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IPV nurse education: Scoping things out to see who's doing what?

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Abstract: 300 words

Introducing best practice approaches to help nursing students identify and respond to patients who are/have been exposed to intimate partner violence (IPV) is instrumental to their professional development. The objectives of this study are to gather preliminary data from the American Association for the Colleges of Nursing (AACN) affiliated schools of nursing to determine 1) if they offer any training of students at the undergraduate or graduate level in identifying and responding to IPV; 2) if so, what are the components of that training, outcomes, and satisfaction with the existing approach; 3) if not, what are the individual and institutional level barriers to offering this training; and 4) if schools are interested in incorporating best practice, IPV training content into their curriculum. Design and Methods: A total of 836 AACN affiliated nursing schools across the US were surveyed using a 64-item electronic survey. Results: Of the 95 (11%) schools that completed at least 40% of the survey, approximately 60% offer IPV training once at the undergraduate level and only 30% offered such preparation at the graduate level. We found that most IPV education took place as embedded material within an existing course. Those nursing schools not providing any IPV education identified that they would like to at both levels and the 50% of nursing schools already providing this education said they wanted to provide more. The greatest barriers to offering IPV education were lack of faculty expertise and time constraints, yet about 70% of the participants stated that IPV education should be an essential part of undergraduate and graduate nursing school. Conclusion: This study provides useful insights to inform IPV curriculum development by identifying common gaps in IPV education experienced by participating schools and strategies for addressing them.

Introduction/Background

Intimate partner violence (IPV) refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm (World Health Organization, 2021). While men may also experience IPV, women and children are the most common victim-survivors of IPV (WHO, 2021). It is one of the most common forms of violence against women with an estimated global prevalence of 30% (WHO, 2021; 2014). This underreported epidemic negatively affects the physical and mental health of victim-survivors, most commonly women and children (WHO, 2012). With IPV comes a host of negative health sequelae often encountered by healthcare providers such as anxiety and depression, gastrointestinal issues, chronic pain, headaches and health risk behaviors including substance use (Ramaswamy, Ranji, Salganicoff, 2019). Children exposed to IPV often display a range of internalizing (anxiety and depression) and externalizing (aggression) behaviours (Vu, Jouriles, McDonald, and Rosenfield, 2016).

Nurses are often among the first providers' women exposed to IPV encounter, placing them in a primary position to interact, respond and care for women who are experiencing IPV. Yet, it has been well documented that despite encountering women experiencing IPV, many health care providers do not feel comfortable or adequately prepared to screen and respond (Hooker, Nicholson, Hegarty, Ridgeway, & Taft, 2021, AWHONN, 2015; Bair-Merritt et al., 2014). The evaluation of the Domestic Violence Enhanced Home Visitation Program (DOVE) protocol, a pamphlet-based safety planning intervention for women experiencing perinatal IPV, showed that training nurses to screen and intervene were essential to quality delivery of its protocol and fueled the desire to stay up to date about the issue and local resources (Burnett et al., 2019).

When women receive IPV screening in clinical settings, it serves to identify abused women and “increase access to resources, decrease abuse, and improve clinical and social

outcomes” (Ramaswamy et al., 2019, p. 5). Miller, McCaw, Humphries & Mitchell (2011) systematic review found an example where an evaluation of a universal brief counseling intervention for women reported 60% of participants ending a relationship because “it felt unhealthy or unsafe” (p. 97). Given the high prevalence of IPV and associated health problems, it is inevitable that healthcare providers will encounter victim-survivors, yet robust pre-licensure preparation to address IPV is lacking (Crombie et al., 2017).

There is a need for nurses at all levels to have the knowledge, preparation and tools to effectively respond to families exposed to IPV with a trauma and violence informed care perspective. This includes prioritizing emotional and physical safety of nurses and patients; encouraging patients to actively participate in decision-making surrounding their care; recognizing that one’s trauma and violence experience creates a significant impact on their life and life choices; and that care plans should be grounded in the existing strengths and capacities that individuals, families and health care providers bring to their situation (Wathen & Varcoe, 2019).

An integrative review evaluating response to domestic violence and abuse in the emergency department concluded that, more needs to be done in nursing education and training around IPV (Ahmad et al., 2016). Similarly, another study examining bachelor nursing student’s perceptions and understanding of IPV reports that students did not feel adequately prepared to manage IPV in a healthcare environment (Beccaria et al., 2018). When health care providers are educated and trained to address IPV they feel more prepared and knowledgeable to address IPV (Bermele et al., 2018). In the United States (U.S.) Health Resources and Service Administration has made IPV training for health care workers in all settings a priority to redress “gaps in knowledge about IPV risks, impacts and interventions” (Health Resources and Service

Administration, 2017). Recent Cochrane review evidence suggests healthcare provider IPV training improves provider IPV knowledge, attitudes and readiness to respond to women however, it is unclear if training changes provider behaviors such as identification and safety planning (Kalra et al., 2021).

It is not known how many U.S. nursing schools educate their students about IPV using either didactic and/or more pragmatic approaches. Moreover, very few studies discuss or evaluate the education of nursing students in addressing IPV at the undergraduate and graduate nursing levels. An Australian study found that the lack of room in the curriculum, expert faculty, and support for this content were barriers to providing IPV related content to undergraduate nursing, midwifery, and paramedic students (Lovi et al., 2018).

In response to the lack of evidence about IPV training and preparation of nursing students, we sought to identify the approaches used in the US and explore the barriers to IPV education. Our purpose was to gather preliminary data from American Association for the Colleges of Nursing (AACN) affiliated schools of nursing to determine 1) If they offer any training or preparation of students at the undergraduate or graduate level in screening and intervening for IPV; 2) If so, what are the components of that training (pedagogy, methods, content, tools), outcomes, and satisfaction with existing approach; 3) if not, what are the barriers to offering this training and preparation (lack of knowledge, lack of expertise, lack of resources, not having an existing developed program to implement; and 4) if they are interested in incorporating IPV screening and intervention evidence-based content into their curriculum.

Methods

This IRB approved study used an electronic 64-item Qualtrics (2013) online survey containing Likert scales, short answer and yes/no response options sent by email to academic

program contacts at the 836 affiliated nursing schools across the US. The questionnaire items explored current IPV training practices, including the approach, strengths and opportunities for improvement, training barriers, gaps and needs. It was intended to help get a better understanding of undergraduate and graduate education on IPV screening and response in the US. The questionnaire was developed by the lead author (CB) informed by reliable and validated IPV instruments previously used to assess health care provider readiness to address IPV and deliver training (Short et al., 2006; WHO, 2019) . Content was also informed by IPV curriculum education content CB previously developed and implemented within an undergraduate nursing course (Burnett, Hudson, Walker-Atwater, Rawat & Schminkey, 2020). A directory of all AACN Schools of Nursing was used to identify key academic program contacts and follow-up communication with nursing schools took place, to clarify the appropriate contact. Once the participant contact list was developed, all potential participants (N=836) were sent an introductory email about the study, its purpose, researcher contact information, and a link to the survey. When participants clicked on the link, they were directed to the survey's first page where they reviewed the consent and agreed to participate. Two subsequent reminder emails to participants were sent out two weeks from the original email and then another two weeks after the first reminder. Once the survey period ended, the data were transferred from Qualtrics into IBM SPSS 25 for management and analysis. The data was reviewed for missing items. If more than 40% of the items in a survey were missing, the record was deleted. This process yielded 95 responses. Frequencies and descriptive statistics were then conducted.

Results

Ninety-five AACN affiliated nursing schools provided data on nurse IPV training content (95/836 or 11% response rate). Table 1 provides an overview of sample characteristics.

Information about nurse IPV training was obtained predominantly from white, female nursing program coordinators or directors from urban nursing schools. Participants reported providing a range of programs, with undergraduate nursing the most common type of training provided.

Table 1. Participant Characteristics [Insert here]

Half of the schools were interested in providing IPV training to students, with 41% already providing training. Up to 8% of schools were not interested in delivering this content. There was more interest for postgraduate IPV education than undergraduate (Table 2), although 45% were interested in delivering IPV training to both undergraduate and postgraduate nursing groups.

Table 2. Interest in Training of Preparation of Nursing Students [Insert here]

Participants were asked to provide information about the IPV training they provided (if any) and specifically, what it entailed and at what level (Table 3). The response to those questions yielded a variety of responses which are captured in the table below:

Table 3. Components of IPV training and Preparation [Insert Here]

Most nursing schools offered some form of IPV preparation as part of a course at the undergraduate and graduate levels. In undergraduate courses IPV content tended to be offered predominately in maternal/newborn child health, community health and mental health courses. Less so in family health, adult health and women's health courses. Whereas at the graduate level, IPV content was found across a variety of courses such as health assessment, women's health, practicum, primary care and nurse practitioner (NP) programs. Seldom was it provided as a workshop, guest lecture or stand-alone course at either the graduate or undergraduate level. At the undergraduate level student IPV education primarily focused on community referrals, general

IPV knowledge and screening. At the graduate level this focus was mostly on IPV screening, community referrals and IPV interventions. Undergraduate training focused on conferences, webinars, websites, research and simulation. Graduate nursing programs reported limited to no focus on simulation, conferences, webinars and websites. Slightly more than half of the respondents (N=56) identified that they had safeguards in place to protect the psychological safety and well-being of their students. Such safeguards included referral to counselling, student briefing and 'trigger alerts' prior to lecture, option to opt out and faculty being present. Only 16% of schools developed their own materials for IPV education, with the majority of schools accessing resources from 'other' sources. These 'other' sources were identified at the undergraduate level as textbooks and agency partners and for graduates, textbooks and websites, however there was wide variation across both levels as to types and sources of material used.

Table 4. shows respondent satisfaction with existing approaches to IPV education and additional support needed to enhance education. Importantly 81% of the schools felt that IPV training should be an essential part of the undergraduate and graduate nursing education. Three quarters of nursing schools wanted more IPV training (75%), especially at postgraduate level-with only 35% of schools being extremely or somewhat satisfied with the current level of training provided (Table 2). Those who wanted more training reported a need for extended IPV training across the campus, not just in the School of Nursing. Those few who did not want more IPV content (25%) reported adequate levels of IPV coverage, however several respondents spoke of time constraints within the curriculum.

Further support was sought from two thirds of the schools, with the most interest in support with the development of /access to course materials (66%) and faculty training (65%).

Table 4. Satisfaction with existing approach and support needed [Insert Here]

Barriers to offering IPV training and preparation

Less than half of the schools surveyed in this study had any IPV related curriculum and only a third of the respondents who did felt that their IPV education was sufficient. IPV education rarely includes opportunities for students to practice skills related to screening, danger assessment or safety planning through simulation. Some schools offer IPV information only once during a students' preparation and far too many do not require it in their core curriculum. Several participants identified offering introductory lectures, screening information and general insight, yet few incorporate simulation, trauma informed care, and research.

In the survey open text responses, participants reported enablers and barriers to providing IPV training within their school. Some schools had faculty expertise which facilitated the embedding and delivery of IPV content.

“...we offer a nursing elective on IPV by a faculty who has worked extensively in this field.”

Others referred to guest lecturers attending to deliver specific content.

“Our nursing honor society had a SANE [sexual assault nurse examiner] nurse speak that was excellent! I want to incorporate her information into the course and have her be a regular speaker.”

However, most comments came from those reporting difficulties with incorporating IPV content into their schools. Reasons included time restrictions, curriculum crowding and a lack of resources including nursing faculty/academic staff with enough knowledge and skill to deliver best practice training on IPV.

“Too little time and too much content so would need readymade materials to do this.”
“The most difficult aspect would be faculty having expertise in this area.”
“If we had time, it would be nice to run with a pre-established curriculum that the faculty is trained on.”

There was particular interest in providing comprehensive curriculum with IPV simulation scenarios and acknowledgement that any IPV nursing training support would be appreciated.

“...in particular, IPV scenarios would be beneficial. I would like to incorporate into simulation materials; however, then I would be at a loss as to what types of [student] participation I could require ...what support services would be available.”

“What we need is comprehensive, compelling, content that could be delivered in a total of 2 hours and is targeted at the nurse-generalist level.”

“We do not currently offer anything in our program so any thoughts would be helpful.”

Discussion

Preparing nurses for all patients they will encounter is essential. We set out to examine the extent and nature of IPV nursing education in the U.S. and found this instruction happens inconsistently and to varying degrees. Our study revealed a significant gap in U.S. nursing curricula concerning IPV prevention and response. Participants identified that they needed support among all four domains of inquiry offered in the survey: faculty training, curriculum materials, IPV best practices and IPV scenarios. Although these nursing schools indicate that educating and training pre- and post-licensure students in IPV is important, it is the extent and comprehensiveness of this training and preparation that needs to be enhanced. U.S. nursing schools are not alone in lacking competent and confident faculty to teach IPV and other trauma and violence informed content, and a survey of Australian Universities found the same issue in their nursing programs (Lovi, et al, 2018). Is it a realistic expectation for every nursing school to include IPV training and have an IPV subject-matter expert on faculty? Given that IPV is

more prevalent than type 2 diabetes mellitus (T2DM), and that IPV is associated with poor mental health, increased incidence of both T2DM and cardiovascular disease, it appears that the answer should be yes (Chandan, et al, 2020). It is reasonable to expect that every school would prioritise IPV education considering the high prevalence and detrimental health impact of IPV, and have faculty with IPV content and training expertise and access to evidence-based information and curriculum strategies that educators can use.

Several other studies concerning IPV curricula in medical schools (Insetta & Christmas, 2020; Lumbreras, 2018), as well as undergraduate health studies programs in Australia (Lovi, 2018) have described time constraints as a major obstacle to offering more comprehensive IPV training. In our study, educators shared insights into the nature of these time-related barriers including a combination of shortage of classroom time, lack of preparation time, and a deficiency of time slot within the overall curriculum. All these factors led to IPV and trauma and violence informed care topics landing on the periphery of the curriculum.

Given these obstacles, it is not surprising that the participants were in favor of a comprehensive curriculum that addressed the content they currently used and integrated content that would be important to include. Helping to prioritize IPV essential content is critical to the uptake of the material and the development of student skillsets in this area. These findings would imply that assembling such a curriculum would help mitigate some of the barriers raised by the participants and address some of the obvious knowledge gaps as well. It would also attend to providing more standardization of essential and fundamental core competencies in IPV training and preparation that nursing schools should adopt in their curriculum. Having the essentials consolidated into a curriculum module, learning kit or guide developed by those with expertise in the field, into formats that are easily accessible and adaptable at the graduate and undergraduate

level is needed. Resources could include adaptations of curricula already developed by the WHO for those in low resource countries (WHO, 2019). Guidelines would need to be developed that consider student (and faculty) emotional safety and protocols for addressing IPV disclosure. This preparation aligns universities and colleges to produce providers who can engage more broadly in the recommended systems-based approach to improving outcomes for abused women and children. A systems-based approach to IPV considers the need for multi-level integrated response to our protocols, policies, and efforts across key stakeholder groups that include health provider education (Miller, E., McCaw, B., Humphries, B., and Mitchell, C., 2011).

The problem of IPV demands a multi-sectoral systems-level response as women and children have multiple needs including health care, shelter, legal protection and social care/welfare. If we are to effectively change behaviors and mitigate adverse health effects from IPV, there must be an avenue to create capacity within the nursing workforce to effectively respond to people who are exposed to violence (Columbini, et al, 2017; Garcia-Moreno et al, 2015; Kalra et al., 2021). Threading IPV and trauma and violence informed care (TVIC) strategies throughout nursing curricula can create a nursing workforce that is more responsive to women who experience violence. We recommend including not only didactic content e.g., the World Health Organisation, LIVES first line approach (WHO, 2014), IPV prevention, universal precautions, healthy communication strategies and safety planning, but also providing opportunities for students to develop skills through simulation in these curricula. Providing IPV curricula at the graduate level prepares students to address the creation of equitable and sensitive care systems by employing the skills and knowledge from IPV training across populations and settings. These advanced students should also focus on effective strategies that health care facilities and services can use to interface with other sectors (e.g. social

services, legal systems, school systems) to provide comprehensive and seamless care to families experiencing violence. Importantly, as graduate level nurses are being prepared for supervisory and other leadership roles, they should be equipped to respond to their own and their colleagues' vicarious trauma that can occur in the course of caring for women experiencing IPV (Jack, et al, 2020).

Conclusion

With the high prevalence of all forms of IPV against women, it is crucial that the academic nursing community commits itself to providing students with experiences that prepare them to recognize and address IPV and provide TVIC as part of their daily nursing practice. This approach is important to creating safety, trust and healing spaces that inform how students should serve their future patients while also providing the opportunity for students to identify healthy or unhealthy patterns in their own relationships. Additionally, training students during their education creates allies in the fight to end violence against women and helps them overcome many of the known barriers to IPV screening and intervention. IPV preparation gives students the essentials of healthy relationship strategies, useful resources and safety planning approaches and other therapeutic communication strategies.

The findings from our study support the need for comprehensive IPV curriculum models that can be utilized across nursing educational levels. Our evidence reveals insufficient on-site expertise to create and incorporate IPV curricula into existing structures. It is clear that professional organizations in nursing education and accrediting bodies need to make development of IPV and TVIC curricular threads a priority for the future of nursing locally and globally.

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