would take my shoes and all the baby's warm winter gear so we couldn't leave": Barriers to safety and recovery experienced by a sample of vermont women with partner violence and opioid use disorder experiences. The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association, 37(1), 35–44. https://doi.org/10.1111/jrh.12518
Stone, R., & Rothman, E. F. (2019). Opioid Use and Intimate Partner Violence: A Systematic Review. Current Epidemiology Reports, 6(2), 215–230. https://doi.org/10.1007/s40471-019-00197-2
Substance Abuse and Mental Health Services Administration (SAMHSA). (2023, January 25). Removal of DATA Waiver (X-Waiver) Requirement. https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement
Sullivan, C. M., Bomsta, H. D., & Hacskaylo, M. A. (2019). Flexible Funding as a Promising Strategy to Prevent Homelessness for Survivors of Intimate Partner Violence. Journal of Interpersonal Violence, 34(14), 3017–3033. https://doi.org/10.1177/0886260516664318
Sullivan, C. M., & Olsen, L. (2016). Common ground, complementary approaches: Adapting the Housing First model for domestic violence survivors. Housing and Society, 43(3), 182–194. https://doi.org/10.1080/08882746.2017.1323305
Terplan, M., Longinaker, N., & Appel, L. (2015). Women-Centered Drug Treatment Services and Need in the United States, 2002-2009. American Journal of Public Health, 105(11), e50-54. https://doi.org/10.2105/AJPH.2015.302821
Testa, M., & Brown, W. C. (2015). Does marijuana use contribute to intimate partner aggression? A brief review and directions for future research. Current Opinion in Psychology, 5, 6–12. https://doi.org/10.1016/j.copsyc.2015.03.002
Texas Council on Family Violence (TCFV). (2021). 2021 State of the State: Creating a Safer Texas. https://tcfv.org/wp-content/uploads/tcfv_state_of_the_state_2021.pdf
Texas Department of Public Safety. (2021). Crime in Texas 2021. https://www.dps.texas.gov/sites/default/files/documents/crimereports/21/2021cit.pdf
Totten, A. M., Hansen, R. N., Wagner, J., Stillman, L., Ivlev, I., Davis-O'Reilly, C., Towle, C., Erickson, J. M., Erten-Lyons, D., Fu, R., Fann, J., Babigumira, J. B., Palm-Cruz, K. J., Avery, M., & McDonagh, M. S. (2019). Telehealth for Acute and Chronic Care Consultations. Agency for Healthcare Research and Quality (US). http://www.ncbi.nlm.nih.gov/books/NBK547239/
U.S. Preventive Services Task Force. (2019). Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Recommendation Statement. American Family Physician, 99(10), Online.
USA Facts. (2022). Our Changing Population: Texas. https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/texas
Van Deinse, T. B., Wilson, A. B., Macy, R. J., & Cuddeback, G. S. (2019). Intimate Partner Violence and Women with Severe Mental Illnesses: Needs and Challenges from the Perspectives of Behavioral Health and Domestic Violence Service Providers. The Journal of Behavioral Health Services & Research, 46(2), 283–293. https://doi.org/10.1007/s11414-018-9624-9
Van Hightower, N. R., & Gorton, J. (2002). A case study of community-based responses to rural woman battering. Violence Against Women, 8(7), 845–872. https://doi.org/10.1177/107780102400388506
Velázquez, T., & Remrey, L. (2022, August 16). Methamphetamine Use, Overdose Deaths, and Arrests Soared from 2015 to 2019. https://www.pewtrusts.org/en/research-and-analysis/articles/2022/08/16/methamphetamine-use-overdose-deaths-and-arrests-soared-from-2015-to-2019
Vidales, G. T. (2010). Arrested Justice: The Multifaceted Plight of Immigrant Latinas who Faced Domestic Violence. Journal of Family Violence, 25(6), 533–544. https://doi.org/10.1007/s10896-010-9309-5
Wachter, K., Cook Heffron, L., & Dalpe, J. (2022). "We Weren't Ready": Provider Perspectives on Addressing Intimate Partner Violence Among Refugees and Immigrants in The United States. Journal of Family Violence, 37(2), 235–246. https://doi.org/10.1007/s10896-021-00285-2
Wachter, K., Dalpe, J., & Heffron, L. C. (2019). Conceptualizations of Domestic Violence–Related Needs among Women Who Resettled to the United States as Refugees. Social Work Research, 43(4), 207–219. https://doi.org/10.1093/swr/svz008
Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., Azocar, F., & Sanghavi, D. M. (2020). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Network Open, 3(2), e1920622. https://doi.org/10.1001/jamanetworkopen.2019.20622
Warshaw, C., Lyon, E., Bland, P., Phillips, H., & Hooper, M. (2014). Mental Health and Substance Use Coercion Surveys: Report from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline. National Center on Domestic Violence, Trauma & Mental Health. http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf
Websdale, N., & Johnson, B. (1998). An Ethnostatistical Comparison of the Forms and Levels of Woman Battering in Urban and Rural Areas of Kentucky. Criminal Justice Review, 23(2), 161–196. https://doi.org/10.1177/073401689802300203
White, W. L., & Evans, A. C. (2013). The Recovery Agenda: The Shared Role of Peers and Professionals. Public Health Reviews, 35(2), 4. https://doi.org/10.1007/BF03391703
Wilson, I. M., Graham, K., & Taft, A. (2014). Alcohol interventions, alcohol policy and intimate partner violence: A systematic review. BMC Public Health, 14(1), 881. https://doi.org/10.1186/1471-2458-14-881
Wingrove, P., Park, B., & Bazemore, A. (2016). Rural Opioid Use Disorder Treatment Depends on Family Physicians. American Family Physician, 94(7), 546.
Woolf, S. H., & Schoomaker, H. (2019). Life Expectancy and Mortality Rates in the United States, 1959-2017. JAMA, 322(20), 1996. https://doi.org/10.1001/jama.2019.16932
Yakubovich, A. R., Bartsch, A., Metheny, N., Gesink, D., & O'Campo, P. (2022). Housing interventions for women experiencing intimate partner violence: A systematic review. The Lancet Public Health, 7(1), e23–e35. https://doi.org/10.1016/S2468-2667(21)00234-6
Zoorob, M. J., & Salemi, J. L. (2017). Bowling alone, dying together: The role of social capital in mitigating the drug overdose epidemic in the United States. Drug and Alcohol Dependence, 173, 1–9. https://doi.org/10.1016/j.drugalcdep.2016.12.011
Zweig, J. M., Schlichter, K. A., & Burt, M. R. (2002). Assisting Women Victims of Violence Who Experience Multiple Barriers to Services. Violence Against Women, 8(2), 162–180. https://doi.org/10.1177/10778010222182991
Zwick, J., Appleseth, H., & Arndt, S. (2020). Stigma: How it affects the substance use disorder patient. Substance Abuse Treatment, Prevention, and Policy, 15(1), 50, s13011-020-00288–0. https://doi.org/10.1186/s13011-020-00288-0

Crime Victims' Institute Advisory Board

Shawn Kennington, Pittsburg
Constable, Camp County

JD Robertson, Wimberely
Director, Office of the Independent Ombudsman, Texas Juvenile Justice Department

Lindsay Kinzie, Fort Worth
Legal Program Director, The Gatehouse

Hector Villarreal, Alice
Assistant Professor of Criminal Justice & Interim Site Director, Coastal Bend College

Abigail Brookshire, Midlothian
Student, The University of Texas at Arlington

Senator Joan Huffman, Houston
State Senator for District 17 & President Pro Tempore of the Texas Senate

Hon. Lee Ann Breading, Denton
District Judge, 462nd Judicial District Court

Erleigh Wiley, Forney
Criminal District Attorney, Kaufman County

Libby Hamilton, Round Rock
Victim Liaison, Texas Board of Pardons and Paroles

Matthew L. Ferrara, Ph.D., Austin
Forensic Psychologist

Brandi Reed, Amarillo
Director of Education, Family Support Services of Amarillo, Inc.

Melissa Carter, Bryan
Victim Assistance Coordinator, Brazos County

Chief Emmitt Jackson, Jr., Argyle
Chief of Police, Argyle Police Department

Hillary England, Pflugerville
Director of Trafficking and Sexual Violence Prevention Programs, Office of the Governor

Texas State University System Board of Regents

Duke Austin
Chairman
Houston

Garry Crain
First Vice Chairman
The Hills

Alan L. Tinsley
Second Vice Chairman
Madisonville

Don Flores
Regent
El Paso

William F. Scott
Regent
Nederland

Stephen Lee
Regent
Beaumont

Sheila Faske
Regent
Rose City

Gabriel Webb
Student Regent
The Hills

Charlie Amato
Regent
San Antonio