JOURNAL OF WOMEN'S HEALTH
Volume 30, Number 9, 2021

DOI: 10.1089/jwh.2020.8699

Family Planning Providers' Assessment of Intimate Partner Violence and Substance Use

Amber L. Hill, PhD, MSPH,[1] Elizabeth Miller, MD, PhD,[2] Sonya Borrero, MD, MS,[3,4] Sarah Zelazny, MPH,[5] Summer Miller-Walfish, MPH,[6] Janine Talis, MPH,[6] Galen E. Switzer, PhD,[3,4] Kaleab Z. Abebe, PhD,[3] and Judy C. Chang, MD, MPH[1,3,7]

Abstract

Background: Intimate partner violence (IPV) and substance use are intersecting health problems that adversely impact sexual and reproductive health outcomes for women seeking care at family planning (FP) clinics. We aimed to characterize whether and how FP clinic providers (1) assessed for IPV and substance use and (2) combined IPV and substance use assessments.

Methods: Providers and patients (female, 18–29 years old, English speaking) at four FP clinics participating in a larger randomized controlled trial on provider communication skills were eligible. Providers received training on universal education, a research-informed IPV assessment approach. Visits were audio recorded, transcribed verbatim, and coded by two independent coders. We used inductive and deductive coding to assess providers' communication approaches and examined codes for patterns and categories. We then converted these approaches into variables to calculate frequencies among recorded visits.

Results: Ninety-eight patient–provider encounters were analyzed. In almost all encounters (90/98), providers assessed for IPV. Many providers adopted best practice IPV assessment techniques, such as universal education (68/98) and normalizing/framing statements (45/98). Tobacco use screening was common (70/98), but alcohol (17/98) and other drug use screening (17/98) were rare. In only one encounter did a provider discuss IPV and substance use as intersecting health problems.

Conclusion: This study provides insight on how FP clinicians, as key providers for millions of women in the United States, assess patients for IPV and substance use. Results show providers' willingness to adopt IPV universal education messaging and demonstrate room for improvement in substance use assessments and integrated discussions of IPV and substance use. Trial Registration Number: NCT01459458

Keywords: IPV, substance use, family planning

Introduction

It is common for U.S. women to use family planning (FP) clinics—stand-alone clinics that provide preventive sexual and reproductive health care—as their primary, and sometimes only, point of health care.[1–5] Approximately 70% of reproductive-aged women visit a FP clinic every year, and 40% of FP patients use FP clinicians as their sole health care provider.[1,5,6] FP providers are in a unique position to address other important and unmet needs related to women's sexual and reproductive health, such as intimate partner violence (IPV) and substance use.[3,7,8]

One in three women have experienced lifetime physical or sexual violence perpetrated by a partner or ex-partner.[9] Among FP clinic-based samples, IPV prevalence is as high as 50%.[10–12] IPV can lead to myriad health consequences

[1]University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA.
[2]Department of Pediatrics, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA.
[3]Department of Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania, USA.
[4]Center for Health Equity Research and Promotion (CHERP), Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania, USA.
[5]RAND Corporation, Pittsburgh, Pennsylvania, USA.
[6]Division of Adolescent and Young Adult Medicine, UPMC Children's Hospital of Pittsburgh, Pittsburgh, Pennsylvania, USA.
[7]Department of Obstetrics, Gynecology & Reproductive Sciences, University of Pittsburgh, Pittsburgh, Pennsylvania, USA.

(*e.g.*, sexually transmitted infections (STIs) and unintended pregnancy) and influence contraceptive use.[11,13] Several organizations have guidelines about how providers should discuss IPV with patients.[13,14]

The Providing Quality Family Planning (QFP) Services Recommendations note that providers should screen women of reproductive age for IPV during preconception counseling.[13] The American College of Obstetricians and Gynecologists (ACOG) guidelines offer recommendations beyond traditional screening (*i.e.*, ''yes''/''no'' questions requiring an individual to answer ''yes'' before receiving resources), including: (1) using normalizing statements (*i.e.*, ''we talk to all of our patients about safe and healthy relationships'')[14] and reviewing confidentiality before discussing IPV, (2) assessing all patients regardless of provider suspicion level, and (3) providing educational resources regardless of disclosure.[14] While QFP Recommendations promote traditional screening,[13] there is evidence of the effectiveness of universal education approaches more in line with ACOG guidelines.[14–16] Universal education is centered around equity-based frameworks, encouraging clinicians to discuss IPV with and provide resources to all patients.[12,15,16] This approach, provided it is conducted in an empathetic and nonjudgmental manner, is supported by patient-centered qualitative literature.[17,18]

Guidelines also exist on the importance of assessing for substance use, including tobacco, alcohol, and other drugs, in sexual and reproductive health care settings.[13] QFP Recommendations suggest that providers screen women of reproductive age for tobacco, alcohol, and drug use during preconception services and for tobacco use only during contraceptive services. Substance use, like IPV, is significantly associated with adverse health consequences.[19–21] Furthermore, substance use plays an influential role in care-seeking behaviors and contraceptive use.[3,13] For example, Hall et al.[3] demonstrated that individuals who used substances sought sexual and reproductive health care more often compared to those who did not use. Understanding substance use behaviors will allow for more effective contraceptive counseling; studies have shown patient acceptability in providers' substance use assessments.[5,22]

There is increasing awareness of the strong association between IPV victimization and substance use, which may exacerbate poor health outcomes.[23–26] IPV exposure may increase use of substances as a coping strategy, and substance abuse may increase risk for exposure to violence.[25] Researchers have described a phenomenon known as substance use coercion, which includes controlling behaviors such as interfering with a partner's substance use disorder treatment, pressuring/forcing a partner to use substances, or reporting/threatening to report a partner's substance use to force that individual to do something against his/her will.[26,27] One national study of over 2,500 women who had experienced IPV noted a 43% lifetime prevalence of substance use coercion.[26] However, the aforementioned guidelines on IPV and substance use currently exist in siloes, offering limited advice about how to address these often co-occurring problems.

Despite guidelines and our knowledge of how IPV and substance use intersect, little is known about how FP providers are asking patients about IPV and substance use. Using audio-recorded clinical encounters, we examined patient–provider communication for both content and approach to characterize whether and how FP clinic providers (1) assessed for IPV and substance use and (2) combined assessments for IPV and substance use.

Methods

This patient–provider communication analysis was embedded within a randomized controlled trial conducted at four FP clinics (two intervention, two comparison) in Western Pennsylvania. Parent study results were previously published.[28] The parent study assessed differences in IPV assessment frequency between clinicians who received interactive training on patient–provider communication skills (*e.g.*, N-U-R-S-E, ask-tell-ask)[29–31] compared to those who received general didactic IPV training. Providers in the intervention arm engaged in role-playing exercises with trained actors to strengthen communication skills in IPV-specific contexts.[28] In both arms, clinicians received IPV awareness training, stressing universal education as opposed to traditional screening paradigms. Researchers trained providers to introduce the topic of healthy/unhealthy relationships to all patients in a normalizing way, inquire if this is a concern in a nonjudgmental tone (*i.e.*, ''is any of this a part of your story?''),[32] provide educational resources to all patients, and respond with validation and empathy if the patient disclosed IPV.[16] This approach is supported by studies demonstrating patients' desires for knowledge and resources without necessitating disclosure on their part.[17,18,33] To facilitate universal education, all providers received wallet-sized safety cards to distribute to patients with important facts and resources on healthy relationships.[10,16,28] Neither arm received training on substance use assessments or communication.

Patient–provider encounters were audio recorded. We sought to describe the content, style, and approach with IPV and substance use assessments (*e.g.*, how providers ask questions and start conversations) in the recorded encounters. These descriptions were converted to variables to assess frequencies among visits. Given the parent trial's null results (*i.e.*, frequency of discussions on IPV was similar between intervention and comparison arms), we grouped all visits for analyses.[28]

All providers from participating FP clinics were eligible. Patient eligibility criteria included: (1) female, (2) 18–29 years, (3) English speaking, and (4) scheduled for a clinic visit with a provider enrolled in the study. Patients who consented to the parent study (and met the above criteria) were asked to participate in an audio-recorded visit with their provider.

Research staff placed a digital voice recorder in the examination room before arrival of the FP provider and collected the recorders after the encounter was completed. Visits lasted between 7 and 115 minutes; most visits were between 10 and 40 minutes. Data were collected from December 2014 to August 2015. All participants provided written informed consent. The University of Pittsburgh Institutional Review Board approved study procedures.

Intimate partner violence

In 2015, a team of research assistants listened to audio recordings in full, transcribing verbatim the parts of the visit where IPV was discussed. Transcriptions were quality checked. Two researchers (A.L.H., S.Z.) coded each transcript separately, using ATLAS.ti (Version 7) to store and organize the analysis. The preliminary codebook was based on a prior study conducted on IPV-related patient–provider communication

(deductive coding).[34] Researchers also applied additional interpretive codes in an emergent manner as they noted processes or content not contained in the preliminary codebook (inductive coding) and met to discuss definitions and applications, updating the codebook as needed.

Substance use

While the original study was designed to investigate IPV assessments, the authors wished to include substance use given its well-established association to both IPV and broader reproductive and sexual health outcomes,[19–21,23–26] as well as emerging awareness of substance use coercion.[26,27] In 2019, a team of research assistants re-listened to the audio recordings in full and transcribed verbatim the parts relevant to tobacco use, alcohol use, and/or other drug use (adding to the previously transcribed portions about IPV). A separate researcher (A.L.H.) performed quality checks on 25% of the transcripts. Two researchers (A.L.H, S.M.W., or J.T.) independently coded each transcript using a previously defined codebook from studies conducted to assess substance use screening among obstetricians,[35,36] adding codes in an iterative and collaborative manner with the assistance of Dedoose (Version 7.0.23).

IPV and substance use

For IPV and substance use, we reviewed all transcripts to determine whether any assessment occurred and, if so, how the providers asked the assessment questions (*e.g.*, style and time frame), how they framed the questions, how they responded to positive disclosure, and the context in which they asked the questions. Intercoder agreement was calculated manually using Cohen's kappa coefficient for the presence/absence of IPV discussions and screening for tobacco, alcohol, and other drug use.[37,38]

Results

Eighteen providers (eight nurse practitioners, 10 medical assistants) participated; we recorded and coded 98 patient–provider encounters. Most patient participants identified as white (79.6%), college educated (65.3%), and being in a relationship/dating one person (62.2%) (Table 1). The mean age was 22.6 years. Participants sought care for contraceptive methods other than condoms (33.3%), STI testing or treatment (14.6%), or an annual checkup (11.5%). Cohen's kappa statistic ranged from 0.91 to 1.0 for presence/absence of IPV-related discussions and 1.0 for presence/absence of substance use assessments, demonstrating excellent intercoder agreement.[38]

Intimate partner violence

Ninety encounters (91.8%) contained discussions related to IPV, healthy relationships, or other controlling partner behaviors (*e.g.*, reproductive coercion). Provider communication on these topics included inquiry/screening for IPV, provision of IPV awareness or education, and/or responses to IPV disclosure. In 68 visits (69.4% of total visits), providers offered universal education through a wallet-sized safety card. In 83 encounters (84.7% of total visits), providers asked patients ''yes/no'' IPV screening questions (*i.e.*, ''Do you feel safe living at home?''). Despite an emphasis on universal education, in 14 of 83 encounters (16.9%) providers asked isolated screening questions with no efforts to normalize the conversation or provide resources. In seven encounters, patients disclosed IPV—six were in response to provider assessment and only one disclosure was spontaneous before the provider initiated any form of IPV communication.

Table 1. Patient Demographic Characteristics

Patient characteristics (n = *98*)	*Total %* (n)
Race	
Asian	1.0% (1)
Black/African American	12.2% (12)
Hispanic or Latina	2.0% (2)
White	79.6% (78)
Multiracial/other	5.1% (5)
Age, mean (SE)	22.6 (0.36)
Education	
Less than 12th grade	16.3% (16)
Finished high school	18.4% (18)
Some college	38.8% (38)
College degree or higher	26.5% (26)
Relationship status	
Single	28.6% (28)
Dating more than one person	1.0% (1)
In a serious relationship/dating one person	62.2% (61)
Married	8.2% (8)
Reason for visit[a]	
Annual checkup	11.5% (11)
Contraception other than condoms	33.3% (32)
STI test or treatment	14.6% (14)
Pregnancy test/option counseling	6.3% (6)
Painful urinations/sores/pain around genitals	1.0% (1)
Irregular bleeding	3.1% (3)
Abdominal pain/pelvic pain	4.2% (4)
Abortion (in clinic today for procedure or follow-up)	1.0% (1)
Other	4.2% (4)

[a]Patients were allowed to select all that apply.

As mentioned, a key goal of the trainings in both arms was to emphasize universal education of IPV; providers discuss IPV with all patients and offer resources regardless of disclosure.[28] Among encounters, 71 patients received the safety card and 68 patients received a description of the safety card, as demonstrated by this example:

> ''[The safety card] does talk about relationships, healthy relationships. If you look at this little thing, it talks about something: people don't realize that they're in controlling, unsafe relationships because they don't understand how things can start with minor kinds of events and activities, and progress where people are telling you what you can do and when you can do it, even though they may not be physically hurting or harming you.''

In offering the safety card, many providers clarified that this information was given to everyone. This type of normalization occurred in 45 encounters (*e.g.*, ''We do want to make sure that everybody is aware of healthy relationships''). These normalizing statements often included suggestions or encouragement for patients to pass along the safety cards and expand awareness of IPV and existing resources, such as:

> ''I'm gonna give you an information card. We give these out to everybody. Anybody who walks through this door gets one. If you don't need it, awesome. If you need it for a friend, that would be helpful; if you know anybody you would give it

out to. It's just something we give out, and it's helpful to our patients because we care about you. If you have any questions, they'll talk to you on the phone.''

Among those 83 patients who were asked screening questions of IPV, 43 were asked about current relationships only, 13 were asked about past abuse only, while 27 were asked about both. Providers screened for IPV with either direct (50/83, 60.2%) or indirect (58/83, 69.9%) questions. By asking directly, clinicians explicitly used terms such as ''abuse'' (*e.g.*, ''Have you ever been physically, emotionally, or psychologically abused at all?''). By asking indirectly, providers assessed for general safety concerns (*e.g.*, ''Do you feel safe at home and in your relationship?). In addition, in 25 encounters (30.1%), providers used both indirect and direct styles, generally using indirect questions to begin the conversation and then continuing to more specific questions.

Another aspect of IPV screening communication was providers' use of leading or grouped questions. Leading questions refer to those in which the provider indicated an expected response or framed the question more as a confirmation of an assumed answer (*e.g.*, ''No problems with domestic violence, no one's hurting you?''). This occurred in 23 of 83 encounters (27.7%) with IPV screening questions. Grouped questions refer to when the IPV inquiry occurred among a cluster of related questions without any pauses between to allow the patient to answer each question individually. Of the 16 encounters with these questions, IPV was mostly grouped with other types of abuse (*e.g.*, ''Are you or have you ever been a victim of child abuse, or were you ever abused as an adult?'').

Finally, only seven patients (7.1%) disclosed IPV experiences, all of which were with previous partners (*i.e.*, not currently experiencing IPV). In all cases, providers responded with follow-up questions. Most commonly, providers asked whether the patient received counseling and assessed if the patient was still with the partner. Responses included empathetic and validating statements (*e.g.*, ''Nobody has a right to do anything to you that you don't want them to''). In some cases, providers' response to the patient's IPV disclosure was considered a missed opportunity for further inquiry and counseling:

Provider: ''Ever have a history of child abuse or any domestic violence?''
Patient: ''Domestic violence, yes.''
Provider: ''Ok.''
Patient: ''With my ex-husband.''
Provider: ''Are you in counseling at all?''
Patient: ''I am in counseling once a week, every week, at [name of place].''
Provider: ''And, do you drink caffeine at all?''

Substance use

Providers screened for tobacco use in 70 visits (71.4%). In all 70, patients were asked about current use; in only four were they also asked about past use. Leading questions were common ($n=30$, 42.9%). Providers varied in their response to disclosure of tobacco use. Of those who disclosed past or current tobacco use ($n=29$), providers asked follow-up questions to obtain more information (*e.g.*, ''How much do you smoke?'') in 16 encounters (55.2%). Some providers offered affirming comments, as demonstrated by the following example:

Provider: ''Do you smoke, honey?''
Patient: ''I quit.''
Provider: ''Alright, good for you! Good for you. How'd you quit?''

In three encounters, providers spent time to educate patients on the adverse health effects of smoking. In only one encounter did a provider offer smoking cessation resources to a patient.

Alcohol use screening was much less common than tobacco use ($n=17$, 17.3%). Among 14 encounters (82.4% of all alcohol discussions), providers assessed current use only. In two visits, the time frame was unclear (*e.g.*, ''alcohol?''). Leading questions were uncommon. A total of 12 patients disclosed drinking alcohol. Of those who were asked and disclosed alcohol use, providers asked follow-up questions in six cases (50.0%). The two most common follow-up questions included: ''Is it social?'' and ''How often?.'' There were no cases in which the provider offered education or resources with regards to alcohol use.

Similarly, drug use screening was uncommon ($n=17$, 17.3%). In 10 encounters, providers assessed for current drug use. Among those, eight also involved questions about past drug use. Only two patients disclosed past drug use. In six encounters, providers combined alcohol use and drug use screening (*e.g.*, ''do you feel like you have any issues with drugs or alcohol?''). Unlike screening for tobacco or alcohol use, providers often asked patients about their partners' use of drugs. For example, in 18 encounters, the provider explicitly asked whether the patient had or has a partner who uses intravenous (IV) drugs. In five cases, the providers only asked about the patient's partner and did not screen the patient for drug use. Other common questions included whether the patient shared needles ($n=13$) or whether she misused prescription drugs ($n=7$). In the two cases where a patient disclosed past drug use, the provider was already aware based on her medical records, tailoring the conversation and assessing for details about treatment. Both patients also had previous partners who used drugs as well.

IPV and substance use

Providers commonly asked about substance use and IPV directly before or after one another. IPV assessments frequently followed tobacco use screening ($n=26$), in addition to conversations about contraception, STIs, or other components of the patient's sexual and medical history. After IPV assessments, providers often discussed contraception or other sexual and reproductive health questions. In 10 cases, providers took vitals, and in another 10 cases, providers asked for urine samples, blood draws, or STI testing immediately after IPV assessments. In 12 encounters, the providers discussed IPV either immediately before or during a physical examination (*e.g.*, gynecological examination and breast examination). Regarding other substances, questions about alcohol use were typically preceded by tobacco use and prescription drug misuse screening and followed by IPV assessments or questions about work hazard exposures. The most common questions before and after drug use screening involved partners' STI-related symptoms and other substance use (*i.e.*, tobacco and alcohol), respectively.

In one encounter in which a patient disclosed lifetime IPV and drug use, her provider explored how her experiences with substance use and IPV were related:

Provider: ''Good, what about as far as any sexual behavior during drug use or anything like that, has that been a problem for you in the past or is that something that you have dealt with?''

Patient: ''It's something that I've dealt with, my ex-boyfriend he's on heroin really heavily and that was the only time he ever wanted to do anything intimate like that.''

Provider: ''Okay.''

Patient: ''We actually broke up because of it because I got really scared the one time because he held me down and said that he was gonna come inside me and get me pregnant or try to get me pregnant and like I got really scared and like I just like didn't want that to happen and like then something be the matter with anything.''

Provider: ''Right. Like with the baby.''

Patient: ''So like we broke up and stuff that was the only thing.''

Provider: ''Okay. Did he force you to use [drugs] or was that something he just did?''

Patient: ''Um…No.''

Provider: ''Or did you consensually do it or did you do at all?''

Patient: ''I didn't really consensually do it. The first time it happened it was not my choice.''

Discussion

We offer direct insight into patient–provider discussions on IPV and substance use during FP clinic encounters. Trained clinicians demonstrated willingness to talk with patients about IPV and provide universal IPV education. Screening for tobacco use occurred frequently but screening for alcohol and drug use was relatively rare. FP providers' assessment styles varied, but common practices emerged. First, providers often asked IPV questions either directly before or after substance use. Second, they frequently asked about current IPV and substance use only without inquiring about past experiences. Third, leading questions were common. Finally, many providers offered validating and empathetic statements in response to patients' disclosures of IPV or substance use.

Despite an emphasis on universal education in intervention and control arms, IPV screening remained more common than universal education. The most common form of screening was through indirect questions, generally different iterations of ''do you feel safe at home?,'' which research has demonstrated poor sensitivity in detecting women's experiences with violence.[39] When providers explicitly named violence, IPV was often grouped with other types of abuse (*e.g.*, child abuse or abuse by a nonpartner) and asked as a multipronged question. Survey research and communication literature demonstrate that these types of questions are often confusing to respondents.[40,41] However, screening questions were often supplemented later in the visit with conversations related to the wallet-sized safety card, which contained relevant resources. This provides some preliminary evidence of the utility of resource aids to help facilitate conversations between health care professionals and their patients. These publicly available resources provide examples of framing statements (Table 2).

Seven patients disclosed IPV, despite previously published quantitative results from the same population showing a lifetime IPV prevalence of 44.7%.[28] Only one patient disclosed spontaneously. These results support other studies which indicate that patient IPV disclosure is unlikely if providers do not raise the topic and is consistent with the myriad studies documenting patient-reported barriers to IPV disclosure.[34,43] Patients are often fearful of retribution from partners, judgment from providers, and legal repercussions (*e.g.*, losing their children), among other factors.[17,18,33] When patients do disclose, it is important that providers have training on how to offer supportive statements (Table 2). To help facilitate this process, guidelines advise that FP clinics formally partner with local domestic violence agencies.[13]

Our findings regarding substance use communication illustrate that providers' screening varied by substance with providers more likely to ask and discuss tobacco use. This is consistent with other research which has shown that providers feel more comfortable and competent discussing tobacco use compared to other substances.[44,45] These findings are also in line with QFP Recommendations, which note that FP providers should assess for tobacco use during both preconception health services and contraceptive services and only assess for alcohol and other drug use during preconception health services.[13] ACOG provides specific verbiage through guidelines endorsing quick educational interventions, such as the five A's (Ask, Advise, Assess, Assist, Arrange) for smoking cessation.[46]

More research is needed to better understand how FP providers see their role in substance use screening, education, and counseling, particularly given the changing landscape of substance use in the United States (*i.e.*, the opioid epidemic). Like IPV, providers face multiple barriers in assessing for substance use. Qualitative literature from primary care settings has demonstrated that despite providers' knowledge that substance use is detrimental to health and should be screened for, barriers such as limited training, time, and resources prevent them from doing so.[47] In an effort to address this in the FP setting, there has been emerging evidence about the feasibility of SBIRT (Screening, Brief Intervention and Referral to Treatment). Hettema et al.[5] noted high rates of patient acceptability of SBIRT among almost 200 women's health clinic patients. In addition, Appel et al.[22] discussed the potential feasibility of implementing SBIRT in an abortion clinic, stating patients' high comfort levels with being asked about substance use. Finally, Gotham et al.[48] demonstrated favorable FP provider opinions about implementing SBIRT. Future research should focus on the effectiveness of quick screening and intervention techniques in improving implementation and quality of substance use assessments, as well as their impact on substance use over time, specific to FP settings.

Finally, while we intended to examine how providers assessed for both IPV and substance use as potentially co-occurring and related phenomena, we only found one example in which a provider assessed for whether a patient's partner influenced her substance use. In this case, the patient's history of substance use was known. Providers often asked about IPV and substance use consecutively during a patient's medical history but questions were siloed and unrelated. To assist providers in having conversations about the intersection between IPV and substance use, Warshaw and Tinnon[27] published a tool kit for providers to incorporate substance use coercion as part of IPV assessment (Table 2).

Warshaw and Tinnon[27] also provided adapted questionnaires, such as CAGE (''cutting down''/''annoyed''/''guilty''/

Table 2. Examples of Provider Intimate Partner Violence Assessment Skills from the Literature

Provider assessment skills	*Examples*	*Source*
Framing statements	''We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health.''	ACOG Committee Opinion No. 518[14]
	''Because relationships can affect our health, I give [resources] to all patients in case you or someone you know needs it. It talks about healthy relationships and what to do if your relationship is not healthy. Take a look…Is any of this part of your story?''	Futures Without Violence, CUES: Addressing Domestic and Sexual Violence in Health Settings[42]
Supportive statements after IPV disclosure	''Thank you for sharing this with me, I am so sorry this is happening. What you're telling me makes me worried about your safety and health…''	
Warm referral to resources	''Would you like me to share some options and resources that folks with similar are often interesting in hearing about? I would be happy to connect you if you are interested.''	
Incorporating substance use into IPV assessments	''Sometimes, people who are being hurt by someone in their life or who have been hurt in the past use alcohol or other drugs to help them cope or get through the day. This includes over-the-counter, prescription, and other kinds of drugs that may not be legally available. Many people report their partner makes them use alcohol or other drugs, makes it hard for them to stop or prevents them from stopping, uses their alcohol or other drug use as a way to control them, or does other hurtful things related to their alcohol or other drug use. Does this sound like anything you might be experiencing?''	Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings[27]

IPV, intimate partner violence.

''eye-opener''; a well-known substance abuse screening tool), to include substance use coercion. The validity of these questions, their acceptability in the FP setting among patients and providers, and how substance use coercion can be incorporated into the universal education IPV approach warrant further research.

While the sample included 98 encounters, there were only 18 providers, limiting generalizability. Providers received IPV awareness training, likely contributing to relatively high prevalence of IPV assessments, making it difficult to extrapolate findings to other FP settings. However, providers did not receive substance use training, thereby making substance use communication findings a more accurate baseline assessment. Finally, these were single recorded encounters between participating providers and patients; whether IPV or substance use conversations occurred in prior or subsequent visits was not known.

Conclusion

Findings underscore the need for strategies to support implementation of IPV and substance use assessments in the FP clinic setting. Results can be used to inform policy and practice recommendations among other primary care settings in which patients seek sexual and reproductive health care services. Given the importance of both IPV and substance use to health, there is a need for feasible interventions to help providers discuss both IPV and substance use in an integrated manner with patients. Second, interventions should focus on key communication strategies that offer providers tools (including scripts) to respond to disclosure of stigmatized health conditions. Finally, research is needed to determine the effectiveness of resource aids in facilitating these potentially challenging conversations.

Acknowledgments

The authors acknowledge Rosemary Iwuanyanwu, Lauren Klingman, Andrew Passarello, and Alexander Riley for their support in transcription.

Author Disclosure Statement

No competing financial interests exist.

Funding Information

This work was supported by funding from the National Institutes of Health R03HD079507 (Chang/Miller) and K24HD075862 (Miller). In addition, this research was also supported by funding from the National Center for Advancing Translational Science of the National Institutes of Health TL1TR001858 (Hill, PI: Kevin Kraemer, MD, MS). The opinions, findings, and conclusions are of the authors and do not necessarily reflect those of the funding agencies.

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Address correspondence to:
Amber L. Hill, PhD, MSPH
University of Pittsburgh School of Medicine
3550 Terrace Street
Pittsburgh, PA 15213
USA

E-mail: alh198@pitt.edu