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Intimate Partner and Sexual Violence Screening Practices of College Health Care Providers

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Abstract

Background—Female college students experience higher rates of intimate partner violence (IPV) and sexual violence (SV) compared to men of all ages, older women and young women who are not attending college. Experts and medical organizations have issued recommendations that health care providers should routinely screen women for IPV and SV. However, most female college students report they are not being screened for IPV and SV at college health centers.

Aim—This exploratory study sought to examine the IPV and SV screening practices of college health care providers and identify individual and organizational influences using a cross-sectional, quantitative survey design.

Methods—Sixty-four health care providers (physicians, nurse practitioners and registered nurses) from five colleges and universities in the northeastern U.S. were invited to participate in an anonymous, web-based survey about their IPV/SV-related screening practices and beliefs, and organizational characteristics of their college health centers.

Results—Twenty-six health care providers completed surveys (56% response rate). The median reported IPV/SV screening rate was 15%. More IPV/SV screening was reported by nurse practitioners, providers at state colleges, and by those in health centers that prioritized IPV/SV screening and had greater organizational capacity for change.

Conclusions—College health centers represent unique, yet often missed, opportunities to screen for IPV/SV in a high-risk population. Provider- and organization-level influences should be incorporated into future interventions to improve IPV/SV screening in college health centers. Future studies with larger numbers of colleges and providers are needed to better understand organizational influences and identify mediators and moderators of effects.

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Keywords

sexual violence; intimate partner violence; violence screening; college women

Sexual violence (SV) and intimate partner violence (IPV) present significant public health threats for women, particularly for young women, ages 18 to 25 (Black et al., 2011). IPV is defined as abusive behavior and/or coercion within an intimate relationship; SV is defined as sexual activity that occurs when consent is not obtained or is not freely given (Breiding, Basile, Smith, Black, & Mahendra, 2015). Female college students are at great risk for IPV and SV, and report higher rates than other age groups and those not attending college (AUTHOR, 2016; Catalano, 2016; Fisher, Cullen & Turner, 2000; Sinozich & Langton, 2014). An estimated 20% – 25% of female college students report experiencing a completed or attempted rape at some time during their college career, and more than 40% report experiencing physical, sexual, verbal or controlling abuse from an intimate partner (Black et al., 2011; Fisher et al., 2000; LoveisRespect, 2011). IPV and SV may result in serious injuries, death, sexually transmitted infections, pregnancy, and psychological distress (Black et al., 2011; Campbell, 2002). Long-term sequelae may include chronic pain, gastrointestinal disorders, anxiety, depression, and PTSD (Black et al., 2011; Campbell, 2002). The annual costs associated with IPV, including health care expenses and loss of productivity, exceed \$5.8 billion (CDC, 2016).

The Institute of Medicine (IOM) recently released recommendations that health care providers (HCPs) should screen all women for IPV/SV (IOM, 2011). Health care providers have reported IPV/SV screening rates as low as 20 – 25% in emergency departments (Glass, Dearwater & Campbell, 2001), 5 – 18% in obstetric and gynecologic practices (Tower, 2006; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000), and 2 – 12% in primary care settings (Caralis & Musialowski, 1997), although these reports predate the IOM recommendation and recent national attention on IPV/SV. In addition, although college women represent a group at great risk for experiencing IPV/SV, little is known about college health care providers' IPV/SV screening practices (ACHA, 2016; AUTHOR, in review). College health care providers may be uniquely positioned to screen for IPV/SV, identify young women at risk and intervene (e.g., treat injuries, engage in crisis intervention, counsel, refer) to reduce violence and improve outcomes. Thus, this study explored individual and organizational influences of IPV/SV screening among college health care providers (HCPs).

Methods

Sample

HCPs from the student health centers at five co-educational colleges and universities in the northeastern U.S. were invited to participate in an anonymous web-based survey of IPV/SV screening practices. The five sites constituted a convenience sample of residential co-educational colleges in the northeast, although schools varied in percent female, private/public, religious affiliation, and undergraduate enrollment. The five sites employed 64 HCPs, all of whom were invited to participate. Pre-contact emails, reminders and an incentive raffle were used to enhance participation. At the end of the survey, participants

were directed to a separate Qualtrics™ site, where they could enter a raffle to win a Kindle if they chose to do so. Participants were given the option to complete the survey in a paper and pencil format if they preferred. All procedures were approved by the IRBs at the authors' and participating colleges/universities.

Measures

Demographics and general characteristics included college/university, HCP role (e.g., physician [MD], nurse practitioner [NP], registered nurse [RN], counselor, other), years of experience and type of college (public, private; religious affiliation). Providers were not asked about race/ethnicity or gender due to the potential for deductive disclosure. They were asked about IPV/SV-related beliefs, intentions and behaviors using Likert-type responses (e.g., "strongly disagree" to "strongly agree"). Multi-item scales were used to measure two key variables from Solberg's (2007) Conceptual Framework to Improve Medical Practice. Specifically, the Change Process Capability Questionnaire (CPCQ) (Solberg, Asche, Margolis & Whitebird, 2008) was used to measure the health center's capacity for change and a multi-item Perceived Organizational Priority (POP) scale was adapted from Solberg's (2007; Solberg et al., 2008) measures to assess organizational priority for screening for depression. Both scales have documented reliability and validity. The outcome variable of interest, rate of IPV/SV screening by individual HCPs, was reported as the percentage of female students seen during the past 3 months who were screened for IPV/SV. Response options ranged from "0%/almost none" to "100%" in 10% increments.

Analysis

Data were collected using Qualtrics™ and downloaded into SPSS v23.0. Pencil and paper survey data were entered by a PhD student who had been oriented to data coding and entry procedures. Data were analyzed using descriptive statistics, t-tests, and non-parametric tests.

Results

Of 64 eligible HCPs, 32 clicked on the link; 25 consented and completed the survey. Another eleven completed the survey using the pencil and paper option. The response rate ($n = 36$) was 56%. Data from two respondents were eliminated because their site experienced a widely publicized IPV event just prior to data collection. Data from respondents who self-identified as counselors, support staff or other ($n = 8$) were subsequently excluded in order to limit analyses to HCPs who provided direct clinical care to students (MDs, NPs, RNs). As is shown in Table 1, the final sample included 5 MDs, 10 NPs, and 11 RNs; most reported many years of experience. Although most HCPs agreed that routine IPV/SV screening would be a good/very good idea, some had concerns that screening would disrupt clinical operations, cost money, or take up a lot of time. The median reported rate of IPV/SV screening was 15%.

Several individual and organizational variables were associated with the outcome variable, reported rate of IPV/SV screening, including HCP role, college religious affiliation, and reports of the college health centers' organizational priority for IPV/SV screening and change process capability. NPs reported more IPV/SV screening than other providers ($t =$

2.596, $df = 18.8$, $p = .018$), and HCPs from religiously affiliated colleges reported less ($t = -2.764$, $df = 23.05$, $p = .011$) screening. Because the outcome variable was non-normally distributed, results were confirmed using the Mann-Whitney test for two groups (NPs / not NPs; $p = .009$). The Kruskal-Wallis Test indicated different distributions across the three HCP groups ($p = .02$). The independent samples median test was also significant ($p = .048$). Both organizational variables, IPV/SV priority and capacity for change, were significantly correlated with reported rates of IPV/SV screening ($r = .617$ and $r = .401$, respectively).

Conclusions

This preliminary study was limited by a small number of providers at only five schools, although the schools varied on a number of characteristics and the response rate was greater than 50%. The main finding of low rates of IPV/SV screening (median = 15%) is supported by the results from two earlier studies in which only 10% – 11% of female students reported being screened for IPV/SV at their last college health center visit (Author, 2016; Author, in review). NPs' reported IPV/SV screening rates were greater than those of other providers; nonetheless, NPs indicated that they were screening fewer than half of their female college student patients for IPV/SV. The findings identified potentially modifiable individual and organizational factors that may be acting as barriers to IPV/SV screening. For example, beliefs that IPV/SV screening may take up too much time or disrupt health center functioning are modifiable and can be addressed in interventions.

There are a number of standardized IPV/SV screening tools and clinic protocols that can help college health centers to implement screening into standard practice. In addition, electronic health records (EHRs) can be customized to include screening reminders, templates for screening, and mandatory sections that must be completed during each clinical encounter. The current study did not explore the types of EHRs that were in use in the college health centers; this should be examined in future studies.

Further research with larger samples of colleges and HCPs is needed to expand our understanding of provider and organizational factors that promote or inhibit IPV/SV screening, and how they exert influence. This information is vital in order to develop interventions that address barriers to IPV/SV screening (Author, 2016; Author, in review). Nurses and nurse practitioners are well positioned to lead research and practice change initiatives in this area. Follow-up studies are currently underway examining the IPV/SV screening practices of hundreds of college health care providers across multiple regions of the U.S.

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Highlights

- Female college students represent a group at high risk for experiencing intimate partner violence and/or sexual violence
- Low rates of IPV/SV screening were reported by college health care providers (overall median screening rate = 15%)
- Nurse practitioners reported higher rates of IPV/SV screening than other college health care providers (median screening rate = 40%)

Table 1

Demographics and IPV/SV-related beliefs, organizational factors and behaviors

	Total	MDs	NPs	RNs
<i>N</i>	26	5	10	11
Years of experience in HCP role	23.56 (11.7)	20.90 (18.4)	24.90 (13.1)	23.55 (6.9)
Years of experience at current college health center	11.85 (9.9)	13.80 (16.3)	11.00 (7.6)	11.73 (9.1)
<u>Attitudes/Beliefs:</u> Asking about IPV/SV is a ___ idea (good /very good)	77%	100%	80%	63.7%
Students would be upset if we routinely screen for IPV/SV ^a	15.3%	0%	10%	27.3%
Routine IPV/SV screening would disrupt clinic operations ^a	30.7%	60%	10%	36.4%
Routine IPV/SV screening would cost a lot of money ^a	7.7%	20%	0%	9.1%
Routine IPV/SV screening would take up a lot of time ^a	34.6%	60%	10%	45.5%
<u>Organization:</u> IPV/SV organizational priority score (possible scores 7-35)	24.31 (6.4)	23.60 (4.0)	27.81 (5.3) [#]	21.45 (6.9)
CPCQ – capacity for change score (possible scores 16 – 80)	58.70 (11.4)	55.00 (3.7)	64.26 (8.0)	55.32 (14.6)
College health center routinely screens all female students for IPV/SV (yes)	15.4%	20%	10%	18.2%
<u>Behaviors:</u> % of female students seen during past 3 months that you screened for IPV/SV	Median = 15% Mean = 22.69% (27.9)	Median = 10% Mean = 12.0% (8.4)	Median = 40% [*] Mean = 39.0% [*] (25.6)	Median = 0% Mean = 12.73% (30.0)

^a % reporting “likely” or “very likely”[#] $p < .10$;^{*} $p < .05$;^{**} $p < .01$;