THE JOURNAL OF RURAL HEALTH

ORIGINAL ARTICLE

"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

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Funding: This research was made possible through funding from the Robert Wood Johnson Foundation Interdisciplinary Research Leaders Program. The thoughts and opinions reported herein do not necessary reflect those of the Robert Wood Johnson Foundation.

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doi: 10.1111/jrh.12518

Abstract

Purpose: This qualitative study explored themes about barriers to substance use treatment for women who experience intimate partner violence (IPV) and opioid use in rural Vermont. The goal was to collect descriptive information to aid in the development of intervention ideas to facilitate better treatment access for women in this situation.

Methods: One-on-one telephone interviews with 33 rural Vermont women who experienced both IPV and opioid use took place between February and August 2019.

Findings: There were 5 main themes that emerged as barriers to accessing needed services: (1) geographic isolation and transportation difficulties, (2) inaccessibility of existing services, (3) lack of integrated substance use treatment and domestic violence services, (4) social isolation, and (5) amplification of stigma in small rural communities.

Conclusions: Improved access to care and increased collaboration between IPV and substance use service providers are required to better serve rural communities in which IPV and opioid use disorder are concurrent problems.

Key words access to care, intimate partner violence, opioid use disorder, recovery, rural health.

Opioid use disorder (OUD) is a major public health concern in the United States.[1] In 2018, 46,802 people in the United States died of drug overdoses involving any opioid.[2] Between 2012 and 2018, the number of deaths involving synthetic narcotics such as fentanyl increased from 2,628 to 31,335, representing a 12-fold increase in overdose deaths.[3] Though opioid use has increased in urban, suburban, and rural settings, at least 1 study suggests that the lifetime incidence of opioid overdose is higher among rural versus urban residents.[4] One reason for this may be that residents of rural communities face substantial barriers to accessing treatment for OUD. A systematic review of the literature on rural-specific barriers to treatment identified limited availability of evidence-based OUD treatment options, including medication-assisted treatment (MAT).[5] Additionally, rural health care consumers face a dearth of treatment options offering concurrent psychiatric services and MAT.[6–8] Where appropriate services do exist, rural residents may still face severe travel hardships, such as longer travel distances to clinics.[9–11]

Rural communities also struggle with high rates of intimate partner violence (IPV). Though rates of IPV are similar across urban, suburban, and rural areas, rural women experience more incidents of severe physical violence and begin to experience violence earlier in a relationship than their urban counterparts.[12–14] Some forms of IPV, such

as stalking and homicide, may also be more prevalent in rural areas,[15,16] and rural IPV survivors may experience worse psychosocial and health outcomes due to the lack of accessible IPV services.[16] For example, 1 study found that the mean distance traveled to the nearest IPV resources was 3 times greater for rural women than for urban women, and that rural IPV services offered fewer on-site shelter services and had to stretch slimmer resources over a greater geographic area.[14] Additionally, rural IPV survivors may face disproportionately fewer employment and housing options than urban or suburban residents, limited or no public transportation, and stigmatizing attitudes about IPV.[17–19] A study of urban and rural IPV service providers in North Carolina and Virginia found that compared to providers in urban areas, more rural providers viewed clients as having multiple concurrent issues that could not be treated by their agencies.[20] The same study found that rural providers were also more likely than urban providers to report that their agencies were understaffed and under-resourced, and more likely to perceive that their clients faced significant stigma.

Opioid use and IPV contribute separately to poor health and psychosocial outcomes in rural communities, and together they create a synergistic effect. There is a known, bidirectional relationship between substance use disorders (SUDs) and IPV, such that substance use may precede IPV, and experiencing IPV is related to subsequent substance use.[21] One meta-analysis found that among women experiencing IPV, the prevalence of co-occurring substance use or dependence ranged from 7% to 25%.[22] Additionally, past-year SUD is over 3 times more prevalent among women experiencing physical IPV victimization in their current relationship (3.6%) than women not in violent relationships (0.7%).[23] Research suggests that abusive partners may coerce partners to use drugs, or interfere with treatment and recovery, to control victims.[24] IPV survivors have also described how substance use by an abusive partner appears to worsen violence, paranoia, jealousy, and arguments over the procurement or sharing of drugs.[25]

Taken together, the literature on both opioid use and IPV in rural communities suggests that these 2 problems may be mutually reinforcing and associated with severe negative health outcomes. They may also be problems for which existing services are mostly unavailable, inaccessible, or inappropriate for those in need. This qualitative study explored themes about barriers to substance use treatment for women who experience IPV and opioid use in rural Vermont. The goal was to collect descriptive information to aid in the development of interventions to facilitate better treatment access for this population.

Methods

Study Overview

One-on-one telephone interviews with women who experienced both IPV and OUD in rural Vermont took place between February and August 2019 (N = 33). All materials and procedures were reviewed by the Boston University Medical Campus Institutional Review Board. Participants received a $50 gift card as compensation.

Study Recruitment and Participants

Participants were recruited via community flyers and snowball sampling (ie, individuals were referred by others who thought they might be eligible). IPV providers and recovery coaches made the advertising flyers available to potentially eligible participants. This was anticipated to be the most resource-efficient way to reach the specific target population as quickly as possible. IPV service providers were contacted about participation by the Vermont Network Against Domestic and Sexual Violence, which is the coalition of domestic violence service providers in the state and was a partner on the research project. Interested individuals contacted research staff for eligibility screening. Eligible individuals were those 18+ years of age, who lived in Vermont or had used a Vermont social service in the past 5 years, had experienced IPV in the past 10 years, and would describe themselves as someone who has struggled with opioid use in the past 5 years. The rationale for choosing the timeframe of past 10 years for IPV experience and 5 years for opioid use was that we wanted to balance the need for recent experiences—which would be most informative for intervention planning purposes—against the fact that Vermont is not a populous state, the target population is rare and hard to reach, and the research team faced constraints related to the timeline and financial resources for the project. As a result, our eligibility criteria were carefully constructed to yield sufficient respondents with the relevant experiences according to the project timeline with acceptable recall of the conditions of interest. Eligible participants were asked to read and fill out an electronic consent form. Once participants completed the consent form, they participated in the interview by phone.

Interview Procedures

The interview guide was developed in consultation with our community partner (author DK) and our project advisory board of 4 individuals with lived experience of OUD and IPV. The guide covered the onset of opioid use and periods of heaviest use, experiences with IPV, the

participant's perception of the relationship between opioid use and the violence they experienced, and participants' experiences with help-seeking, including barriers or obstacles to care and what they would change to help other people in similar situations. The average length of time per interview was 38 ± 10.7 minutes and the median was 37 minutes. One interview was only 15 minutes in length due to participant preference not to go into depth in discussing upsetting experiences. This participant was still able to provide helpful information on their help-seeking experiences and barriers to care. Interviews took place by phone because it was more convenient, and in some cases safer, for research participants to not be required to travel and meet somewhere in person. It was also more resource-efficient for the research team. Authors RS, JC, and ER conducted interviews. JC and ER had prior experience as domestic violence shelter employees and counselor-advocates, and RS had prior experience as a domestic violence qualitative researcher. Researchers used a semistructured interview script and asked participants to describe their life and their experiences with IPV and opioid use. Regarding opioid use, participants were instructed that if they were prescribed opioids and used them exactly as indicated by a doctor, that would not count as misuse. However, if they took more than prescribed, or took opioid medications not prescribed to them, we would like to hear about it. Quantitative demographic questions were also asked. Audio-recordings of the interviews were transcribed, all personally identifiable information was removed, and transcripts were analyzed.

Analytic Procedures

The transcribed interviews were coded according to the flexible coding techniques described by Deterding and Waters,[26] guided by sensitizing concepts suggested by our review of the literature on substance use and IPV in rural communities. Sensitizing concepts have been referred to as "background ideas that inform the overall research problem" and can provide a starting point for building analysis, but they are not the end point of the analysis.[27,28] In this analysis, the sensitizing concepts were used as a jumping-off point for deeper analysis of the meaning and interrelationship of these concepts in the lives of our participants. Through this open-coding approach, we identified 5 major themes: (1) geographic isolation and transportation challenges, (2) inaccessibility of existing OUD and IPV services, (3) lack of integrated OUD and IPV services, (4) social isolation, and (5) amplification of stigma in small rural communities.

To establish reliability for these themes, we followed a procedure for coding in-depth semistructured interviews as described by Campbell and colleagues.[29] Two authors coded 50% of the interview transcripts each and compared their results. Disagreements over codebook interpretations were resolved through discussion. Disagreements stemming from different unitization of the transcript data were resolved by taking a sample of 30 "unit of meaning" excerpts from a randomly selected sample of approximately one-quarter of the interview transcripts. Two authors coded these unitized excerpts and achieved 90% intercoder reliability (Cohen's $k = 0.877$, $z = 10.4$, $P < .001$, 95% bootstrap CI: 0.73-1.00, SE = 0.068). Based on these results, the coding for the remaining interviews was refined according to the updated codebook.

Table 1 Demographic Characteristics of Participants

	N
Gender	
Female	32 (97%)
Transgender or nonbinary, gender queer	1 (3%)
Race	
Black/African American	0 (0%)
White	28 (85%)
Hispanic	1 (3%)
Multiracial	3 (9%)
Asian	0 (0%)
Native Alaskan, Native Hawaiian, Native American, or American Indian	1 (3%)
Other	0 (0%)
Native language	
English	33 (100%)
Spanish	0 (0%)
Other	0 (0%)
Age in years (mean ± SD)	34 ± 8
Presently a resident of Vermont	33 (100%)

Results

Sample Demographics

Almost all participants identified as female (97%); 3% identified as transgender, gender nonbinary, or gender queer. The majority (85%) identified their race as White, and the average age was 35 years. Demographic characteristics of study participants are displayed in Table 1. Vermont is the second-most rural state in the United States by rural population according to USDA-ERS definitions.[30] At the time of data collection, 82% of participants lived in a nonmetro area, though many participants had lived at multiple addresses during the time period covered by the interview guide. Approximately half (47%) said that they had ever had an opioid overdose experience. Approximately 64% said they had ever been to residential substance use treatment, 90% said they had ever participated

in outpatient substance use treatment, and 67% said they had ever participated in a 12-step program (eg, Alcoholics or Narcotics Anonymous). Over two-thirds (79%) of participants said they were the biological parent to any children. Approximately half (52%) indicated that they had been incarcerated in the past 10 years. Information about opioid use and IPV experiences is presented in Table 2. Based on responses to the survey questions, 31 (94%) of 33 participants met criteria for OUD in their lifetimes.

Themes

Theme 1: Geographic Isolation and Transportation Difficulties

One of the major barriers to getting free from abusive relationships and/or obtaining SUD treatment services was the rural setting and relative geographic isolation. This theme appeared in interviews with 16 participants (48%). In at least 2 cases, abusive partners were able to use geographic isolation to further their control. For example, they would leave participants stranded in their homes or on the sides of rural roads as a form of punishment. The remoteness of some rural communities, and how difficult this remoteness made it for participants to leave their homes to seek help, was exacerbated by Vermont's freezing winter weather. In the words of 1 participant:

> He would take my – my shoes and all the baby's, like, warm winter gear, so we couldn't leave […]. He would unplug the phone so I couldn't call nobody. […] The nearest town was, like, 2 miles away. And we would – like, me, I could do it easily, but with a newborn baby without a winter coat… I was aware of a lot of places that I could go, [but] I just couldn't. I wasn't able to. (Theresa)

More commonly, geographic isolation meant that needed services were located far from where participants were living. Participants were aware of service providers and organizations that could help them, but these were rendered inaccessible by distance:

> I mean, there was nowhere that I could go [near me] to check myself in or try and detox. I could've gone to [a facility], but that's almost 2 hours away, and same with [a second facility]. (Samantha)

Far-flung population centers and their resources were made even more inaccessible by the lack of public transportation:

> Because of the way that Vermont's structured, there's no regular public transportation or anything.

Table 2 Opioid and Partner Violence Experiences

	N (%)
Have you ever had an opioid overdose experience?	
Yes	14 (47)
No	16 (53)
Have you ever taken any of the following drugs in the past 5 years? (Check all that apply)	
Heroin	24 (73)
Methadone	10 (30)
Buprenorphine	15 (46)
Morphine	7 (21)
MS Contin	1 (3)
OxyContin	21 (64)
OxyCodone	16 (49)
Other opioid analgesics (eg, Vicodin, Darvocet)	30 (91)
Think about the period of time when you were using your opioid drug of choice. (Check all that apply)	
Did you ever need to use more opioids to get the same high as when you first started using the opioids?	32 (97)
Did the idea of missing a fix (or dose) ever make you anxious or worried?	27 (82)
In the morning, did you ever use opioids to keep from feeling "dope sick" or did you ever feel "dope sick?"	31 (94)
Did you worry about your use of opioids?	25 (76)
Did you find it difficult to stop or not use opioids?	28 (85)
Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high?	26 (79)
Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids?	28 (85)
In the past 10 years have you ever experienced a conflict with an intimate partner (romantic or sexual partner, spouse, boyfriend, or girlfriend) where that person did any of the following to you? (Check all that apply)	
Slapped, pushed, kick, bit, punched, pinched, shook you	33 (100)
Burned you, or hit you with something hard other than a fist	11 (33)
Threatened to kill you, your children, a family member, or a pet	20 (61)
Threatened you with a knife or gun, or shot a gun to scare you	16 (49)
Forced you to do sexual things that you did not want to do	15 (46)
Did something that resulted in a restraining order against that person	20 (61)
Have you received helping services from any Vermont domestic violence agency in the past 10 years?	
Yes	22 (69)
No	10 (31)
Missing	1 (3)
Have you been incarcerated in the past 10 years?	
Yes	16 (52)
No	15 (48)
Missing	2 (6)
Are you the biological parent to any children?	
Yes	26 (79)
No	7 (21)
Have you ever been in residential substance abuse treatment?	

(*Continued*)

Table 2 Continued

	N (%)
Yes	21 (64)
No	12 (36)
Have you ever participated in outpatient substance abuse treatment (Not AA or any 12-step program)	
Yes	29 (90)
No	2 (9)
Missing	1 (3)
Have you ever participated in any 12-step program for 3 or more sessions?	
Yes	20 (67)
No	10 (33)
Missing	3 (9)

> There was nowhere to go. I was in a town. The next town…was 20 miles away, [another] town was 15 miles away, and this was the only little town in between. And I walk a mile 1 way, I'm on the interstate. I walk a mile the other way, I'm on the interstate. There was nowhere to go. (Kristin)

Participants reported that most buses did not drive between towns but provided transport only to the local hospital or grocery store. Buses that went further distances did not operate on weekends, which was a major barrier for those who relied on buses to get to clinics for opioid-use-related medication:

> I would have to get up at 4:00 in the morning, get on a bus, and…even though I only had to dose for 5 minutes, I'd be at the [bus hub] for 3 hours waiting for the next bus to come back. (Kristin)

Weekend access was even more difficult:

> On Sundays, the bus doesn't run, so usually I have to find a ride, and that's money coming out of my pocket that I don't have. (Liza)

Although in some areas substance use treatment centers have established their own van or bus services for those needing to get to the clinics, participants explained that they faced similar scheduling problems with these special transport services—including long wait times, and inconvenient early morning schedules. Participants explained that dependence on these vans and buses made it difficult for them to arrange childcare and to find or maintain paid employment.

Theme 2: Inaccessibility of Existing Substance Use Treatment and Domestic Violence Services

Two-thirds of our study participants described inaccessibility of services as a barrier to care (n = 22, 67%). A difficulty commonly described was the lack of space at existing substance use treatment and domestic violence service programs. For example, participants cited waiting lists as barriers to needed services.

> Every time you called [to get into substance use treatment], you would hear, oh, we'll give you a call in 3 months. And when you hear that you can get into rehab in 3 months, that's not really…reality for you. (Peggy)

Peggy had visited an emergency room for assistance with opioid use recently and reported:

> …it was a 6-hour process to get a prescription for that day and the next day. […] Just like I told them right there at the hospital, you're crazy if you think that anybody would come and sit here and be sick for 5 hours before they get something from you guys. […] If you had told me that I had to wait 5 hours and then come back every 2 days, I would have told you it was easier to get dope off the streets.

Leslie also sought help through the emergency room and faced a 2-week wait for a bed in a treatment center. Wait lists and delays also existed for IPV services, especially for temporary or permanent housing support. Cheryl said:

> They can give you a certain amount of days in a hotel, but once that's gone, it's like, what's next? It's such a long process to get permanent housing nowadays that it got to the point where it would be 30 [degrees] at night, and I would be walking the streets with [my child] and finally a friend of mine would take him for the night and I'd sleep in my friend's car.

Similarly, Yolanda faced a long wait for space in a women's shelter:

> I kept calling [the DV Shelter] to see if there was any space available, because I had just gotten out of a domestic violence situation. It took a couple months, but [I got in] because I was persistent in calling and calling and calling.

Participants also identified a shortage of recovery or transitional housing options for women in particular,

especially for women with dependent children. Liza explained:

> There's no halfway house for women around here, and if there is, it's way down by [name of town] or something 3 hours away.

Another participant explained that even if space was available in a women's shelter, she could not access it if the shelter did not allow children:

> "I wish there were more family shelters. There's not hardly enough. The shelters I called, I couldn't have kids there. And I'm like, I have kids, I can't go to a shelter and not have my kids there, so what, I'm gonna go sleep in the car? Or I'm gonna go inside and have my kids sleep in the car outside? Are you kidding me?" (Leslie)

Cheryl echoed this sentiment:

> I think that there should be definitely a lot more family shelters because there's like none. If you are a single mom, or a mom with children getting out of a bad relationship, they can only house you in a hotel for as much as economic services says.

Theme 3: Lack of Integrated OUD and IPV Services

Also problematic was the perceived lack of services to meet dual IPV and OUD needs. As Linda succinctly described it:

> There needs to be more places where there's a combination of getting out of [domestic violence] toxicity and detoxing. There should be a bigger place for battered women and [survivors of] sexual assault. It should all be in one building, like a big, big building for all of us.

Another participant expressed frustration that all she was able to receive in substance use treatment was "detox" services, and that facilities often offered little in the way of counseling, rehabilitative programming, or other supportive services. Jennifer said:

> When I went [to treatment] in January, Medicaid only paid up to 2 weeks. […] It was like getting in the door and getting pushed out the door as quick as possible. The therapist and counselor people […] talked to me once, then it's all paperwork from there on out. […] At least I was able to get in.

When asked about suggested solutions to help other participants facing similar barriers, participants described desiring a group living situation for women in recovery, preferably with supportive IPV services:

> Maybe a giant house where there's a bunch of rooms, and you can have a normal existence and be supportive while you're trying to [deal with IPV and OUD]. Kind of like a shelter. Kinda like that, only for people that are coming off drugs and domestic violence. (Linda)

Theme 4: Social Isolation

Social isolation was described as a lack of contact with other community members or community resources. This theme appeared in interviews with 19 participants (58%). In some cases, social isolation was used by abusive partners as a control tactic. Abusers demanded access to participants' phones, limited their contact with friends and family, and monitored their movements. This made it difficult for women to reach out for services that provide assistance with leaving the relationship or for substance use treatment. For instance, Antoinette explained that:

> He wanted my punchout slips when I got home from work. He was always accusing me of talking to people, going through my phone.

In at least 1 case, a participant's abusive partner kept her socially isolated by supplying and controlling her opioids to keep her dependent:

> When people would stop by to buy [drugs] they'd ask about me, and he would say I was sleeping even when I wasn't. He didn't let me talk to anyone. He didn't let me see anyone. Basically, he isolated me, and he basically got me my own painkillers as well as additional pain killers. (Courtney)

In other cases, the isolation was not as clearly an intentional abuse tactic, but the result of circumstances or experiences that made women feel it was better to be with their abuser than to be alone. Poor relationships with other family members, separation from children, and struggles with depression and anxiety often resulted in women having very small or nonexistent support networks outside of their partners.

> Instead of getting help, it's like I already have all these emotional issues, I'm depressed, and I spiraled, especially with this partner whom I should've rejected at that time, but had I done so, I would've been completely alone. (Carly)

Similarly, Kristin explained:

> I just kept thinking I should be just like him or he won't like me because with my father dying, […] he was kind of all I had.

Kristin's desperation to maintain this "really bad" relationship drove her to use more drugs:

> If I do more of the drugs that he does, and I get really on his level, then he won't leave me' […] I was trying to keep up with the amount of drugs that he was doing, and the next thing I knew, I couldn't get rid of the heroin.

Theme 5: Amplification of Social Stigma in Small Rural Communities

Participants struggled with the dual stigma of IPV and opioid use, especially in their small rural communities (n = 9, 27%). Their fear of being judged led to withholding information from service providers that could have been useful for referrals. For example, Rhonda successfully contacted the local IPV shelter for help leaving her relationship but continued to struggle with substance use:

> They didn't really know I was an addict. I never told them. I was like, more embarrassed.

Similarly, Linda said:

> I didn't even wanna ask. I used [a domestic violence shelter], and I didn't wanna tell them I was still on [opioids], and I wanted to get off it.

Reluctance to self-disclose substance use problems limits the ability of service providers to connect clients to other needed resources. For example, Lynn, who had previously worked as a human services professional, explained:

> I knew the resources, I knew where they were, I referred people there, and it was really my own sense of shame. […] I was too ashamed to seek them out probably because of the drug use because in my mind I thought maybe – well, I didn't want to get found out, I wanted to keep my job, I wanted to save face.

Participants reported that they felt more fear of being "found out" when they were living in rural communities than during the times in their lives that they had lived in cities.

> Everyone knows…. It sucks when you say "I'm going to [a domestic violence shelter]," and everyone knows you're going for domestic violence. [Services are] supposed to be confidential, but it really isn't [in a rural area]. (Courtney)

This concern was particularly salient for women using opioid-related medication-assisted therapies through local clinics, which offered very little privacy for clients waiting for their appointments:

> Well, we have a clinic here, and the thing about the clinic is you go in and dose every day, but it's also in front of everybody, and everybody that goes is gonna know you're going. That's what I don't like because in the meantime, I'm trying to maintain my job, and if everybody knows that I'm an addict, then I'm probably gonna lose my job. […] I mean, the clinics are great, but I don't think it's great that you stand in a line where everybody sees you. There's no privacy to it really. I mean, you sign forms that say, "I won't talk about anybody I see," but that doesn't really do anything. I mean, everybody knows who's in the clinic and who's not. (Diana)

The combination of social isolation and stigma contributed to restricted sharing of information through participants' limited social networks, leaving many unaware of available support services. Participants felt they had no one to talk to about what they were going through, at least not without risk:

> The whole thing is scary, being in relationships like that, being on drugs and then not knowing what exactly to do or not having many people to talk to. But then you have that fear of getting in trouble. (Cindy)

Discussion

In this study of rural Vermont residents, the interaction of IPV victimization, OUD, and rurality produced significant barriers to accessing needed services. Our results demonstrate that existing services are not meeting the needs of rural residents experiencing OUD and IPV. Geographic isolation meant that participants often lived far from service providers, and transportation issues made it difficult to get treatment or services. Moreover, these challenges were often exacerbated by harsh Vermont winter weather. Research on access to IPV services in rural environments in other US states supports our finding that few existing service providers, and long travel times to reach

them, is a substantial barrier to women obtaining needed resources in rural areas.[14,20,31,32]

The relative lack of service providers meant that participants faced long wait lists for beds in SUD treatment clinics or IPV shelters, with few options available for women with dependent children. This problem is also common in rural environments across the United States, where the few services in rural areas that do exist to support survivors of IPV, or those struggling with SUD, are often smaller in scope and size than similar services in urban areas.[14] Long wait times may serve to temporarily, or permanently, deter people from seeking care, especially if individuals experience it as a recurring problem. Furthermore, we found that existing services tended to be designed to meet the needs of SUD or IPV populations separately, but not the complex needs of people experiencing both. Accordingly, there is a need for increased cross-collaboration, training, and integration of care between IPV and OUD service providers.

Finally, social isolation and stigma limited information sharing through participants' networks, leaving many unaware of available services in their communities. While a lack of proximity to neighbors facilitates social isolation by making it harder for rural residents to develop friendships and social support networks,[30] shame and fear associated with reporting and utilizing services for IPV and OUD may act as a compounding deterrent to help-seeking behavior.[32]

The accounts shared here raise several potential solutions. First, an increase in the number of OUD and IPV service providers would help to reduce wait times but would not address the need for services that accommodate individuals experiencing concurrent OUD and IPV. Thus, there is a need for residential and outpatient services with programming developed by both addiction and recovery specialists and IPV service professionals. It is also important that such services accommodate the needs of women with dependent children. In particular, our participants identified the need for affordable, trauma-informed, medium-term housing options where women could live with their children while transitioning out of residential treatment facilities or abusive relationships. Second, there is a need for improved transportation services. Health care providers in rural West Virginia have reported success in utilizing non-emergency Medicaid transportation services to transport pregnant females struggling with OUD to health care appointments.[32] When possible, IPV and SUD facilities may consider leveraging existing transportation services covered by Medicaid for those who are eligible in order to expand accessibility and promote continuity of care. Telehealth solutions may also help overcome distance barriers, particularly as rural Internet infrastructure is strengthened. Third, stigma was identified as a primary barrier to help-seeking. Interventions that lessen stigma faced by IPV survivors and people with OUD experiences will be useful. For example, changing social norms through media campaigns that encourage acceptance of people with these and other problems could be beneficial. Finally, in reflecting on the stigma and secrecy surrounding both IPV and OUD experiences, many participants called for increased public education and awareness raising, beginning with school-aged children, and improved outreach by service providers to their communities.

Limitations

This study was limited by several factors. First, all data were self-reported and thus may be limited by participants withholding specific information that did not seem relative at the time of the interview, or because they wanted to appear more socially desirable to researchers. For example, a greater number of participants may have experienced transportation difficulties, but if this was not the most important barrier to them at the time of the interview, they may not have raised this concern. Additionally, due to the sensitive nature of the topic, it is possible that participants did not feel comfortable sharing certain aspects of their experiences with interviewers, and that some relevant themes or barriers were not explored. Therefore, our results describe the most salient concerns for our participants, but they do not comprise an exhaustive list of all concerns. Second, our sample of residents of rural Vermont is almost all White, thus our results likely do not capture the experiences of rural residents who are non-White and who face more severe barriers to OUD treatment[5] and remain underrepresented in the rural IPV literature.[33] Third, our eligibility criteria did not require that women had experienced IPV or OUD in the very recent past. It is possible in theory that if they experienced IPV 10 years ago, some of the challenges that they relayed could have been different than what women experience today. However, the themes that were raised by women with the more distant past experiences were reiterated by women in the sample with more recent experience, suggesting that the challenges faced by IPV survivors have not lessened or changed substantially in the past decade, and remain salient. Fourth, during our interview we specified that the opioid use in which we were interested was use other than "exactly indicated by a doctor," but we did not reiterate that language when we asked survey questions after the interview. It is therefore possible that some participants believed that we had switched topics to medical use of opioids for the survey, though we believe this possibility is extremely remote. Finally, due to our recruitment method, it is possible that our sample was biased toward

middle- and older-adult women with children, and that this particular subpopulation encounters different barriers from, for example, young women without children. Further research is needed to better understand the experiences of younger people experiencing both IPV and OUD.

Conclusion

This exploratory qualitative study is intended to elucidate the barriers to services faced by rural Vermont residents experiencing both OUD and IPV. To our knowledge, it is among the first to explore this topic from the perspective of rural people with lived experiences of concurrent IPV and OUD, and it highlights important treatment and service gaps that contribute to poor health and social outcomes. Our results provide a foundation on which to build larger, more complex research studies, particularly those conducted in collaboration with survivors and service providers, which will lead to more accessible, acceptable services and improved rural health.

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