Beyond Screening: Implementing a Response to Substance Use Coercion in Clinical Practice

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Disclosure Information

Beyond Screening: Implementing a Response to Substance Use Coercion in Clinical Practice

April 25, 2026 at 1:30pm

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- No disclosures

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- No Disclosures

Carole Warshaw, MD

- No Disclosures

Learning Objectives

- Describe the key tactics used in substance use coercion within intimate partner violence (IPV) relationships and their impact on recovery and treatment.
- Recognize key components of a comprehensive approach for identifying and addressing substance use coercion in clinical settings
- Utilize resources that can help support individuals experiencing SUC and providers aiming to support these patients

Outline

- Introduction to Substance Use Coercion and Scope of Problem
- Recognizing and Responding to Substance Use Coercion
- Results from Substance Use Coercion Pilot Study
- Updated Toolkit and Associated Resources for Providers and Clinics

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Case

- 24yo F comes to see you in your primary care clinic, accompanied by a new partner. She has been your patient for several years and has been stable on 8-2mg buprenorphine-naloxone daily for the past six months.
- Her last routine urine drug screen was positive for fentanyl and negative for buprenorphine. You ask her about the result and her partner jumps in immediately, telling you that she is allergic to buprenorphine and asks you to prescribe buprenorphine monoproduct.

Introduction

- IPV is a pattern of assaultive and coercive behaviors designed to dominate and control a partner through fear and intimidation
- This can take the form of physical, sexual, emotional, and/or economic abuse, isolation, deprivation, and stalking, as well as coercion and threats and can include
  - Abuse targeted toward a partner’s health, mental health, wellbeing, and access to healthcare
  - Emotional manipulation of children
  - Threats related to deportation or child custody
  - Outing a partner’s gender identity or sexual orientation
- People who abuse their partners leverage societal stigma to further their control
- These behaviors result in physical and psychological harm

Ganley, 1995, Warshaw & Tinnon, 2018

Trauma, Mental Health, Substance Use, and IPV: What Are the Connections?

- IPV has significant substance use-related effects
- There are high rates of IPV and other trauma among people accessing substance use disorder (SUD) treatment
- People who abuse their partners actively use SU issues against their partners as a tactic of control, particularly in relation to custody and credibility
- IPV impacts the ability to access and engage in SUD treatment
- Integrated approaches to IPV, trauma, MH, and SU are critical to the safety and recovery of survivors and their children

Warshaw & Zapata-Alma, 2021; Warshaw & Tinnon, 2018

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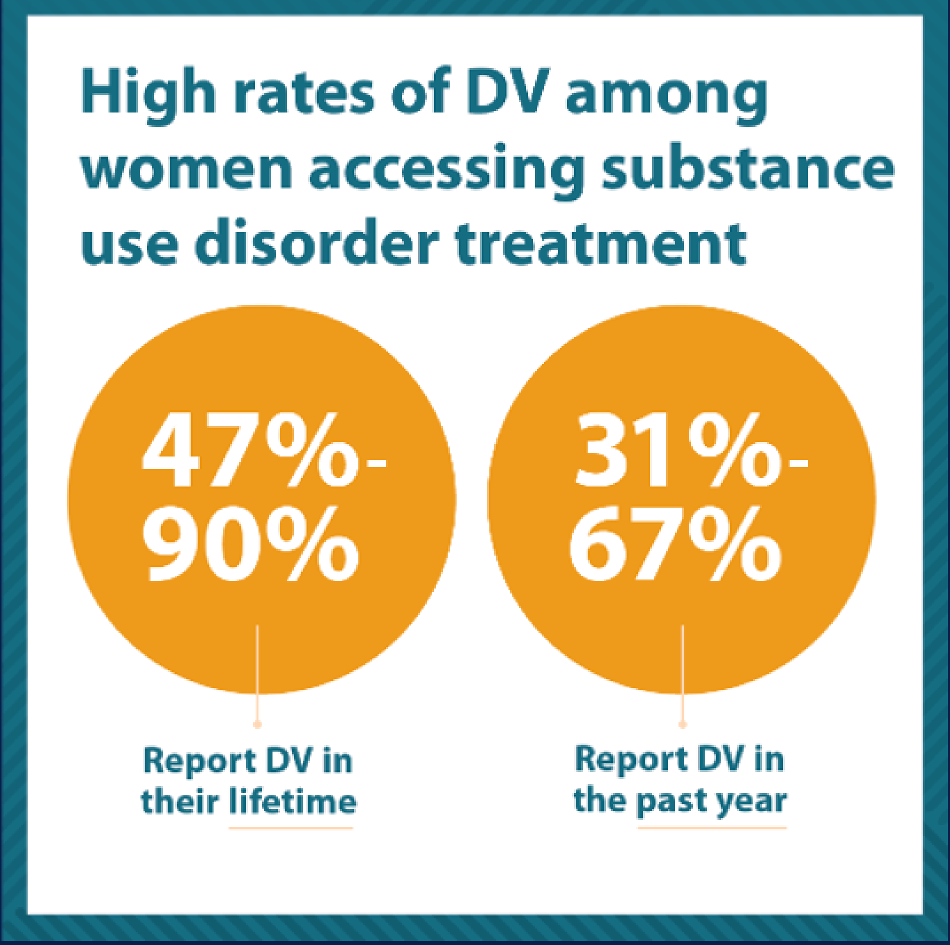
IPV Has Significant Substance Use Effects

Wagner et al., 2009; Bennett et al.,1994; Smith et. al., 2012; Ogle et al.,2003; Eby, 2004; LaFlair, et al., 2012; Nuttrock et al., 2014; Nathanson et al., 2012; Lipsky et al., 2008; Breiding et al., 2014; Bonomi et al., 2009;

IPV is Prevalent Among People Accessing SUD Treatment



Rivera et al. 2015 (NCDVTMH); Phillips et al. 2014 (NCDVTMH)

IPV and Opioids

- IPV increases a person's risk for opioid use
- High rates of IPV among people accessing OUD treatment:
  - 90% of women accessing services in a methadone clinic had experienced IPV
- Women who experience IPV are at increased risk for relapse and for opioid OD
- IPV and opioid ODs have increased during COVID-19
- IPV and substance use coercion create unique risks that directly threaten safety and well-being.

Engstrom, et al., 2012, Rivera et al., 2015; Holland 2021

Less well recognized are the ways people who abuse their partners engage in coercive tactics targeted toward a partner's use of substances...

Warshaw et al., 2014

Substance Use Coercion Survey
National Domestic Violence Hotline and NCDVTMH Survey

N=3,224

26%	Ever **used substances to reduce pain** of partner abuse?
27%	**Pressured or forced to use** alcohol or other drugs, or made to use more than wanted?
15.2%	**Tried to get help** for substance use?
60.1%	**If yes,** partner or ex-partner **tried to prevent or discourage you from getting that help?**
37.5%	**Partner or ex-partner threatened to report** alcohol or other drug use to someone in authority to keep you from getting something you wanted or needed?
24.4%	**Afraid to call the police** for help because partner said they wouldn't believe you because of using, or you would be arrested for being under the influence?

Warshaw C., Lyon E., Bland P., Phillips H., Hooper M., NCDVTMH/The Hotline, 2014

Substance Use Coercion Survey: Qualitative Findings

- Coerced use
  - Initiated into using
  - Pressured to use with partner, unable to refuse
  - Manipulated or threatened into using
  - Drugged by partner
  - Subjected to drug-induced debilitation
- Treatment Interference or Recovery Sabotage
  - Prevented from attending meetings/treatment
  - Transportation/childcare withheld
  - Harassed into leaving
  - Medications controlled
  - Substances kept in home after treatment
  - Forced to watch partner use
  - Escalating violence if tried to cut down or stop

Warshaw, et al., 2014

Substance Use Coercion Survey: Qualitative Findings

- Threats to Report or Discredit
  - Reported to judges, CPS, police, probation officers, employers
  - Made false allegations
- Substance Use-Related Sexual Coercion
  - Coerced or forced sex
  - Pressure to use
- Blaming abuse on partner's use and benefiting from lack of services
  - Stigma re: women and substance use

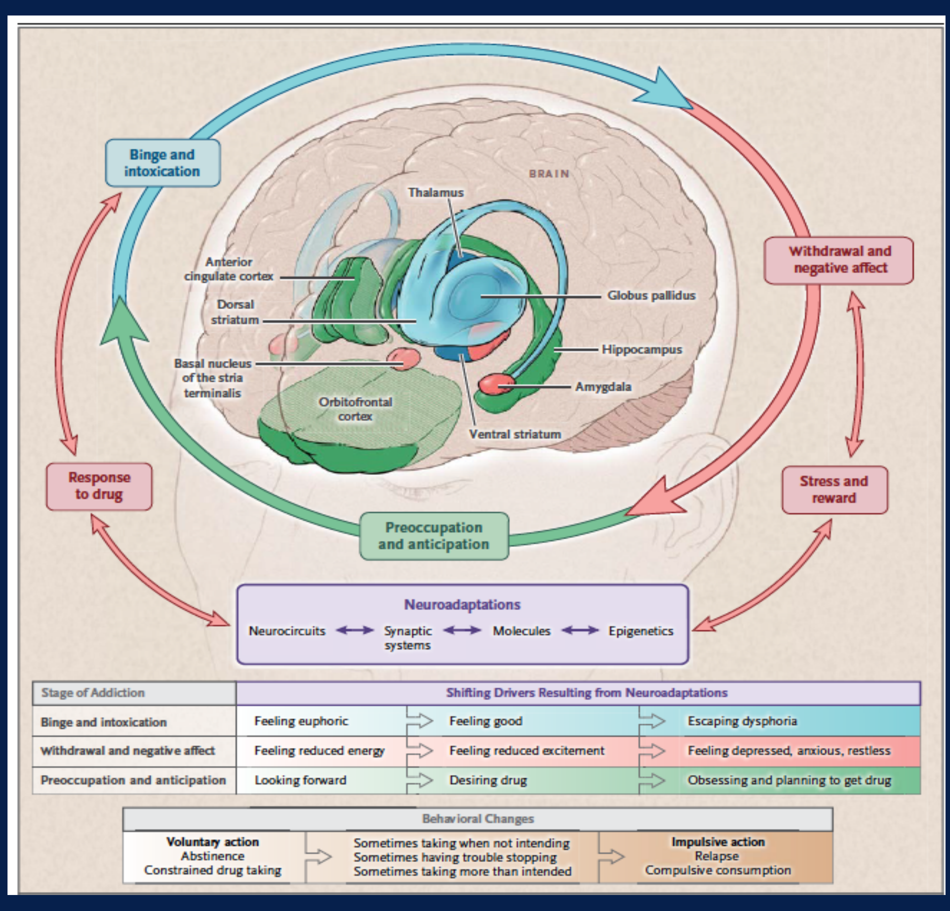
Warshaw, et al., 2014

Substance Use Coercion and Opioids

- Introducing partner to opioids/controlling supply
- Threatening to put a partner into withdrawal
- Coercing partner to engage in illegal activities
- Forcing partner to use unsafely
- Injuring partner to obtain pain meds
- Sabotaging treatment
  - Stalking at regular MAT appointments; Keeping a partner from meeting Tx requirements; Controlling or diverting meds
- Using opioid history as threat and tactic of control: Custody, CPS, LE, housing, jobs, probation/parole; planting drugs

Warshaw & Tinnon, 2018 , Phillips et al., 2020

Considering the Neurobiology of Relapse Cues in the Context of Substance Use Coercion



- Provoking relapse as a tactic of abuse
  - Exposure to addictive/rewarding drugs
  - Conditioned cues from the environment
  - Exposure to stressful experiences
- Involves activation of neural circuitry (e.g., reward, incentive, salience, and glutaminergic pathways, including pathways involved in the stress response).
- These can be “deliberately” activated by an abusive partner who engages in substance use coercion

Volkow et. al, 2016. Warshaw et al, 2014

Trauma, IPV, and MH/SU Coercion: Complex Picture

Abusers control treatment and medication and sabotage recovery

Abusers actively undermine their partners' sanity, sobriety, and parenting

Abusers use these issues to control their partners and discredit them with sources of support

Impact on IPV Survivors and Their Children

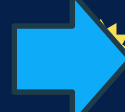
IPV and other trauma associated with increased risk for range of MH/SU conditions

Stigma compounds risks. Concerns re: custody and system involvement impact help-seeking

Warshaw-NCDVTMH 2013

Outline

- Introduction to Substance Use Coercion and Scope of Problem



- **Recognizing and Responding to Substance Use Coercion**
- Results from Substance Use Coercion Pilot Study
- Updated Toolkit and Associated Resources for Providers and Clinics

Integrating Responses to IPV and Other Complex Needs into Clinical Practice: What Is Involved?

Create Safe Opportunities to Talk About IPV, SU Coercion and Other Sensitive Concerns

Create an IPV- and Trauma-Informed Practice Setting

Offer Comprehensive Integrated Array of Services

Diana Samberg, MD, MS

Red Flags for Substance Use Coercion

- Partner is overbearing and makes it difficult to see patient alone
- Evasive when talking about partner
- Missing or coming late to appointments
- Losing prescriptions, misplacing medications, asking for early refills
- Negative drug screens for prescribed medications
- Increase in or resumption of alcohol or drug use

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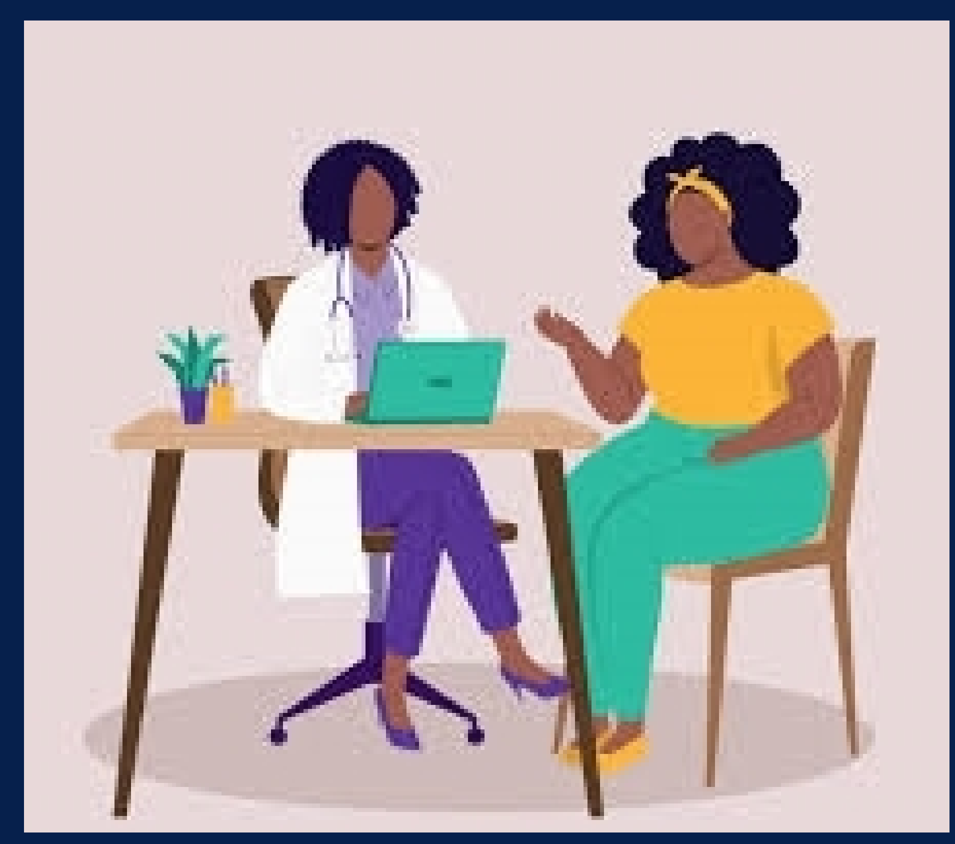
Opening a conversation about SUC

- **Normalize**: “Many of our patients have told us that their partners interfere with their treatment or sabotage their recovery.”
- **Personalize**: “Sometimes partners might …. [provide SUC examples that might align with patient’s situation]”
- **Empathize**: “We understand that using substances can also be a common way to deal with physical and emotional pain caused by a partner.”
- **Offer support and space**: “If you’ve had these experiences, or if they come up, know that we are here to support you.”



Warshaw & Tinnon, 2018

Affirm and Validate Person's Experience

- “It’s not your fault”
- “You always deserve dignity and respect”
- “It sounds like your partner is _______, which is making it hard to _______”
- “I believe you, you are not alone

Warshaw & Tinnon, 2018

Responding to Coercion and Safety Planning

- Impacts on treatment planning
- Integration of harm reduction
- Ensuring patient safety (immediate and long-term)
- Documentation and open access issues
- Special considerations for telemedicine safety
- Roles of clinic team members and referrals to community resources

Strategize Together about Safety

- Determine if there are immediate safety concerns
- Ask about preferred/safest forms of communication
- Remind about flexible scheduling policies; offer telehealth appointments
- Consider changes to treatment plan
  - Use of long-acting injectables
  - Giving fewer days in each prescription

Warshaw & Tinnon, 2018

Document with Safety In Mind

- Discuss importance of documentation as record of IPV/SUC and to provide full picture of health conditions
- Discuss issues around open access and related patient choices:
  - Inactive accounts completely if unable to keep passwords protected
  - Block notes from patient portal – relies on all providers knowing the situation and remember to proactively block sensitive records
- Remember chart notes can be subpoenaed
  - Highlight patient's strengths (including parental strengths if applicable)
  - Document connections between IPV and substance use
  - Record specific instances of IPV/SUC

Warshaw & Tinnon, 2018

Responding to Coercion and Safety Planning

- Impacts on treatment planning
- Integration of harm reduction
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- **Substance Use Coercion Pilot Study**
- Updated Toolkit and Associated Resources for Providers and Clinics

SUC Pilot Study

- Joint project of National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) and University of Pittsburgh Medical Center (UPMC)
- NCDVTMH Toolkit piloted in two UPMC clinics to address SUC-related barriers to recovery
  - Primary care clinic for individuals with substance use disorders
  - Women's specific substance use treatment clinic

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Domestic Violence, Trauma & Mental Health

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

Carole Warshaw, MD and Erin Tinnon, MSW, LSW

March 2018

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National Center on Domestic Violence, Trauma & Mental Health © NCDVTMH 2018

SUC Pilot Study

- Clinic mapping and integrating components of toolkit into workflows
  - Provider and staff trainings
  - Rooming policies
  - Patient education materials (incl. placement in clinic)
- Clarifying roles of individual clinical team members and improving team-based coordination and communication
- Fostering community partnerships and referral networks
- Develop refined intervention, tools, and implementation guidance
- Evaluate feasibility, helpfulness, and usability for providers and acceptability and helpfulness for patients through surveys and interviews

Findings from Pilot – Process Analysis

- Major Achievements
  - Provider feedback from clinic sites informed procedural and policy changes
  - Provider trained to increase knowledge and skills related to working with patients with IPV/SUC
  - Recognition of the unique role of peer support and need for specific training for peer recovery specialists
  - EMR modifications to prompt and guide conversations with patients
  - Quick reference guides around clinic
  - Patient-facing materials developed including posters

Findings from Pilot – Interviews

- Semi-structured interviews with health professionals (August –October 2024) and patients (July 2024-January 2025) about experiences with the pilot
- Compensation provided

Health Professionals (n=16)

- Mean age: 44
- Race: 75% White
- Ethnicity: 87% Non-Hispanic
- Role
  - Provider (Physician, APP) = 44%
  - Staff = 19%
  - RN, Social Worker, Peer Recovery Specialist = 13%
- 50% from a women's recovery clinic

Health Professionals (n=16)

Meaningful Improvements in Providers':

- Comfort in addressing substance use coercion
- Offering information about SU coercion
- Discussing immediate safety concerns
- Asking about SU coercion, treatment interference, and recovery sabotage
- Offering emotional support
- Engaging in safety planning with patients
- Offering warm referrals to DV programs
- Documenting with IPV/SU coercion in mind
- Feeling prepared to be helpful and supportive

"With the new assessment questions and style, I have witnessed an increase in positive responses to IPV. I feel like the number of identified patients on my caseload had doubled. This is great because more women can talk openly about their relationship issues and feel safe to disclose."

"More willingness to share their experiences and feeling safe to do so."

"Creating a gentle space from a scary experience."

"Patients seem more engaged in their recovery."

Health Professionals (n=16)

- Importance of initial and ongoing assessment for SUC that creates a safe and supportive space for patients to share their experiences

It's really trying to work with them to get them to, you know, to build up a relationship with them. (IMREP_F)

- Need of ongoing training for staff and providers to recognize SUC and provide appropriate referrals and documentation

More like …. training on both sides. Just more resources. (IMREP_B)

- Increased workload and emotional labor in caring for individuals who experience substance use coercion must be considered

Please do not take this all upon yourself and ….. no matter how badly we want them to change, It's not for us to do it… We just have to show up every day… [and] give them what we can. (PWRC_F)

Patients

- Mean age: 39
- Race: 100% White
- Ethnicity: 87% Non-Hispanic
- Self-identified IPV survivors: 50%
- Women's Recovery Center: 50%

Patients (n=16)

- Importance of an open, trusting relationship with recovery clinic staff and providers

They have really … helped me and got to know my story and my situation and you know and just were so helpful. (PWRC_A)

- Ensuring patient safety and confidentiality

Yeah, I remember seeing this in [the] office. I remember reading it and being like. That's Oh, frighteningly relatable. (PWRC_H)

- Efficient access to resources and referrals for social needs such as safe housing

I know that if anything was to happen, I could always go to them and, you know, express my concerns and they would be able to help me with pretty much any situation. (IMREP_D)

Findings from Pilot - Surveys

- Surveys conducted with health professionals at both clinics at baseline, interim and final pilot timepoints
- 100% participation for each survey
- Compensation for completion provided

Provider Comfort

- Provider comfort around asking about SUC and strategizing with patients in response to safety concerns increased throughout the pilot

Provider Comfort	Baseline N (%)	Interim N (%)	Final N (%)
Low- 1	1 (4%)	1 (3%)	-
Medium- 2	13 (48%)	13 (42%)	13 (39%)
High- 3	13 (48%)	17 (55%	20 (61%)
TOTAL	27	31	33

Emotional Support

- Provider ability to provide emotional support to patients experiencing IPV and/or SUC increased during the pilot

Emotional Support	Baseline N (%)	Interim N (%)	Final N (%)
Infrequently- 1	8 (30%)	7 (28%)	4 (14%)
Sometimes- 2	9 (33%)	10 (40%)	9 (32%)
Often- 3	10 (37%)	8 (32%)	15 (54%)
TOTAL	27	25	28

Safety Planning

- Provider increased engagement in safety planning with patients

Safety Planning	Baseline N (%)	Interim N (%)	Final N (%)
Infrequently- 1	8 (30%)	7 (32%)	4 (14%)
Sometimes- 2	10 (37%)	8 (36%)	11 (39%)
Often- 3	9 (33%)	7 (32%)	13 (46%)
TOTAL	27	22	28

Recommendations from Peer Recovery Specialists

Peers and Their Unique Relationship with Patients

- Trusted Engagement: Lived experience fosters credibility and trust
- Reducing Shame and Stigma: Normalizing, reducing isolation
- Awareness and Education: Help individual recognize coercive behaviors as for of abuse
- Addressing Stigma: Help patients overcome fears and negative previous experience with health system

Special Considerations for Peers

- Trauma-Informed Communication
- Boundaries and Self-Care

Recommendations from Peer Recovery Specialists

How Peers Can Empower People Who Experience Substance Use Coercion:

- Validating Experiences
- Reducing Internalized Stigma
- Advocating Within Medical Systems
- Providing Education and Resources

Special Considerations for Peers

- Confidentiality and Safety
- Understanding Stigma Around MOUD

King, C. 2025

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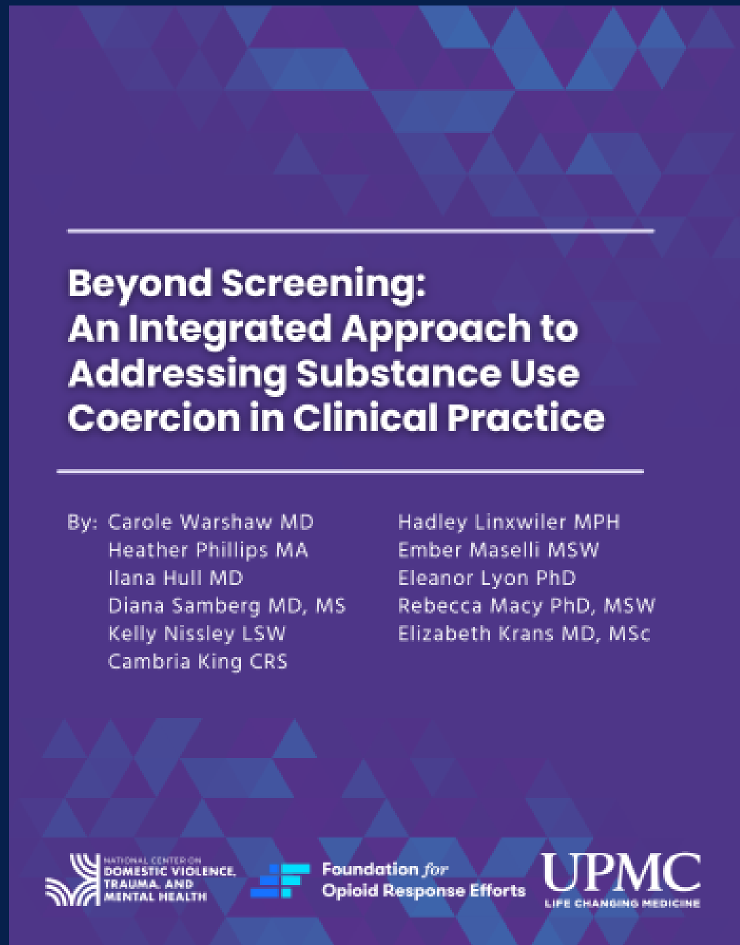
Beyond Screening Toolkit: What it Contains



Beyond Screening Toolkit:
1. Background and Overview

Background and Overview

Intro	Introduction
Research	Research on Substance Use Coercion
Approach	The *Beyond Screening* Approach: Overview, Pilot, and Findings
How to Use	How to Use This Guide

Tools and Resources

- Substance Use Coercion Survey Report
- Mental Health and Substance Use Coercion Toolkit
- Pilot Evaluation Report

Beyond Screening Toolkit:
2. Preparing Your Practice Setting

Planning and Assessment

Engage	Engage Your Team
Identify	Identify Clinical Champions
Assess	Assess Current Practices and Policies
Map	Map Clinical Flow

Tools and Resources

- Quick Reference Guide
- Provider Self-Assessment Tool
- Clinical Flow Maps

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Beyond Screening Toolkit
Preparing Your Practice: Quick Reference Guide

Preparing Your Practice: Quick Reference Guide

Implementing an IPV- and Substance Use Coercion-Informed Approach in Your Clinical Practice Setting: A Quick Reference Guide

Step 1. Establish Your Implementation Team and Identify Clinical Champion(s)

- Engage staff across roles (leadership, admin, clinicians, peer recovery specialists, social workers).
- Share why addressing substance use coercion matters (e.g., mini-presentations, tip sheets).
- Provide initial training and resources to build team buy-in.
- Include staff in shaping workflows so they feel confident, equipped, and invested.
- Build planning into staff meetings; secure protected time if possible.
- Identify clinical champion(s):
  - Lead, support, and sustain the implementation process.
  - Qualities: strong communicator/mentor, passionate about IPV/SU coercion, advocacy and negotiation skills, clinical credibility, trusted by staff and leadership, embedded in the clinic with face-to-face presence.
- Set regular, protected meeting times with leadership support.

Step 2. Assess Your Current Practice and Clinical Flow

- Review provider knowledge, skills, and comfort addressing IPV/SU coercion.
- Assess prior training, current comfort in opening conversations, responding to disclosures, incorporating into treatment planning, referrals, and documentation.
- Identify existing safety/privacy/confidentiality policies and resources.
- Map clinical workflow:
  - Patient journey from entry to exit—who rooms patients, conducts intakes, provides treatment, recovery support, counseling, referrals, and documentation.

Step 3. Review and Update Policies and Procedures

- Safety, Privacy, and Confidentiality
- Adopt universal rooming-alone policy.
- Assess clinic layout and establish safe exit strategies; consider security or escort options.
- EHR/Open Notes:
- Block portal access and sensitive notes to prevent abusive partner access.
- Use discreet indicators and inter-provider communication strategies.
- Document with safety in mind: explain risks and options to patients.
- Update telehealth safety protocols (safe times/places, code words, spyware awareness, documentation of safety strategies).
- Transparent child welfare/mandatory reporting policies.
- Access to Care
- Ensure flexible scheduling, attendance, and prescribing policies to reduce risks from missed visits or stolen meds.
- Identify transportation and childcare supports.
- Adopt ACOG/ASAM urine drug screen guidelines: voluntary with informed consent and clear rationale to support clinical care
- Referrals and Clinical Integration
- Establish or strengthen relationships with local DV programs.
- Create warm referral pathways and consultation processes.
- Universal policy: incorporate IPV/SU coercion into assessment, treatment, referral, and documentation (via intake/assessment forms and EMR templates)

Step 4. Develop Resources and Tools

- Provider Self-Assessment Survey.
- Clinical flow maps.
- EMR templates with IPV/SU coercion prompts.
- Provider palm cards, conversation guides, and quick start guides.
- Training materials on IPV/SU coercion (scripts, case examples).
- Patient-facing posters and discreet resource information.
- DV program partnership and peer recovery specialist guidance.
- Clear internal/external referral protocols.

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Provider Self-Assessment Tool: Responding to IPV and Substance Use Coercion in Clinical Practice

Current Intake and Assessment Practices

1. How often do you currently ask patients about IPV during initial visits?

2. How often do you currently ask patients about IPV during follow-up visits?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

3. How often do you currently ask patients about substance use coercion?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

4. How often do you currently ask patients about IPV-related safety, privacy, and confidentiality concerns?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

... to ask about IPV? (Select all that apply)

- ...creening protocol
- ...njuries
- ...behavior/demeanor
- ...ent adherence issues
- ...er behavior during visits
- ...nt disclosure of relationship problems
- ...er: ______________
- ...n't currently ask about IPV

...pts you to ask about substance use coercion?

...u suspect or identify IPV, how confident are you in your ability to:

Confidence in Responding to IPV and Substance Use Coercion

	Not Confident	Slightly Confident	Moderately Confident	Very Confident	N/A
...appropriate support					
...cument appropriately					
Address patient safety					
Address treatment interference					

Clinical Flow Diagrams

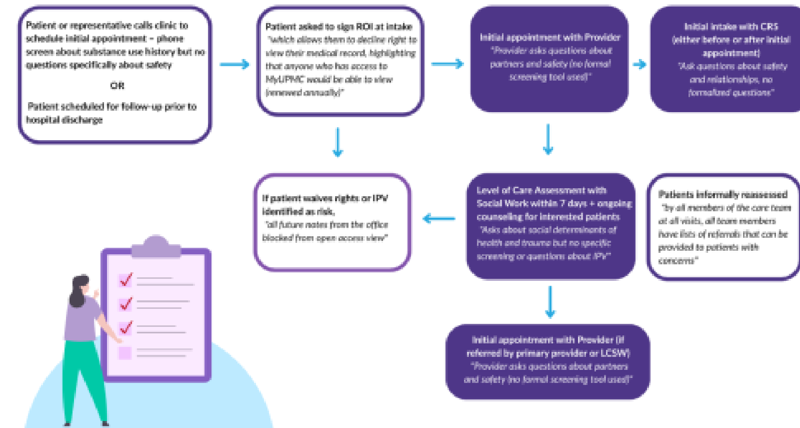
Workflow for Current IPV Screening and Referrals at IM-REP

Clinical Roles at IM-REP

- LCSW (two) – Provides level of care assessment for all patients, ongoing counseling for select patients
- CRS (three) – Initial outreach usually prior to visit, ongoing engagement varies based on patient needs
- RN (two) – Care coordination role, administers injections, phlebotomy
- MA (one position, not currently filled) – Rooms patients and collects basic interval history at all visits
- Primary care/addiction care providers (10 physicians, 1 fellow) – Maintains individual panel of patients
- Psychiatrist (1) – sees IM-REP patients with psychiatric needs to assist with diagnostic clarity and medication management ½ day per week

Referral Sources

- Inpatient – screened by social work during inpatient hospitalization for safety and IPV
- Other UPMC and non-UPMC referrals (including UPMC telebuprenorphine bridge clinic)
- Self-referral



Preparing Your Practice: Implementing New Clinic Policies and Protocols to:

Address Safety/Confidentiality Risks

- Safe exit strategies
- Rooming alone policies
- Safe communication strategies
- EMR Safety/Patient portals
- Mandatory reporting
- Telehealth safety

Reduce Barriers to Care

- Flexible scheduling/Medication options
- Urine Drug Screen policies
- SDOH/HRSN

Support Clinical Integration

- Adapt clinical flow
- Incorporate IPV/SU coercion into routine assessments and treatment
- Establish consultation and referral processes with DV program(s)
- Develop new EMR templates
- Create resources for patients and providers
- Conduct universal training for staff

Preparing Your Practice: Implementation Tools and Resources

- Creating a shared EMR template
- Provider guide and palm cards
- Patient-facing posters
- Partnering with domestic violence programs
- Training materials on IPV and SUC, including role plays and scenarios

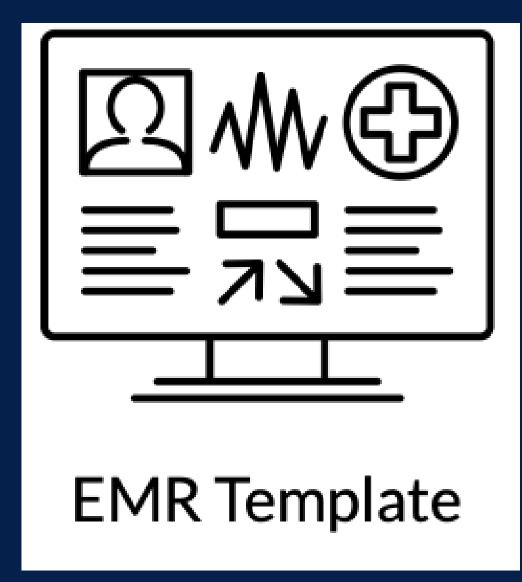
EMR Template Design and Implementation

Confidentiality and Privacy

- Unique to each clinical setting
- In-depth discussions and problem-solving to ensure EMR features used remain confidential

Template Design

- Questions to prompt discussions around substance use coercion
- Guidance on what to do and how to refer



EMR Template Design

Notes

Create Note | Attestation 1

My Note

Insert SmartText

Psychiatry: ***

Housing/resources: ***

Partner/family: ***

Substance use coercion/IPV

Has your current or former partner ever tried to control your use of substances or pressure or force you to use or use more than you want to? YES/NO

Has your current or former partner ever done things that impact your ability to access treatment, manage your medications, or maintain your recovery? YES/NO

Is anyone in your life hurting you or threatening you in any way? Are you concerned about your safety? YES/NO

IPV Resources (Optional)

Children:

Children

- [x] Immediate safety needs
- [ ] Impact of SU coercion on treatment planning
- [ ] IPV Resources
- [ ] IPV Documentation
- [ ] IM-REP Internal Support

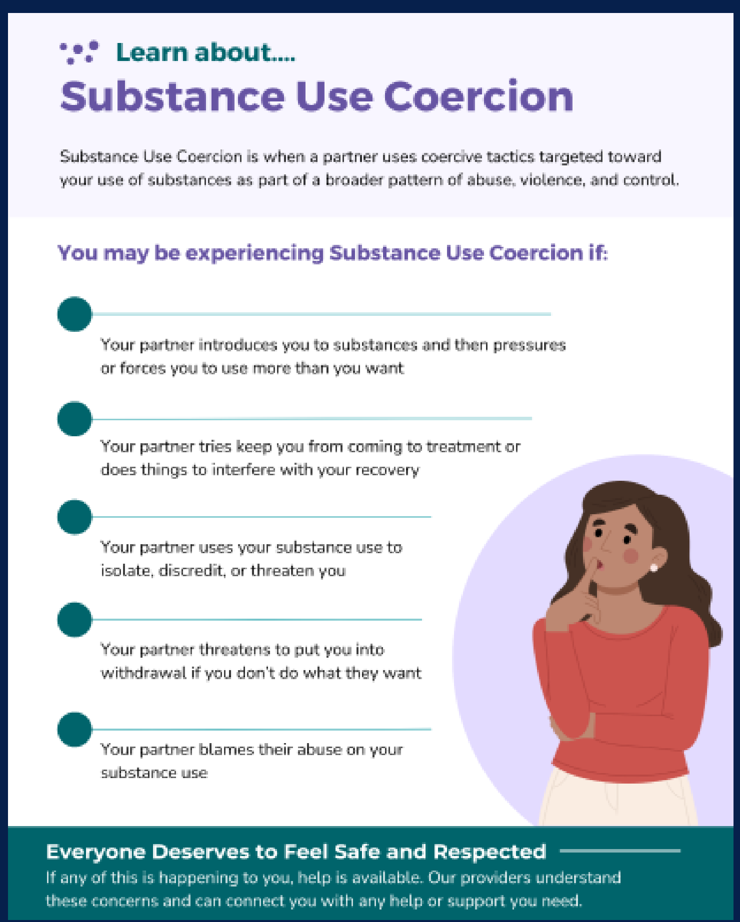
Patient-Facing Posters

Safety for Survivors

- Different designs for different clinical spaces (i.e. waiting room vs. bathroom)
- Promoting cultural shifts in clinic; showing patients this is a safe place to discuss IPV and substance use coercion

Poster Design

- Created in partnership with peer support specialists and SAC
- Uses language that is easy to understand



Does Your Partner Support Your Recovery?

Sometimes partners discourage recovery as a way to maintain their abusive, violent, and/or controlling behavior. This is a form of Substance Use Coercion. Other signs of Substance Use Coercion include:

Pressures You to Use

Your partner pressures you to use substances or use in ways that you don't want to.

Prevents You from Quitting

Your partner tries to prevent you from cutting down or stopping using alcohol or other drugs OR threatens to put you into withdrawal if you try to quit.

Discourages Treatment

Your partner tries to prevent you from accessing treatment and support, controls your medications, and/or sabotages your recovery efforts.

Everyone Deserves to Feel Safe and Respected

If someone is harming you, taking your medication, or preventing you from getting care, there is help. Let your provider know if you would like to talk to someone about your safety and recovery.

Partner Support + Substance Use Recovery

Is your partner supportive of your recovery or do they sabotage your recovery efforts? Having a partner that supports your recovery can make all the difference for your progress. When unsupportive, common forms of Substance Use Coercion may occur, including treatment interference and recovery sabotage.

Positive partner support of your recovery looks like:

Everyone Deserves to Feel Safe and Respected

If someone is harming you, taking your medication, or preventing you from getting care, there is help. Let your provider know if you would like to talk to someone about safety options.

Beyond Screening Toolkit: 3. Integration into Clinical Practice

Integration

- Addressing initial safety/confidentiality concerns
- Incorporating conversations about substance use coercion into assessments
- Responding to disclosures
- Strategizing re: safety, access, and meds
- Providing counseling and support
- Offering referrals to DV and other services
- Documenting with IPV in mind

Tools and Resources

- Provider Guides
- The Role of Peers
- Working with DV Programs
- EMR Template Guide

Provider Guide

Substance Use Coercion Palm Card

Substance Use Coercion Red Flags

- 🚩 Partner is overbearing and makes it difficult to see patient alone
- 🚩 Discomfort when talking about partner
- 🚩 Missing or coming late to appointments
- 🚩 Losing prescriptions, misplacing medications, or finishing prescriptions too quickly
- 🚩 Negative drug screens for prescribed medications
- 🚩 Increase in or resumption of alcohol or drug use

Open a Conversation

- **Normalize:** "Many of our patients have told us that their partners interfere with their treatment or sabotage their recovery"
- **Personalize:** "Sometimes partners might .... [provide SUC examples that might align with patient's situation]"
- **Empathize:** "We understand that using substances can also be a common way to deal with physical and emotional pain caused by a partner"
- **Offer support and space:** "If you've had these experiences, or if they come up, know that we are here to support you"

Affirm and Validate

- "It's not your fault"
- "You always deserve dignity and respect"
- "It sounds like your partner is ______, which is making it hard to ______"
- "I believe you, you are not alone"

Provider Guide

Safety Plan: Access & Autonomy

Strategize Together About Safety

- Determine if there are immediate safety concerns
- Ask about preferred/safest forms of communication
- Remind about flexible scheduling policies; offer telehealth appointments
- Decide on a code phrase that signals it is not safe to talk
- Change prescription frequency or type, if appropriate
- Disclose your role as a mandated reporter before discussing sensitive topics

Document with Safety in Mind

- Block notes, if concerned that partner may inappropriately access medical records
- Use dotphrase: .PWRCSUCSCREEN
- Chart notes can be subpoenaed! Be sure that you:
  - Highlight patient's strengths (including parental strengths, if applicable)
  - Document connections between IPV and substance use
  - Record specific instances of IPV/SUC

Connect to Community Resources

- Women's Center & Shelter of Greater Pittsburgh 24/7 hotline: 412-687-8005
- Kelly N, Substance Use and Recovery Specialist at WC&S: 412-894-2089

Beyond Screening Toolkit:
4. Sustaining Your Work

Sustainability

- Ongoing Training
- Supporting Staff
- Evaluation and CQI

Resources

- Links to additional resources and training
- Evaluation tools

Clinical Implications

- Ongoing assessment for SUC coercion as a co-occurring experience within recovery clinics is crucial both at intake and throughout care

- Addressing SUC requires
  - Targeted training for staff
  - Focus on establishing a trusting relationship
  - Increased clinical support
    - Protected time
    - Acknowledging and addressing burnout
    - Establish connections with local resources (especially warm handoffs)

- Acceptability of posters and fliers in patient facing areas increases

Final Takeaways/Summary

- IPV and SUC are prevalent among patients with SUD
- SUC may involve is a tactic of control and may involve forced use, withholding medications, interfering with treatment, and using a partner’s substance use to threaten custody, legal status, or credibility
- Patients experiencing SUC are at increased risk for relapse, overdose, and difficulty accessing treatment
- Routine, private, and nonjudgmental assessments for SUC can help identify at-risk patients
- Clinicians should integrate harm reduction strategies, flexible prescribing, and individualized safety planning to support patients while minimizing risk
- When documenting in the EMR, clinicians should balance patient safety with the need to appropriately document. Ultilize strategies within the EMR to facilitate this.
- Partnering with social workers, case managers, IPV advocacy organizations, and harm reduction services ensures patients have comprehensive support

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