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# Screening and Intervening Evaluating a Training Program on Intimate Partner Violence and Reproductive Coercion for Family Planning and Home Visiting Providers

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Project Connect training aims to reduce barriers to screening for and intervening with women with histories of intimate partner violence and reproductive coercion. This study sought to assess the effectiveness of trainings, provider facility with Project Connect tools, and areas for improvement in a pilot state. Results indicated that providers found training useful, and those in supervisory roles particularly appreciated the universal tools and skill set given to participants. Providing these tools supports the provision of trauma-informed care. Areas for improvement included increased emphasis on initiating screening, enhancing training for different types of providers, and developing follow-up training. **Key words:** *intimate partner violence, qualitative analysis, reproductive health, women's health*

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**H**EALTH CARE PROVIDERS are often confounded by issues that begin for patients outside of the care setting but lead to complex clinical issues. Such issues include intimate partner violence (IPV) and reproductive coercion, both of which have a range of health impacts on women, children, and families.<sup>1-6</sup> The complexity of these issues is created by traumatic interactions among violence, vulnerability, and health. Intervention approaches to these issues must therefore apply trauma-informed strategies to training providers. One means of accomplishing this is to equip providers with tools to identify trauma histories among patients and to respond effectively and immediately. This article reports a qualitative evaluation of Project Connect, a program that provides such training to reproductive health care and family home visiting providers.

## BACKGROUND AND SIGNIFICANCE

Intimate partner violence encompasses a range of behaviors, but it is most often

defined as a pattern of abusive, coercive, or controlling behavior perpetrated by someone who was or is in an intimate relationship with the victim of abuse.<sup>7,8</sup> These behaviors can be physical, sexual, emotional, verbal, or relational in nature and range from battering to social isolation to basic deprivation.<sup>8,9</sup> The prevalence of IPV victimization among women in the United States ranges from 10% to almost 30% depending on which types of behaviors are examined.<sup>10</sup> Women are overall the most commonly and most severely affected by IPV, although men also experience IPV and likely at higher rates than are typically reported.<sup>11,12</sup>

### **IPV and health**

Studies indicate that experiencing IPV can affect women's overall educational and earning potential,<sup>5</sup> health care utilization, and overall perception of health.<sup>13</sup> In addition, IPV has been linked to chronic pain,<sup>14</sup> chronic fear and stress states,<sup>15</sup> postpartum depression,<sup>16</sup> substance use,<sup>17,18</sup> cardiovascular disease and hypertension,<sup>19</sup> as well as chronic inflammation<sup>20</sup> and accelerated telomeric attrition.<sup>6</sup> Clearly, the trauma of IPV thus extends well beyond the acutely abusive experience and the provision of trauma-informed care to affected individuals is crucial to reducing its impact.

### ***Reproductive coercion***

The traumatic intersection of IPV and health is particularly evident in cases of reproductive coercion. Reproductive coercion includes a range of controlling behaviors by one partner that reduce or eliminate reproductive choice for another.<sup>21-23</sup> These behaviors may include contraceptive sabotage, pregnancy coercion, and intimidation or pressure with regard to reproductive decision making.<sup>21,24,25</sup> Since reproductive health and decision making directly affect women's bodies, it is clear that reproductive coercion represents a potential source of intimate partner trauma for women.

### ***Screening***

In 2004, the United States Preventive Services Task Force (USPSTF) determined that evidence to support the benefit of screening women for IPV was insufficient to recommend such screening.<sup>7</sup> In 2013, however, this recommendation was revised to recommend that clinicians screen women of reproductive age for IPV and provide or refer to supportive services for affected women of any age.<sup>26</sup> This revision was based in part on findings from studies indicating that women of reproductive age are most at risk for IPV and, clearly, reproductive coercion and that women themselves endorse universal screening.<sup>11,16,23,27,28</sup>

In addition to the USPSTF recommendation, many professional organizations endorse IPV screening standards. The American College of Obstetricians and Gynecologists suggests that in addition to routine screening, women presenting for obstetric care should be screened for IPV throughout pregnancy and postpartum.<sup>29</sup> The American Medical Association recommends routine screening for IPV and specifically includes coercive unprotected sexual contact among the list of behaviors to be considered in the screening process.<sup>30</sup> The American Nurses Association also recommends routine screening for IPV and that providers be trained in identifying abusive situations among their patients.<sup>31</sup> Furthermore, The Joint Commission—the accrediting and certification organization for more than 20,000 health care organizations and programs in the United States—requires that all covered entities have in place policy and procedure directives for the identification, treatment, and referral to services for victims of abuse.<sup>32</sup>

Despite the recommendations, however, studies of IPV screening practices among health care providers yield very low estimates of routine screening—typically around 10%.<sup>28,33,34</sup> Providers report that they fail to screen patients for a variety of reasons. These include personal discomfort with broaching the subject of IPV, perception that IPV is relatively rare, fear of offending the patient or invading patient privacy, lack of knowledge of

how to screen or intervene, concerns about priorities in a visit, lack of knowledge of resources for affected women, as well as other concerns.<sup>8,33,35-38</sup> All of these issues decrease potential for the provision of trauma-informed care to patients affected by past or current IPV.

Two studies of provider screening practices suggest that motivation to screen may stem from the provider's understanding of IPV or personal connection to the issue. In a qualitative study of physicians and nurses ( $N = 931$ ), about 7% of nurses and 4% of physicians identified a specific personal or professional experience that facilitated asking about IPV.<sup>39</sup> Although these numbers are relatively small, this suggests that understanding the dynamics and significance of IPV—and by extension, reproductive coercion—may improve screening rates. The same investigators also found that training and direct screening experiences in the professional area were associated with feeling more competent to screen for and intervene in cases of IPV.<sup>40</sup> The second study interestingly also found that nearly half of the respondents reported that they themselves, a friend, or relative had experienced abuse—yet more than half also indicated they had never received specific training on screening for IPV.

### Setting of the current study

This article reports on a qualitative, focus group and interview evaluation of Virginia's Project Connect, a joint venture between the Virginia Department of Health (VDH) Office of Family Health Services and Futures Without Violence. Project Connect is an initiative that aims to improve the public health response to IPV and reproductive coercion.<sup>41</sup> This is accomplished through training in a brief screening procedure and intervention or follow-up preplanning. Both the training and intervention incorporate principles of trauma-informed care, such as recognizing the impact of violence on individual development and coping processes, supporting empowerment through partnership between provider

and patient or client, maximizing the individual's opportunity to choose and navigate a personal path to survivorship, and supporting the individual's need for safety and nonjudgmental support in care provision.<sup>42</sup> In addition, Project Connect training is specifically adaptable to culturally competent care strategies, which are fundamental to the identification and remediation of trauma in diverse populations.<sup>43</sup>

In 2010, Futures Without Violence selected the VDH as 1 of 10 pilot sites for Project Connect in the United States. By 2012, more than 1,100 Virginia-based providers had received training and these providers saw more than 84,000 unduplicated clients in a single fiscal year.<sup>41</sup> To achieve this level of dissemination, VDH officials targeted family planning clinic providers and members of the Virginia Home Visiting Consortium (VHVC), which is a collaborative statewide organization of early childhood home visiting programs serving families from pregnancy through the child's fifth year.<sup>44</sup> Many VHVC providers provide extended periods of service to clients and develop significant relationships with them. In contrast, providers in VDH family planning clinics have limited time with clients and may see them only once or twice. Targeting these groups for training offered a variety of settings for application of training, tools, and resources.

### Sample

The study sample included 47 providers from diverse settings around the state. Approximately half (53.2%; see Table 1) were Caucasian, a third (31.9%) were African American, and they had been in their current position for an average of 9 years (mean =  $9.01 \pm 8.83$  years; range = 0.5-40 years). Additional demographics are included in Table 1.

### METHODS

Data were collected via focus groups and individual interviews. Potential participants were identified using the Project Connect

**Table 1.** Participant Demographics ( $N = 47$ )

	<i>n</i>	%
Ethnicity		
Caucasian/white	25	53.2
African American/ black	15	31.9
Asian American	1	2.1
Hispanic/Latino	3	6.4
Multiracial	1	2.1
Other	2	4.3
Highest education		
High school/GED	4	8.5
Associate's degree	9	19.1
Bachelor's degree	21	44.7
Graduate school	12	25.5
Employment status		
Full-time	46	97.9
Part-time	1	2.1
Minimum age	29 y	
Maximum age	66 y	
Mean (SD)	49.57 (10.30)	
Minimum years in position	0.50	
Maximum years in position	40.00	
Mean (SD)	9.01 (8.83)	

Abbreviations: GED, General Education Development test; SD, standard deviation.

trainings registration database, and the invitation to participate was delivered via e-mail with a follow-up information sheet. Informed consent was completed before beginning participation. For focus groups, the investigators reviewed the consent forms with participants in person and obtained signatures. For individual interviews, the process was the same if completed in person; or if the interview took place via telephone, the consent document was mailed to the participant beforehand with a return envelope, and verbal reaffirmation of consent requested before interviewing. The consent document included a notice that focus groups and interviews would be recorded and asked permission to record. Participants were asked not to use any names or other identifying information during recording. The signed consent forms and the audio files were

stored separately and securely at the primary investigator's home institution. Since VDH guidelines prohibited compensation for employees participating in focus groups, focus groups were held at lunchtime and food provided. For individual interviews, participants received a similarly valued gift card to a local business.

### Data collection

Focus groups and interviews took place between February and May 2013. Both focus groups and interviews followed an original, semistructured guide consisting of open-ended questions with follow-up prompts. The primary investigator developed the guide with input from the coinvestigator. Questions covered participants' expectations of the training, their use of the Project Connect tools, experiences with screening for and responding to identification of IPV and reproductive coercion, barriers to screening, suggestions for improvement, and thoughts on how to support universal screening. Focus groups lasted approximately 1 hour; individual interviews lasted 20 to 40 minutes. All data collection was completed either in the offices of participating agencies and clinics, by telephone, or in another private location. All sessions were recorded using secured audio equipment, and recordings professionally transcribed under confidentiality agreement.

### Analysis

The investigators elected to use a qualitative approach to the evaluation because evidence suggests that implementation of screening for and intervention in cases of IPV and reproductive coercion is somewhat situational in nature.<sup>39,40</sup> Qualitative research in general aims to discover and discern participants' making of meaning from both routine and unique experiences pertaining to the phenomenon of interest.<sup>45</sup> Qualitative study also permits the investigator both to elicit a detailed description of events and context and to explore the evolution of personal processes related to these.<sup>46</sup> Thematic analysis in particular lent itself to this project because the

overarching question guiding the research was whether or not trained providers achieved implementation fidelity with the Project Connect tools. Thematic analysis allows for identification of patterns within data and is useful in developing understanding of “ways the broader social context impinges” on how individuals make meaning of experiences.<sup>47</sup> Such understanding is necessarily important in examining how providers do or do not implement screening for and intervention in cases of IPV and reproductive coercion. Both issues are embedded in relationships, and providers’ expectations of these processes are thus likely to be informed by social context.

Data were analyzed using ATLAS.ti software from Scientific Software Development GmbH (Corvallis, OR) Analysis began even before transcription in that the investigators took detailed field notes during focus groups and interviews and these served as reminders of particularly emphasized points or repeated attention to a particular point. The investigators also used a form of member checking in each instance of data collection to establish ongoing interpretation across the evolving data set.<sup>48</sup> This involved using reflective and inductive statements to clarify and ensure appropriate interpretation of participants’ points during focus groups and interviews. As data accumulated, the investigators iteratively reviewed transcripts, field notes, and recordings to identify and elucidate thematic elements. Each investigator coded the transcribed data independently and *in vivo* and then the team worked collaboratively to establish consensus and develop conceptual agreement about the codes and their meanings. The themes identified in this article are based on analysis of the focus group and interview data, as informed by the investigators’ experiences of data collection. These experiences were captured through field notes and iterative data review.

### Theme development

Applying the criteria established by DeSantis and Ugarriza,<sup>49</sup> theme development pro-

ceeded from examination of the codes supporting the theme to assemble the unifying aspects of providers’ experiences into a meaningful whole. Similar codes were clustered, condensed into families, and then assessed iteratively for commonalities that formed the basis for generating the themes. Commonalities were sought at both the semantic and latent levels as described by Braun and Clarke<sup>47</sup> such that both direct language about the concepts encapsulated in the themes and more oblique references to these concepts were captured. In this analysis, the overall entity was the Project Connect protocol implementation; structure, function, form, and mode were considered for each theme. The themes that emerged most significantly were “How it’s done,” “Starting the conversation,” and “Follow-up.” Selected *in vivo* codes, code families, and the major themes are shown, along with their contributions to the criteria for theme, in Table 2.

One of the aims of the study was to discover whether or not the Project Connect training had helped providers gain confidence and develop competence in screening for and intervening with clients affected by IPV and reproductive coercion. For this reason, the interview guide included questions designed to elicit information about how the providers were or were not implementing the Project Connect protocols. These questions yielded some of the data incorporated into the themes “How it’s done” and “Starting the conversation.”

The mode of the “How it’s done” theme, the “recurrence of the experience” as defined by DeSantis and Ugarriza,<sup>49</sup> proceeded from identification of instances in which providers talked about their routines of screening and intervention. These instances were coded *in vivo* initially and then examined for similarities, such as the duration of interaction the provider felt was needed and what tools they felt were most useful. These similarities provided the form of the theme, the pattern and set of variations in the providers’ uses of the Project Connect tools. Once these variations were established, and the investigators agreed

**Table 2.** Themes, Families, and Sample Codes

Major Theme	Code Families Included	Sample Codes Included	Consensus Concept
How it's done	Problems	"Clinical judgment," "breaking the shell"	Barriers or needs to effectively screen
	Provider actions	"Then what?," "we care"	Negotiating support in the setting and facilitating successful use of the tools
Starting the conversation	How do I approach	"Finding a way," "cultural issues," "have some discomfort"	Determining when to screen in the relationship or the routine of care
	Provider expectations	"It's not going to go away," "what's enough," "what are we doing here"	Providers' view of screening for these issues and its place in their work
Follow-up	Seeking consistency	"More exposure," "troubleshooting the process"	Applying the tools for maximum benefit
	Making it better	"Reminders," "championing"	Reinforcing and supporting the knowledge gained

that the field of variations was saturated, the function of the theme was established—in this case, unifying the set of behaviors that providers engaged in related to the processes of screening for and intervening in cases of IPV and reproductive coercion. The meaning of "How it's done" thus came from identifying and fitting together the diverse patterns of implementation.

Under "How it's done," *Problems* was the family in which were grouped codes for providers' struggles with things they viewed as barriers to implementing the Project Connect protocol or to carrying out screening in general. Codes included "clinical judgment" and "breaking the shell." These represented things that the providers felt were necessary to properly screen for and intervene with women who had histories of or current experience with IPV and reproductive coercion.

In the family *Provider actions* were codes used to describe how the providers felt they contributed to or participated in screening and intervention with clients. "We care" was an important code because all of the

providers, regardless of work setting, stressed that IPV and reproductive coercion were important issues in the lives of their clients. This code particularly foregrounds the importance all the types of providers placed on their own dedication to and focus on helping their clients. Similarly, "Then what?" represented providers' feelings about what to do if they were to identify historical or current IPV or reproductive coercion.

Like "How it's done," the theme "Starting the conversation" was developed from the providers' emphasis on a particular aspect of the screening and intervention process. In this case, the mode of the theme was how to open the screening or intervention dialogue. The form of the theme followed from discovering multiple instances of these descriptions and then devising the related code families. The function of this theme was to bring together the different ways in which providers identified the initiation and impact of screening and intervention. The families included in the theme were named *How do I approach* and *Provider expectations*. The first of these encompassed both the provider's desire to ask

about IPV and reproductive coercion at a time when it would be most effective and finding the way to broach the subject and thus included codes such as “finding a way,” “cultural issues,” and “have some discomfort.” These identified instances where providers described ways that they sought to make the tools more socially or culturally appropriate to their client populations.

Relatedly, *Provider expectations* referred to how the providers anticipated clients responding, or what they hoped to see as a result of initiating screening and intervention processes. This family contained codes that imparted value to the acts of screening and intervening—among them, “it’s not going to go away,” “what’s enough,” and “what are we doing here.” These codes suggested that overall providers recognized the value of the Project Connect tools but that they were still unsure that the tools were effective.

The third theme, “Follow-up,” resonated across interviews and focus groups as providers repeatedly expressed desire for additional practice, training, and interaction around learning to screen for and intervene in cases of IPV and reproductive coercion. This repetition was the mode for the theme, and the form emerged from its recurrence across interviews and focus groups, even among different types of providers. The code families for “Follow-up” included *Seeking consistency* and *Making it better*. *Seeking consistency* reflected concerns that not every situation could be covered in a single Project Connect training. This family included the codes “more exposure” and “troubleshooting the process.” The code “more exposure” was suggested by participants’ concerns that they were not as skilled as they wanted or felt they needed to be in screening and intervening based on the training they had received. The code “troubleshooting the process” was more directly indicative of a desire for feedback and validation of screening and intervention activities by individuals. The *Making it better* family of codes referenced participants’ ideas about how to better disseminate or update the train-

ing modalities. Codes included “reminders,” which indicated suggestions about revisiting the tenets of training regularly and “championing,” which indicated the need for support from within the home agency.

## RESULTS

The data reported here exemplify the content of the themes and the broad range of ways providers talked about the Project Connect training and tools in their practices.

### How it’s done

The theme “How it’s done” was identified from participants’ descriptions of how and when they screened clients for current or previous experiences of IPV and reproductive coercion. Although participants did not implement screening and intervention processes or use the Project Connect tools in exactly the same ways across settings, they did implement and use them (“because different people are . . . more comfortable doing it one way or the other”). As one participant said,

I stopped—sorta-kinda—stopped using [hard copies of the tools] cause I think maybe because . . . of my comfort level I feel very comfortable talking about that with my patients, clients, and/or the partner. But I think I’ve also incorporated some of it into my thought process or my communication . . .

Interestingly and importantly, there were clear differences in screening behaviors between the family planning providers and the home visit providers. One such difference was in the amount of time that providers felt they could or should spend with the client before performing the initial screening. For the family planning providers, who were clinic based, time was limited because of the clinic schedule and they often had to decide how to prioritize needs. This meant that they did not always screen for IPV or reproductive coercion unless they felt they had a reason (“in the clinic you know we’re covering so much,” “. . . there’s not a heck of a lot of time to go into it”). In contrast, for



the home visiting providers, establishing a rapport over time and being confident that the client would answer honestly was often the goal. This meant that they also did not ask at every encounter, but instead made it clear over time that they cared about and were prepared for disclosure from their clients (“I usually don’t do it the first visit”).

Among the family planning providers—all of whom were licensed clinicians—the “clinical judgment” code (code family: *Problems*; see Table 2) had special significance. As one of the clinic supervisors noted,

... it depends on the patient. ... sometimes the patient will come in and say that ... they’re just here for birth control pick up but also they want to [be] tested for an STI ... then [that] may trigger ... further questioning.

These providers stated repeatedly the importance of their ability to identify situations in which screening or intervention was needed, even if they could not always describe exactly how they did so (“the little cards ... I have not used them,” “we do lots of questionnaires ... we actually handed the tool to them”). As a nurse coordinator added, “We don’t have a set ... time. It’s when the situation warrants it ... I really cannot put my finger on [the trigger].”

“Breaking the shell” was more resonant among the home visiting providers and was as unique to these participants as “clinical judgment” was to the family planning providers. This code marked instances where the home visitors focused on needing to delay screening or intervention until “there’s a point when you keep on seeing her ... that it’s going to come out.” Another participant, referring to a written screening tool, suggested that early on the client-provider relationship, “They’re not gonna fill it out honestly, because they’re gonna be afraid ...” Another participant in the same group echoed, “... after the first or second visit they’re not going to [answer honestly], because there’s no rapport between them.” In these instances, the home visiting providers asserted the need for a solidly established relationship with

the client such that they could expect accurate or truthful answers in response to screening.

Under the family *Provider actions*, the code “we care” referred to providers’ focus on IPV and sexual assault as important issues, even if they found it difficult to accommodate screening logistically. As a family planning nurse noted,

Well, it adds one more step for us, but I don’t have a problem with that and I don’t think [my colleague] does either; it’s just given us—it’s just something added ... but if we identify we certainly wouldn’t let that go, no way would we do that.

A home visiting provider described how,

... you can tell the girls over and over “I’m there for you.” But actions speak, and after a while—because I was just riding down the street with a girl and she told me some things that happened to her ... and I couldn’t help—I was crying and she was crying.

Following on “we care,” some providers wondered “then what?” which became a code for how to proceed from screening and identification. Some were quite confident about the next steps, as one home visiting supervisor reported, “Oh absolutely we have a close relationship with both the domestic violence shelters and we’ve had training ... [we] definitely are comfortable and know exactly what to do.” Others were less convinced that such resources were helpful: “I mean, you’re out of your luck if you’re not documented. And that’s a big problem ...” At the same time, some clinic-based nurses felt overwhelmed by the array of options and unsure which resources were appropriate: “... all the different groups and the areas that are involved in the community that you need to report to, and who’s involved in the situation and who you need to go to and who you refer that person to ...”

### Starting the conversation

The second theme, “Starting the conversation,” included instances where providers described feeling uncertain or worried that they

would not have adequate skills to support an affected woman (“... you have to feel okay with yourself to be able to say something, too”) and because they were not sure whether the process was working (“I think that sometimes we don’t realize how much the little ... cards and stuff are helpful for [clients]”).

The family *How do I approach* included acknowledgment of both the importance of and the difficulty in asking about IPV and reproductive coercion, with codes including “finding a way,” “cultural issues,” and “have some discomfort.” One participant stated,

I think sometimes it’s uncomfortable, initially. You know you—it’s something you want to do and it’s just one of those things, like, ok so let me kinda fall into this now, you know, let’s go on to the next question ... but I have noticed that if you just ask it, like, well, when you’re asking about the STDs or whatever, routinely asking everyone and continuing asking the same things then it makes it a lot easier.

In another instance, a nurse supervisor described struggling to adapt the tools to a different population served by her agency:

... we do serve a number of refugee families and we weren’t able to use the tools with them at all. ... often with our refugee families the interpreter is either a man or someone they’re afraid might know them or other people they know and sometime the communities are small of these refugee families ... so that made it harder to administer the tools ...

In the same interview, the participant noted that even when translation was possible, additional explanations were often required because some concepts were different or otherwise difficult to make clear in another language. A focus group participant also noted concern about cultural mores such that someone from a small ethnic community might not want to divulge IPV or reproductive coercion because of alienation or lack of appropriate resources:

Sometimes there is some confusion on part of the women as far as what I’m getting at and being realistic of what their possibilities are because many of them are very dependent and feel isolated with

the men in their lives ... There’s not a lot of resources for them so if they do come forward and want your help it’s very hard to find help for them that’s culturally sensitive and the language is there.

The family *Provider expectations* in this theme included the codes “it’s not going to go away,” “what’s enough,” and “what are we doing here.” An example of “what are we doing here” came from a home visiting supervisor who described the uncertainty of offering resources and materials to clients, without ever seeing any response:

I think it’s helpful for them to have the information and the knowledge that they’ll need to ... maintain their safety in their environment or be able to get out of that environment ... but knowing that they have the information and the phone numbers ... I think you know it’s helpful but we’re just not gonna see the benefit of that.

Others worried that regardless of effort “it’s not going to go away,” such as the nurse from a family planning clinic who worried that younger clients did not recognize controlling or abusive behaviors and might not respond to screening:

But now you also have to remember, I think from what I hear that even in schools there’s more of the physical contact, even in the hallways of the school. So some of the younger girls have grown up with the shoving ... between their boyfriends ... girlfriends, whatever. And they’ve grown up with a lot of that ... And so when we ask that question, I’m not sure and maybe we need to delve into it more so, because sometimes I just think it’s very acceptable.

A home visitor in the same focus group added, “I don’t think it matters how you ask them ... if they’re going to tell you, they’re going to tell you. And if they’re not, they’re not going to tell you.”

### Follow-up

The theme “Follow-up” was developed to conceptualize providers’ desire for more learning and validation in screening and intervention routines. A nurse coordinator noted,

“... you know, you’re in a situation and kinda have to figure it out as you go, but if you have a lot of different things [presented in training] ... I think it should be done like once a year.” References to concerns about not attending adequately to some aspects of screening and intervention supported “troubleshooting the process,” such as with the supervisor who stressed the importance of providing “reassurance and desensitization” as staff of one agency began actively using the tools—“to make them feel comfortable enough ... to be able to make that change in the way they operated.”

Included in the family *Making it better* were codes for providers’ suggestions to enhance training and learning—“reminders” and “championing.” One participant commented, “We get a lot of ... requirements so we’re doing this, we’re doing that, so sometimes ... we forget the big picture,” and needing to remember and refocus on the importance of screening. Another noted, “[we] cover so much—you have to know so many different areas so I think it’s easy to push one aside cause I gotta focus [on something else] ... so I think a ... refresher would be good.” The code “championing” referred to agency support for trained providers to use the tools. As a family planning clinic supervisor said,

It’s more than the one training, it’s got to be more than just that. . . . You’ve got to have someone in the organization who’s saying “is this being done?” and “how often?” and making sure that it is. And then what questions [are asked]—like that.

## DISCUSSION

Although this evaluation particularly focused on the Project Connect protocol, the findings here are relevant to any screening and intervention protocol for IPV and reproductive coercion, particularly if the ultimate goal is the provision of trauma-informed care and support to women affected by IPV and reproductive coercion. For providers working in settings where at-risk women are apt to seek treatment, being able to identify, inter-

vene, and offer support to those affected represents an important component of the provision of true trauma-informed care. From the results of this study, it is clear that providers both value and struggle to implement universal screening and intervention protocols such as those included in Project Connect. The providers in this study indicated repeatedly that the presence of the tools and the training did help bring their attention to the issues of IPV and reproductive coercion, but they struggled with approaching the issue and screening all clients routinely. It may be that greater emphasis on the potential positive impact of trauma-informed care for patients and clients with histories of IPV during the training would encourage providers to overcome these concerns.

In addition to worrying that they were sacrificing other services to take time for screening, some providers were not certain that there were benefits to screening even if they identified IPV or reproductive coercion. Kulkarni et al<sup>50</sup> found that clients experiencing IPV might be seeking to balance safety on a daily basis with seeking out recommended support—and thus might not immediately respond to screening or offers of intervention. This may also be important to emphasize when training providers to screen for and intervene in cases of IPV or reproductive coercion. A trauma-informed approach could thus facilitate providers’ support of safety planning and harm reduction with clients who have histories of or are currently dealing with IPV.

The family planning clinic providers in particular felt constrained by their duties in time-limited visits. They worried about limited access to and time with their patients and the wide variety of things they wanted to address. Faced with competing goods, these providers experienced moral distress.<sup>51</sup> Moral distress has been described with regard to health care providers and nurses, in particular, and occurs when the appropriate or “best” course of action is clear but the provider is not able to follow that course because of other constraints or concerns.<sup>51,52</sup> Among the providers in this

study, moral distress occurred when the clinic was too busy to allow for thorough screening or intervention, or when home visiting providers felt that clients were overwhelmed or not ready to be honest about their relationships. This type of internal conflict could play a role in reducing providers' overall motivation to screen and intervene in cases of IPV and reproductive coercion. It was clear that providers not only recognized the potential good to be done by screening and intervention for IPV but also felt that it was equal in potential to all other visit activities and were uncertain how and when to prioritize. Additional understanding of how to incorporate a trauma-informed approach throughout care provision could help relieve possible moral distress among providers working with clients at risk for IPV.

Another means of addressing providers' struggles with screening may be to emphasize that engaging in screening and intervention with women at risk for or with a history of IPV and/or reproductive coercion helps create a culture of safety in the practice environment, encouraging disclosure and enhancing opportunities for providers to engage in trauma-informed care throughout the interaction. In a study of women seeking legal recourse to experiences of IPV, repeated telephone contacts with nurses increased the women's safety-promoting behaviors over a period of 6 months, with maintenance over 18 months.<sup>53</sup> This suggests that ongoing references to providers' desire to help women with exposure to IPV and reproductive coercion—such as via universal screening and trauma-informed care consultations—may enhance affected women's commitment to help-seeking and safety promotion. The results of this study, in which providers emphasized caring about clients as well as desire to provide the best care to them, indicate that screening and intervention also need to be presented as integral to comprehensive, trauma-informed quality care. Engaging providers in developing a culture of safety for clients, an environment in which clients feel comfortable disclosing IPV or reproduc-

tive coercion, may thus help overcome some of the concerns identified here.

## LIMITATIONS

This study was limited by its small sample size and focus on one type of training in screening and intervention. An additional limitation was the lack of comparison of screening practices with those of untrained providers—it may be that the providers in this study were more likely to screen their patients even before training due to the nature of their practices. Finally, the focus group design may have created a kind of peer pressure, making participants more or less likely to accurately report their feelings about screening and intervention than they might otherwise have been. Effort was made to reduce this effect by excluding supervisors from focus groups and instead conducting individual interviews with those in positions of organizational influence.

## CONCLUSION

Screening for and intervening in cases of IPV and reproductive coercion are vital to supporting the health of affected or at-risk women. Reproductive health and home visiting care settings represent important opportunities to engage in these practices, but many providers lack confidence in their ability to do so effectively. Programs such as Project Connect offer providers the opportunity to develop confidence and support systems for screening and intervention such that they can integrate trauma-informed practices into their work more effectively. Offering specific training to providers who serve at-risk populations of women is likely to increase screening for and intervention in cases of IPV and reproductive coercion and to decrease the overall burden of these problems on the health care system. Furthermore, trauma-informed care strategies including this type of screening can contribute to such reduction by decreasing the long-term health impact of IPV and reproductive coercion on women.

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