STATUTORY RAPE: MANDATORY REPORTING IN THE TITLE X CLINICS OF NORTH CAROLINA

by
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ABSTRACT

DEBRA RISISKY: Statutory Rape: Mandatory Reporting in the Title X Clinics of North Carolina
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Federal family planning clinics provide adolescents a safe place to receive contraception and maintain reproductive health without parental consent or prohibitive expense. The purpose of this study was to explore knowledge and opinions of family planning providers regarding counseling minors on sexually sensitive matters. Topics examined included providers': knowledge of state's statutory rape laws and federal Title X regulations; perceptions regarding counseling on sexually sensitive matters; and opinions on the possible conflict between mandatory statutory rape reporting and federal regulations regarding protection of confidentiality.

This cross-sectional study surveyed all North Carolina health department family planning providers. Quantitative methods were used to examine knowledge levels and counseling comfort levels among providers. Qualitative analysis methods were used to examine the potential conflict between mandatory reporting and protection of confidentiality.

Completion rate was 64% (n=397). Providers had higher knowledge of federal Title X regulations ($\bar{x}$=3.51 out of 4) than state statutory rape laws ($\bar{x}$=1.94 out of 4). Analysis of statutory rape knowledge and provider characteristics showed that only attending a larger number of training workshops was statistically significant; no statistically significant differences were seen among other provider characteristics and Title X knowledge.

Providers had high levels of comfort concerning general and sexual health counseling, with mean scores of 3.44 and 3.35, respectively out of 4. Comfort dropped considerably when counseling a

client who discloses sexual abuse ($\bar{x}$=2.86) or statutory rape ($\bar{x}$=2.69). Nurse practitioners and those with more continuing education had significantly higher comfort levels counseling on sexual abuse and statutory rape. Participants were evenly split regarding whether reporting hampered confidentiality; those agreeing felt it could limit clinic use and increase negative health consequences; those who disagreed felt it was important to advocate for their clients.

This study is the first to delve into providers' opinions on their ability to meet the reproductive health needs of their adolescent clients given state laws and regulations. Increased training on sexual violence is desired by providers. Policies should be structured to ensure providers can protect the current and future health of adolescent clients.

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INTRODUCTION

This study explores knowledge and opinions of North Carolina Title X family planning providers regarding counseling minors on sexually sensitive matters, including providers': perceptions regarding their ability to counsel adolescents on sexually sensitive matters (e.g. sexual behavior and sexual coercion); knowledge about the federal Title X regulations and state mandatory reporting laws; and opinions on potential conflict between mandatory reporting of statutory rape and protection of confidentiality. Results from this study may provide insights as to how to help the providers best serve and protect their adolescent clients.

In 1998, new language addressing sexual coercion among minors was created for the Title X program. Providers were encouraged to counsel minors on preventing sexual coercion, which the providers correctly interpreted to mean a stronger emphasis on statutory rape discovery.[1] In most states, including North Carolina, providers are mandated to report the discovery of statutory rape.[2, 3] Title X regulations also instruct providers about the protection of confidentiality of all clients.[4] Unfortunately, these two concepts may be in conflict when working with young adolescent clients.

The 1999 implementation of the new federal sexual coercion regulation required that all providers counsel adolescent clients on the prevention of sexual coercion. The regulation was tied to funding – a failure to counsel could lead to a loss of Title X funds. Some providers worried that clinics would lose a proportion of their adolescent clients due to the requirement to break confidentiality in order to file mandatory reports to the Department of Social Services.

Anecdotal evidence suggests some degree of provider discomfort regarding counseling adolescents on sexual coercion, including those under the age of consent (currently 16 in North Carolina). Providers may be uncomfortable discussing coercion because such conversations could lead to the discovery of statutory rape as well as other serious health issues, such as previous sexual abuse. In addition, some providers may not be equipped to handle in-depth counseling on these sensitive topics.[5]

Finally, some providers may not want to break confidentiality by reporting consensual sexual activity that meets the legal criteria for statutory rape, and so may avoid asking questions about their clients' sexual partners, including the partners' ages. Some adolescent clients may lie about their ages, and/or their partners' ages because they know that the provider would have to report statutory rape.[6, 7] Having the correct information on a client's age and sexual activity is essential to deliver accurate and appropriate services.

It is unknown whether these regulations impact providers' ability to work with adolescent clients while maintaining their health needs as the top priority. This study allowed us to better understand providers' opinions on their ability to meet the reproductive health needs of their adolescent clients. This study also looked at the knowledge levels of providers with regard to state statutory rape laws and Title X regulations on adolescent service provision and comfort level when counseling adolescent family planning clients.

Background and Significance

Adolescent Sexual Behavior

Sexual Initiation

By age sixteen, one of three adolescent girls have engaged in sexual intercourse, and by eighteen, two of three girls have initiated intercourse.[8] Adolescents tend to engage in sexual activity sporadically, which can lessen the chance that contraception is used. Adolescents tend to practice

serial monogamy, and the younger they initiate sexual activity, the higher the number of partners they are likely to have.[9]

Early initiation of sexual activity can be classified as statutory rape. Based on data from the 2002 National Survey of Family Growth, the incidence of statutory rape at first sex is 13% when using initiation of sexual activity at or before age fifteen and a partner three or more years older. This proportion has remained consistent from 1995 when the incidence was 14%.[10] The average age difference between partners in a statutory rape classification is 5.1 years; for non-statutory rape situations the difference is 1.5 years.[10]

Large partner age differences can have a detrimental effect on sexual debut, with important differences by gender. One study using data from the National Longitudinal Study of Adolescent Health found that 51% of females' first partners were at least two years older. Among males, the percentage was 13%.[11] Age difference between partners is related to the girl's age at sexual debut; the younger a girl is at her first sexual intercourse, the more likely she was to have an older partner. Among girls initiating sexual intercourse prior to age 14, 65% had a partner at least 2 years older; 25% had partners who were at least 4 years older.[11] Contraceptive use is less likely when girls are involved with partners who are more than two years older. Girls fourteen and under are the least likely to use contraceptives with their older boyfriends.[12] In addition, having an older partner may involve a power imbalance in the relationship, which may then lead to higher risk for pregnancy and infections due to the inability to negotiate use of partner methods or other contraception.

Adolescent Pregnancy

Although adolescent pregnancy has been on the decline in recent years, the United States still has one of the highest rates among industrialized nations. In addition, pregnancies among adolescents under the age of sixteen continue to increase.[13] Four in ten girls will become pregnant prior to their 20th birthday, with a birth rate of 57 per 1,000, compared to 24 per 1,000 in Canada and 6 per 1,000 in the

Netherlands.[14] Among U.S. adolescent pregnancies, 100% of pregnancies to girls under 15 are unintended and 82% of pregnancies to girls ages fifteen through nineteen are unintended.[15] The rates of repeat pregnancies among adolescents are also concerning. Within twelve months post-delivery the estimates for a repeat pregnancy range from 17% to 25%.[16] Adolescents who give birth to children fathered by older partners tend to be younger than those girls who give birth to children fathered by partners that are their peers. Additionally, girls who give birth with older partners are more likely to initiate sexual activity earlier, not be enrolled in school, and be involved with tobacco and other drugs.[17]

Sexually Transmitted Infections

Sexually transmitted infections are common during adolescence due to high rates of changing partners and lower rates of barrier contraception use when compared with adults. Condoms are the most effective contraceptive method to protect against infections, yet less than 60% of sexually active adolescents use them regularly.[12] Chlamydia (CT) is one of the most prevalent sexually transmitted infections in the U.S., and the majority of those infected are people under the age of 25. Girls aged 15-19 represent 46% of CT cases among women in the U.S. In 2000, the overall U.S. rate was 257.5 per 100,000 and 287.4 per 100,000 in N.C., one of the highest state rates in the nation.[18-20] Adolescent females have extremely high rates of Gonorrhea, 715.6 per 100,000 in the year 2000.[21] Adolescents are one of the sub-populations with increasing rates of HIV infection, with females disproportionately infected.[22] Among new adolescent infections, almost two-thirds occurred in females.[22] Younger adolescent females with older partners are at even higher STI risk than their adolescent peers with similar age partners.[22]

Use of Family Planning Services

While rates of adolescent sexual activity are slowly declining, sexually active adolescents in the U.S. still use contraception less frequently than sexually active adolescents in other developed countries.

Approximately 20% of adolescents do not use contraception at first intercourse, and the average adolescent waits 14 months from the initiation of sexual activity to visit to the family planning clinic.[11, 23]

Adolescents need access to high quality family planning services in order to maintain health during adolescence and into adulthood. For many adolescents, Title X services are their only option for contraceptive care, due to the lack of parental consent required for Title X services and availability of sliding scale fees. Confidentiality is integral in working with adolescent clients; those that feel that their confidentiality will be breached may either delay or avoid seeking services for reproductive health care. This can lead to delays in seeking prenatal care and treatment of sexually transmitted infections, which could have long-term repercussions, including mental and physical health problems, including infertility.[24-27]

Physical and Sexual Violence in Adolescence

Prevalence of Violence

Adolescents are the age group most at risk for sexual assault.[28] One study noted that among reported cases of sexual assault, 43% of the victims were between the ages of thirteen and seventeen.[29] Adolescents are less likely to report sexual assaults than their adult counterparts.[30] Once a girl has been violated in some manner, she is at increased risk for additional physical and sexual violence in her lifetime, including during adolescence.[31] In order to address statutory rape with young clients, the provider needs to be aware of other types of sexual violence that the adolescent girl may disclose during family planning counseling.

Consequences of Sexual Violence and Statutory Rape

The potential consequences of sexual violence and statutory rape can have effects throughout an individual's adolescence and into adulthood. Child sexual abuse has a significant impact on the sexual functioning of adult women. Women who had been touched sexually as a child were more likely to have experienced: more than ten sexual partners, oral and anal intercourse, group sex, inability to

experience orgasm within the last year, less pleasurable sex, anxiety about sexual performance, and/or difficulty with lubrication during intercourse.[32, 33] In addition to detrimental long-term sexual health effects, there are also a number of other health effects seen among those with child sexual abuse histories. These include substance use and abuse, sleep difficulties, suicide attempts, high rates of smoking, and obesity and eating disorders.[33]

An adolescent who has experienced unwanted sexual activity at some time may have an unhealthy view of sex. This can be manifested in a number of ways. The adolescent may be promiscuous and have a number of different partners.[33] This behavior is the result of indirect learning (through the abuse) that "your body is not yours to do with as you want/choose." In some cases this leads the victim to believe that her body is for others to do with whatever they choose, and that her personal opinion does not matter. This is one reason that sexual coercion may be more likely among adolescents with a history of abuse.[31] Some adolescents may become asexual, avoiding sexual encounters due to an intense fear of being touched. This can stem from a lack of trust, or it can be used as a method to regain control over her body.[1]

There is also increased risk of unplanned pregnancy and disease transmission among young people who have experienced unwanted sexual activity compared with adolescents in general. This phenomenon is related to sexual behaviors, primarily multiple sexual partners and numerous sexual acts, coupled with low use of protection.[22] Even during acts of consensual sex, victimized women may find it difficult to assert their feelings or their opinions enough to negotiate with their partners regarding condom (or other contraception) use. Because of past experiences, if the partner declines to use protection, the young woman may feel helpless and engage in unprotected sex.[7]

Counseling Adolescents on Sexually Sensitive Matters

Counseling Skills

Providers who work with adolescents are in a unique position to address and affect adolescent sexuality, including the consequences of the adolescent's behaviors.[34] For adolescents who are not receiving appropriate guidance from their parents, the messages sent by health care providers about sex and relationships are particularly important. Working with sexually active adolescents requires a thorough understanding of developmental, physiologic, psychological, economic, social, and cultural factors that could threaten consistent contraceptive use among adolescent clients.[35] Health care providers are also in the unique position of being able to assist vulnerable adolescents by consistently teaching about factors which provide the possibility of protection in potentially coercive situations.[1]

Health counseling includes the medical interview, which consists of anticipatory guidance and discussions regarding how to address identified health problems. This includes counseling adolescents to reduce health compromising behaviors such as engaging in sexual activity with older partners.[36] In order to ask the relevant questions, a comfortable and confidential environment should be provided for all clients. These questions include sexual history, partner information, and history of violence. With a few additional questions, providers are able to screen for the presence or potential of coercive relationships with the adolescent client. Time in the clinic is always a concern for health care providers, as many clinics are currently understaffed. That said, family planning providers need to be gathering most of this information as part of routine gynecological care for all clients. Sound professional judgment, informed by clinical assessment, training and experience are needed to address a patient's potentially sensitive situation.[37]

Providers also need to understand the legal aspects that go along with counseling young clients and be aware of their state laws.[7, 34, 37] There is a potential dilemma regarding the reporting of statutory rape versus protecting confidentiality when working with adolescent clients. To report may require

breaking the trust of the adolescent, which could lead to the client becoming reluctant to use health care or to her giving inaccurate answers during the health history interview.[7]

North Carolina State Laws

Statutory Rape Definition

Title X defines sexual coercion as statutory rape; therefore for the purpose of this research, sexual coercion is defined as the legal definition of statutory rape in North Carolina, under §14-27-7A: "Statutory rape or sexual offense of person who is 13, 14, or 15 years old." This statute has two components. Part A states that it is a Class B1 felony to engage in vaginal intercourse or a sexual act with another person who is 13, 14, or 15 and the defendant is at least six years older than the person.[3] The second part is a Class C felony, with the difference being in the age of the defendant; the range for this felony is more than four but less than six years older, except in the case of a lawful marriage.[3] The age of consent in North Carolina is currently sixteen years of age; therefore, minor clients are considered to be all clients age fifteen and below.

Mandatory Reporting of Child Abuse

Statutory rape falls under child abuse statutes and is therefore to be reported in the same manner as child abuse.[1] In North Carolina, N.C. General Statute §7B-301 notes that any person or institution that has cause to suspect abuse should report this case to the Director of the Department of Social Services.[2] N.C. General Statute §7B-310 notes that no privilege is grounds for failure to report except in the case of attorney-client privilege.[1] While approximately 31 states have specific statutes regarding failure to report, North Carolina is not one of them.[1] Therefore, while providers are mandatory reporters of statutory rape, if it is discovered that they did not report suspected abuse, they can not be held liable or charged by the Attorney General for a misdemeanor.

In North Carolina, all individuals are mandatory reporters of child abuse, including family planning providers. There is limited flexibility within state law to cover individuals who do not report. North

Carolina does not have specific penalties for failure to report, so providers can opt to not report a case of statutory rape.[1] The lack of penalties provides clinics an opportunity to decide how and when to report statutory rape at the clinic level.

Title X

History

PL 91-572, Title X of the Public Health Service Act, is the national family planning program of the United States. The goals of the program are to provide services to help prevent unintended pregnancy, reduce the number of abortions, lower rates of sexually transmitted infections, and improve reproductive health overall.[23, 38] Services take place in a network of almost 5,000 clinics throughout the United States; these clinics are housed at state and local health departments, hospitals, community and migrant health clinics, Planned Parenthoods, and independent clinics.[39] Today most clinics receive 25% of their funds from the program.[38] One of Title X's main goals is to provide services for those who cannot afford reproductive health care; no individual is turned away for inability to pay, and upwards of 60% of clients have incomes below the federal poverty level.[38] Title X is often the entry point to health care for many women and their families who might otherwise lack access. Title X plays an integral role in reducing adolescent pregnancy in the United States.[38] Annually, Title X helps prevent one million unintended pregnancies, half of which would end in abortion.[38]

Title X Program Guidelines

The Title X Program Guidelines lay out the rules for agencies which accept Title X funding, including both service plans and protocols. The Guidelines specifically address counseling, including the goal of allowing the client to reach an informed decision regarding his or her reproductive health, which includes choice of family planning services and contraceptive method. The Guidelines include a long list of items to address during the history collection component of the visit. Two that must be included are partner history and sexual history; these two items may lead to the discovery of statutory rape.

Adolescent Services

The Program Guidelines have a specific section to address care for adolescent clients, which is important as approximately 30% of clients are under the age of twenty.[39] Almost 60% of sexually active girls use public clinics, such as Title X clinics, as their primary source of reproductive health care.[40] Adolescent clients must be given age appropriate information, and while providers are encouraged to not assume that every adolescent in the clinic is sexually active, adolescents are to be informed of all contraceptive methods, including abstinence.[4] Providers should encourage minor clients to include their family in the decision to seek family planning services as well as to "provide counseling to minors on resisting attempts to coerce minors into engaging in sexual activity."[4] It is within this section of the Program Guidelines that the language from the 1998 mandate is incorporated.

The Title X Program Guidelines address confidentiality in two sections: Legal Issues and Adolescent Services.[4] The Program Guidelines note that client confidentiality must be assured and safeguards provided to guard against invasion of personal privacy. Disclosure of information by project staff regarding services received is prohibited without written permission, except as required by law.[4] Even then, safeguards need to be in place. Under Adolescent Services, the Program Guidelines address counseling and age-appropriate information. In regard to confidentiality, the Guidelines note that adolescents must be given assurances that counseling sessions are confidential. Parental consent for provision of services is not allowed, nor can parents/guardians receive information on services received.[4, 24, 41]

North Carolina Title X Funding

At the federal level, Title X funding is housed at the Office of Family Planning, based in the Department of Health and Human Services Office of Population Affairs (OPA). OPA distributes the money to each of the ten Regional Offices, based on the number of clinics and in-need clients. North

Carolina is based in federal Region IV. The program is administered at the state level and the state office signs the assurances regarding the following of the Program Guidelines.

North Carolina has 100 counties, all of which have at least one health department. Currently, 99 out of 100 county health departments accept Title X funds from the state health department and are referred to as Title X delegates.[39] The only county that refuses the funds is Wake County; however, their family planning clinic does adhere to the rules as laid out in the Title X Program Guidelines. In total, there are 120 clinics in North Carolina receiving Title X funding.

Federal Regulations in Relation to State Laws

Neither state laws nor federal regulations address the conflict between protecting client confidentiality and mandatory reporting for statutory rape. The regulations note that providers must counsel adolescents on sexual coercion, which is Title X's wording for statutory rape.[1] Title X also acknowledges that it is important to abide by state laws, thereby acknowledging that it is aware of the conflict, yet offering no guidance on how to work within this conflict.

There are opportunities outside of North Carolina state law that allow for flexibility with regard to confidential services for minor clients. Title X funding (National Family Planning Act), administered by the U.S. Public Health Service, has written into their regulations strong confidentiality protection for adolescent who receive services in Title X clinics across the country. These clinics are predominately health departments in North Carolina.[42] These confidentiality regulations are designed to reduce the barriers to Title X family planning services for adolescents and these regulations supercede state law.[24]

Similar to Title X regulations, some federal laws set up provisions for services, with notes that state law must be followed. The law in most states, including North Carolina, offers two aspects of protection with regard to adolescent reproductive health care. Minor adolescents, while unable to consent for general health care, are able to consent for reproductive health care including contraceptive services, pregnancy-related services, sexual assault services, and STI/HIV prevention and care.[42, 43] The

second aspect of protection is that information about care will not be disclosed without client permission, even to parents or guardians.[44] This affords serious protection since research shows that if adolescents think that their parents or guardians will become aware of a family planning visit, they will not seek care.[26, 27, 45]

Due to a lack of clarity in the statutes and overlapping definitions of statutory rape, uncertainty exists about the prosecution and reporting of statutory rape by providerss.[42] The state laws for reporting statutory rape tend to be more confusing and complicated than the laws on sex crimes. This is because the reporting of crimes against children often falls under state child abuse statutes, leaving a lack of clarity whether statutory rape should fall under sex crimes or child abuse and neglect.[46]

There is a need for clear and unambiguous messages about the availability of confidential health services to those sexually active adolescents so that they are able to take advantage of needed services.[24] Adolescents who feel they will not receive confidential care will either delay care or not seek out the care they need, which could have detrimental health consequences for them such as pregnancy and infections.[45, 47] These messages can also be used to develop clinic plans for protecting confidentiality that are respectful to the state laws, clinic procedures, and most of all, the adolescents served by the clinic.

Gaps in the Literature

To date, there is no literature on knowledge or counseling behaviors of Title X providers and there is only one article looking at the conflict presented in the Title X clinics by statutory rape reporting. The study took place in 1997 (prior to the mandated change in the funding language) in Kansas among family planning program managers.[6] There was a complementary study conducted by the same group of researchers looking into the opinions of District Attorneys in Kansas regarding statutory rape reporting.[48]

The Kansas study utilized a 14-item structured survey instrument and was mailed to all 77 eligible administrators; 68 returned the survey instruments.[6] While it was noted that the managers do see clients, they also have administrative duties and therefore client care is not their only priority. The questions intended to gather provider opinions regarding the exemption of reproductive health workers from child abuse reporting requirements; the effect on enforcement of reporting on the emotional and/or financial support of the adolescent; and public and personal support for the enhancement of statutory rape reporting.[6]

Results showed that the managers strongly supported aggressive enforcement of statutory rape laws, while remaining unclear on the potential impact on their adolescent clients. Concern over protecting confidentiality was high, and was often noted as a reason for choosing not to report. Similarly, age differences between the client and her partner also impacted the intent to report a case of statutory rape, where the greater the age difference, the more likely the report.[6]

As noted, this is the only study that looks at the conflict between protecting confidentiality and mandatory reporting. However, in addition to it being almost eight years old, there are other problems with the study. Only program managers were surveyed and providers who are on the front line would have been more appropriate. The survey instrument only had fourteen items on it and there was no qualitative aspect. The questions were on a five-point scale, which allows for respondents to select "neutral" as their answer; the "tougher" questions had large percentages in the middle selection of "neutral".[6] Finally, the study only discussed how program managers feel about mandatory reporting laws, without addressing issues related to counseling clients or the potential impact on the client's health related to the reporting.

Theoretical Framework

The Stage Theory for Organizational Change was used to inform this study. This theory helps explore how organizations adapt to change, such as new goals, programs, policies, and ideas.[49] In

some cases, the change comes from outside the organization.[49] In this case, in 1998 a major change in the funding language regarding counseling adolescents on sexually sensitive matters, such as sexual coercion, was instituted by the Office of Population Affairs at the federal level. As a result, the North Carolina Title X program, had to undergo a policy change with regards to adolescent minor clients.

Stage Theory was originally developed in the 1950's from a three-stage model by Lewin and the Diffusion of Innovations Theory. In 1978, the model was expanded to seven stages by Beyer and Trice.[49] Today, a four stage model is more commonly used: problem definition/awareness, initiation of action/adoption, implementation, and institutionalization.[49, 50]

The first stage is **awareness, or definition of the problem**. At this point, the change is recognized and methods to address the needed change are analyzed and evaluated.[50] In the case of this study, the new Title X funding language regarding counseling adolescents on sexually sensitive matters, including sexual coercion, was identified and those at the state level looked into methods to ensure that all providers would be able to follow the new rules within the clinic setting.

During stage two, **adoption** of action occurs. Resources are needed at this stage to ensure that action is initiated.[50] In North Carolina, the method used for adoption was a change to the history form used in all Title X funded clinics; a new check box was included at the end of the history questions to ensure that providers asked adolescent clients about sexual coercion.

The third stage deals with the **implementation** of the change; it looks at the reactions that occurred and how role changes have impacted the organization.[50] Training about the new language was implemented so that providers would have the skills to be able to counsel adolescents on sexually sensitive matters, including sexual coercion. This training continues regularly around the state.

The final stage is **institutionalization**, which can also be thought of as maintenance. The change becomes a part of the organization and methods are employed to maintain this change.[50] In the case

of this research project, the history forms and continued training help to ensure the institutionalization of counseling minors about sexually sensitive matters, including statutory rape. This study will look at how the impact of this new federal regulation on providers' in the final stages – in order for true institution to occur, training of providers must be appropriate and effective.

Conclusion

This study looked at provider knowledge levels of state statutory rape laws, knowledge levels of federal Title X regulations, personal perceptions of counseling skills with regard to adolescent clients, and finally, the potential conflict between mandatory reporting of statutory rape and the protection of client confidentiality. Comparisons were made by provider characteristics, including provider experience, provider training, and location of provider's clinic. The two experience variables, type of provider and years in the family planning setting, were selected as two previous studies gathering knowledge and counseling information from family planning providers found these characteristics to be important predictors in knowledge level and counseling behaviors.[51, 52] Amount of training a provider participated in was selected as previous work has shown that attending training sessions can have a positive impact on family planning counseling behaviors.[53] Finally, the type of community a provider's clinic was located in was selected as smaller clinics do not have staff dedicated solely to the family planning clinic like larger clinics do. Those who work primarily with family planning clients may have different levels of knowledge and comfort than those providers who rotate throughout many clinics. The information gathered from this study will help to inform clinic policy and practice. Additionally, it will help to determine what level of training is needed in North Carolina and who to include in the training activities.

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STUDY DESIGN AND METHODOLOGY

This cross-sectional survey study employed a mailed questionnaire to North Carolina family planning providers to gather their opinions on the possible conflict between mandatory reporting of statutory rape and the protection of client confidentiality.

Specific Aims and Research Questions

Specific Aim One (Paper 1):

To describe the level of knowledge regarding state statutory rape laws and Title X regulations related to reproductive health for adolescent clients among Title X providers in North Carolina.

RQ.1.1: How knowledgeable are Title X providers regarding North Carolina statutory rape laws?

RQ1.2: Do Title X providers' knowledge of state statutory rape laws vary by their experience?

RQ1.3: How knowledgeable are Title X providers regarding Title X regulations for adolescent reproductive health care?

RQ1.4: Do the providers' levels of knowledge regarding Title X regulations for adolescent reproductive health care vary by the providers' experience?

Rationale: Provider knowledge of state laws and Title X regulations are integral to ensuring that clients receive appropriate care and that Title X funding is not put in jeopardy. If knowledge level is low, training can be provided to ensure providers understand the laws and regulations within which they need to operate in the clinic setting.

Specific Aim Two (Paper 2):

To gather information on the comfort levels of North Carolina Title X providers when they counsel adolescent clients on sexually sensitive topics.

RQ2.1: Do North Carolina Title X providers feel they have the skills needed to counsel minors on sexually sensitive topics?

RQ2.2: Do these perceptions vary by the provider's experiences?

RQ2.3: What questions, if any, do providers feel uncomfortable asking minor clients during a family planning visit?

RQ2.4: What reasons, if any, do providers give for a lack of comfort while counseling minor clients on sexually sensitive topics?

Rationale: Counseling and establishing a good relationship with young clients is especially important in the early visits. Having a positive experience with a health care provider could lead to an increased likelihood of repeat visits throughout her reproductive years.[1] Poor provider counseling skills may lead to an adolescent discontinuing family planning rather than return to the clinic. Knowledge gained from the responses to these research questions can also help guide the content of future provider training.

Specific Aim Three (Paper 3):

To gather information on the perceptions of Title X providers on the possible conflict between mandatory reporting of statutory rape and protection of confidentiality of minor clients.

RQ3.1: Do North Carolina Title X providers feel that mandatory reporting hampers their ability to provide confidential services to minor clients?

RQ3.2: What are the expressed opinions of North Carolina Title X providers regarding mandatory reporting of statutory rape?

RQ3.3: What are the expressed opinions of North Carolina Title X providers regarding the impact of mandatory reporting on minor client's health?

Rationale: The new counseling regulation was implemented approximately seven years ago and there has been little, if any, examination of providers' perceptions of the regulation's impact on their ability to serve adolescent clients. Gathering providers' opinions can help guide clinic practice at the state and local level to better ensure that the health needs and safety of young clients are the top priority.

Study Design

Participant Recruitment

The potential participants for this study included all family planning providers working within 99 of the 100 North Carolina Title X Health Department based family planning clinics that accept Title X funds from the North Carolina Department of Health and Human Services, Women and Children's Health Branch. Wake County does not accept these funds, although they do operate according to Title X funding regulations, and they were not included in the study. Additionally, there are a few independent clinics, such as Planned Parenthood and migrant health clinics, which receive state Title X funding. The Women and Children's Health Branch chose for the study to only include the health department clinics given that the findings would guide their training and policy, neither of which do they provide to the few non-health department Title X delegate clinics.

Providers eligible for the study included nurses, nurse practitioners, physicians, physician assistants, health educators and social workers. Any provider who worked directly with adolescent clients, in either a counseling or clinical mode, was eligible. Those providers in administrative-only capacities were not eligible.

Recruiting of participants was a multi-step process beginning with assistance from the Women and Children's Health Branch. I was given a list of county and/or district contacts and asked to

write an email soliciting names of providers. This email was sent to the listserv of Title X district contacts from the Women and Children's Health Branch, and requested names be provided to me via email response. In addition to my information, the Branch Director also included an introductory note so that participants would be aware that the Women and Children's Health Branch supported this approved project. Due to the high number of requests for participation in surveys, it was felt that having the Branch Director include a note would allow potential responders to know that this was an important project and not spam email.

After one week of waiting for email responses from county and district contacts, very few arrived. Approximately ten counties sent information along, and it was clear that some of the counties did not send complete information, based on the number of providers included and the known size of the county. Therefore, the second phase of recruiting took place utilizing the county phone list. After numerous calls, it was apparent that the contact person on the list was not always the appropriate person to call and therefore each call began by asking for the clinic family planning manager. There also appeared to be some confusion regarding the definition of a provider – each clinic had its own definition. Using the phone to recruit allowed for clarification of this issue and ensured that the appropriate people were included in the study. Phone follow-up took seven business days to complete. It was assumed by the Women and Children's Health Branch that there would be approximately 500 potential participants in the study; by the conclusion of the phone follow-up, there were 657 potential participants on the mailing list and all eligible counties were complete.

Human Subjects

This project was approved by the University of North Carolina Office of Human Research Ethics, Public Health Institutional Review Board.

Data Collection

This study employed Dillman's Tailored Design Method for mail surveys.[2] In the Spring of 2005, each eligible participant received a pre-letter providing information about the study and inviting them to participate. Four days later, a second mailing was undertaken that included four items: the survey instrument, informed consent letter, a return envelope with postage, and a pen. The pen was used as a small incentive and thank you gift. A pen was determined to be the best option given the rule restrictions that financial incentives could not be given from the federal funding source provided to this study.

There was one minor problem with the return postage; due to misinformation provided by the post office, there was not enough postage on the initial return envelopes. Participants who called or emailed regarding this matter were told to return the envelope as-is; difference in postage was paid at delivery. This did not appear to hamper the return of the survey instruments.

A third mailing, namely a follow up postcard, was sent one week after the initial mailing of the survey instrument. This mailing went to all participants and served two purposes: to thank those that had already sent back the survey instrument for their participation and to ask those who had not yet returned their survey instrument to do so. Three potential participants contacted me to note that they had not received their original survey instrument mailing and were sent a new set of materials on the same day of their call or email. The final mailing was sent approximately four weeks after the original mailing. This final mailing was sent only to those potential participants who had not responded – approximately 300 participants. This mailing included an informed consent letter explaining the importance of the survey study, a survey instrument, and a return envelope with the correct postage.

Once the survey instruments were completed and returned, qualitative data were transcribed verbatim into Microsoft Word ©. Analyses were conducted using Atlas.TI[3] to identify themes found

among the responses. The quantitative information was entered into a database created using EpiInfo; this database software allows for the creation of a database in Microsoft Access© format.[4] The data analysis for this research study was generated using SAS software, Version 8.2 of the SAS System for Windows. Copyright 199-2001 SAS Institute Inc. SAS and all other product or service names are registered trademarks of SAS Institute Inc., Cary, NC, USA.

Data safety was assured through a number of methods. All survey instruments (including those from the pilot study), were kept in a locked filing cabinet. The data were kept a computer that was password protected. Only aggragate information is presented in the results to prevent deductive disclosure of the providers.

Instrument

The survey instrument, found in Appendix I, contained both open- and close-ended questions focusing on providers' sociodemographic information, clinic information, knowledge of statutory rape laws, knowledge of Title X regulations, perceptions regarding counseling minors, and opinions of the potential conflict between mandatory reporting requirements and protecting confidentiality. The survey instrument was designed to take little time to complete, so as to lessen the response burden and maximize the response rate. The first page of the survey instrument contained information about the study and consent information; participants were told they could tear off this page and keep it for their records. The final page of the survey instrument allowed for participants to include their email addresses if they wanted to receive a copy of the final report. Individuals were allowed to complete this final page even if they chose not to participate in the survey study. This page was torn off and put in a separate file to protect the confidentiality of the participant regardless of whether they opted to receive the report. The email will be sent to all participants at one time, using the "Blind Carbon Copy" option for their addresses to protect recipient's confidentiality.

Pilot Study of Instrument

The survey instrument was pilot tested in Louisville, Kentucky in 2004. This pilot test was conducted anonymously during a one-day training course that I taught to fifteen providers who work with minors in the Title X clinic. These providers were similar to those in North Carolina in terms of gender, race, clinic experience, and experience with the Title X system.

With approval from the State Family Planning Program staff in Kentucky, the survey instrument was tested prior to the course delivery, when clinicians arrived to check in. This allowed the pilot study to be the least disruptive for the course as well as to not interfere with the provider's schedule outside of the course. Most clinicians completed the survey instrument in approximately 20-25 minutes.

Information gathered from the pilot study was useful in revising the survey instrument. It was found that the instrument took the approximate time that was originally estimated (20 minutes), therefore, no major items needed to be deleted. The question regarding level of nursing education was expanded due to a missing response option for one type of nursing education. Questions that were developed on a scale showed variability, as suggested by Dillman.[2, 5] The pilot test was approved by the UNC Office of Health Research Ethics Public Health Institutional Review Board.

Variables Gathered in the Survey

Provider Characteristics

Demographic data collected included provider gender, race, Hispanic ethnicity, religion, and education. Other provider characteristics that were examined in this study included experience, community setting, and training. Experience consisted of two variables; the first was type of clinical provider (nurse practitioner, registered nurse, non-nurse) and the second was the number of years working in a family planning clinic, with a provider considered to have a high level of experience if they had worked in a family planning clinic for three or more years. Participants were asked to self-

define whether the clinic they work at is located in a rural, urban, or mixed urban-rural community. Clinic setting was used as a proxy for whether the provider was solely dedicated to the family planning clinic (in large, urban clinics) or would rotate through a number of clinics (in small, rural clinics). Provider's training was measured on a scale from zero to four, based on four types of continuing education offered throughout the year: 1) general health counseling skills; 2) sexual health counseling skills; 3) coercion counseling training skills from a general workshop; and 4) coercion counseling training skills from their specific clinic.

Clinic Characteristics

The survey instrument asked participants about information related to adolescent service provision at their clinic. These questions asked about four services that are appropriate for adolescent family planning clients: pregnancy testing, birth control, STI testing, and PAP testing. Providers were first asked which of the four services are available at their clinic for adolescent clients and then they were asked to identify the most commonly requested of the four services by adolescent family planning clients.

Providers were also asked about policies related to adolescent services. The first policy providers were asked about was whether their clinic had a policy for instances when a client discloses sexual abuse; if so, they were asked if this was a written policy and whether they had a copy of the written policy. The survey instrument also asked participants whether their clinic had a policy for instances when a client discloses statutory rape, with similar follow up questions regarding whether the policy was written and if the participant had a copy.

Knowledge Level

This study has two knowledge-based variables of interest. One of these variables is *providers' knowledge of state statutory rape laws*. Three questions were posed to assess this type of knowledge. The first question asked participants to select the North Carolina age of consent for

sexual intercourse, which is sixteen, from a selection of ages ranging from 12 through 17 and a final option of "I don't know." The second question asked participants to identify where to report a case of statutory rape, with the correct answer of Department of Social Services being one of the three state agencies listed. The third question focused on the two categories related to age differences between partners that would constitute statutory rape; it had two correct response options and two incorrect response options. Providers received one point for every correct response option chosen, for a possible range of scores from zero to four.

The second knowledge-based variable of interest, *knowledge of federal Title X regulations*, was also measured on a scale from zero to four. Four questions were used, each created with true/false response options, and one point was given for each correct answer. The first question asked about information provided on contraceptive options to adolescents. The second question asked whether it is permissible to require parental permission for family planning services. The final two questions focused on whether it is permissible to notify parents prior to (question three) or after (question four) an adolescent has requested and received family planning services. The survey instrument can be found in Appendix A.

Comfort with Counseling on Sexually Sensitive Matters

Four questions were used to assess providers' comfort level when counseling in the family planning clinic. Each of these four questions asked the provider to choose how comfortable they felt conducting a particular type of counseling session, including general health counseling, sexual health counseling, counseling concerning disclosure of sexual abuse, and counseling concerning disclosure of statutory rape. A four-point Likert scale was used with the response options ranging from 1=very uncomfortable to 4=very comfortable.

A second set of ten questions was used to assess providers' comfort level with questions that are always asked at the beginning of a family planning visit. Participants were given a

hypothetical scenario stating: "*A 15-year-old is in the family planning clinic. She reports that she is sexually active and would like to go on regular contraception*." Participants then were asked to imagine that they were attending to this client and to circle their level of comfort asking each of the ten questions using a scale of 1=very uncomfortable to 4=very comfortable. The questions focused on: reason for clinic visit, desired and current contraceptive care, sexual behavior (debut, frequency of activity), sexual partner information (number of partners, age of partners), whether the adolescent talks to their parents about contraception, and sexual violence history.

An open-ended question was used to follow-up these two sets of questions on counseling comfort. Providers were asked, "*What are the reasons, if any, for <u>your</u> discomfort when you are counseling minor clients on sexually sensitive matters?*" Instead of providing a possible list of answers, the question was open-ended in order to ensure that no potential reasons were excluded from the data collection.

<u>Mandatory Reporting and Protection of Confidentiality</u>

This study used both a close-ended and an open-ended question to assess providers' opinion on the potential conflict between mandatory reporting and protection of confidentiality. The close-ended question asked was: "*As a clinician, I believe that being a mandatory reporter of statutory rape hampers my ability to guarantee minor clients confidential services*." The four response options were strongly agree, agree, disagree, and strongly disagree. There was an open-ended follow up question which allowed providers to explain their responses to the close-ended conflict item. A second qualitative question asked participants "*As a Title X clinician, what are your opinions on mandatory reporting for all sexually active clients under the age of consent (e.g. statutory rape)?*"

Analysis Methodology

Univariate analyses were used to determine frequencies of clinic and provider characteristics.

Knowledge Level

Univariate analyses were first used to examine knowledge scores for each of the seven knowledge questions. Bivariate analyses were then conducted to examine each knowledge question by provider's experience level and training received using PROC SURVEYFREQ. Additionally, mean scores for statutory rape knowledge and Title X knowledge were calculated for the total group and examined by experience and training characteristics. Regression analyses were used to determine if there were meaningful differences in the mean knowledge scores, controlling for type of provider (registered nurse, nurse practitioner, non-nurse), level of experience in family planning (low, high), community in which the provider practices (rural, urban, mixed rural-urban), and number of training workshops attended. PROC SURVEYREG was used to generate p-values which adjusted for interclass correlation by health department. An alpha of .05 was considered significant for all analyses.

Comfort with Counseling on Sexually Sensitive Matters

Frequencies were determined for the comfort level of the four types of counseling common to the family planning clinic: general health, sexual health, sexual abuse disclosure, and statutory rape disclosure. Bivariate analysis on these counseling variables was then conducted using the three main provider characteristics of provider type, community setting and training participation. Rao-Scott chi-square analysis[6] was used to determine whether there were significant differences in counseling comfort by provider characteristics while adjusting for interclass correlation by health department.

Exploratory factor analysis was then conducted to determine if there were any underlying constructs among these four counseling variables. The principal factor method was used to extract the factors, and this was followed by a promax (oblique) rotation.[7] Two latent variables were found in the analysis – *standard family planning counseling* and *disclosure counseling*.

To determine the level of comfort for the ten questions of the hypothetical scenario of the intake interview, both frequencies and mean scores were derived. P-values are based on regression analysis which adjusted for interclass correlation by health department.

To establish a list of the most common reasons for counseling discomfort, qualitative analysis was conducted. Qualitative responses were transcribed verbatim into Microsoft Word © and then imported into Atlas.TI[3] for analysis. Using the transcribed information, a list of codes was generated based on common reasons stated. Each statement was then coded using this list of generated codes. Each time a code was matched to text, the code box recorded the frequency; at the conclusion of the coding, these frequencies were used to determine the most common reasons stated by providers for counseling discomfort.

Mandatory Reporting and Protection of Confidentiality

Frequencies were determined for the conflict item; mean scores of the conflict item were then generated for the sample. Additionally, mean scores were examined by both provider characteristics and knowledge scores. As noted earlier, p-values were generated using regression analysis which adjusted for interclass correlation by health department.

Qualitative analyses were then conducted to identify themes found among the responses. Codes were created by me after reading through the transcripts. The first qualitative question was linked to the quantitative conflict item, and therefore the codes were created to also include whether the participant had chosen “agree” or “disagree” options from the item. The second question, which focused on general opinions related to mandatory reporting, was analyzed using codes created based solely on providers’ qualitative responses. The codes were matched to the comments within the transcripts by the same individual who created the code system. Code and retrieve analysis was then conducted using the most common themes found within the text.

Cluster Analysis

This survey study requested information from individuals who may work in similar health departments, which could create a bias due to clustering.[8] There were 99 eligible health departments in this study; however some health departments act as a district with providers rotating throughout multiple counties. This occurred twice, with three counties making up one district and seven counties making up another district. Therefore, there were a total of 91 "health departments" which were each considered to be one individual cluster with zero to 25 providers who completed the questionnaire. The majority of health departments had between two and seven eligible providers, while the range was from two providers to 33 providers. All counties did have at least one provider who returned the survey instrument, although in two counties no providers completed the instrument. It should be noted that one of these two counties had only two providers and one of those providers filled out an instrument from a separate county as this provider works multiple counties. Sixteen counties had a 100% completion rate. All analyses were conducted to adjust for any interclass correlation that might have occurred by having multiple providers from one individual county respond. Methods used to adjust for interclass correlation included using SAS PROC SURVEYFREQ and PROC SURVEYMEANS, as opposed to analyzing using regular frequency and means methodology.

Sample

Of the 657 providers on the mailing list, 39 providers responded clarifying that they were not eligible for the study. Reasons included not working directly with clients, not being in the family planning clinic, or recently transferring to a new clinic within the health department. Therefore the total eligible number of participants for the sample was 618.

At the conclusion of data collection, 461 (74.6%) survey instruments were returned. However, a number of participants (64) sent the survey instrument back blank, which signified that they chose

not to participate. A total of 397 survey instruments were completed and returned for a completion rate of 64.2%. Completion rates were derived using CASRO-defined equations where the completion rate is defined as the number of completed interviews divided by the number of eligible surveys in the sample.[9]

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FAMILY PLANNING PROVIDERS' KNOWLEDGE OF STATUTORY RAPE LAWS: IMPLICATIONS FOR PROVIDER TRAINING AND CLINIC POLICY

Abstract

The goal of this study was to describe the knowledge level of state statutory rape laws and federal Title X regulations among family planning providers who work with adolescents in public clinics. A self-administered questionnaire was mailed to providers at 99 county health-department based Title X family planning clinics in North Carolina. Over 64% of those contacted completed the survey instrument, for a total of 397 health care providers. Providers' knowledge of state statutory rape laws was low, with a mean score of 1.95 questions correct out of a possible 4.00. Participants had difficulty correctly identifying age-related components of the state statutory rape laws, but were able to identify Department of Social Services as the agency to file mandatory reports of abuse. Those with more years of clinical experience had a significantly higher mean score, 2.00, than those with fewer years of experience, 1.74 ($p=0.01$). Compared with providers who attended no training workshops (1.78 questions correct), providers who had attended all four training workshops had significantly higher mean scores (2.11 questions correct, $p=0.02$). Linear regression of statutory rape knowledge and the provider characteristics showed that only training workshop attendance was statistically significant; it explained approximately 22% of the variance in provider knowledge of statutory rape laws. Title X regulation knowledge was high with a mean score of 3.51 questions correct out of 4.00. Information regarding the ability to require written parental consent for services was the question that providers found the most difficult; only 63% correctly answered this question yet there were no statistically significant differences by provider characteristics. Linear regression of Title X knowledge with the provider characteristics also had

no significant results. Based on these findings, additional training is needed regarding state statutory rape laws for those who work with young adolescents to ensure appropriate care and follow up.

Introduction

Adolescents need access to high quality family planning services in order to maintain health during adolescence and into adulthood.[1-3] Confidentiality is integral in working with adolescent clients; those who feel that their confidentiality will be breached may either delay or avoid seeking services for reproductive health care.[1-4] Treatment delays could have long-term health repercussions, including physical problems such as Pelvic Inflammatory Disease and infertility as well as subsequent mental health problems such as depression which may occur after learning of early infertility.[1-4]

For many adolescents, Title X services are the most viable option for contraceptive care, due in large part to the availability of sliding scale fees and to the fact parental consent is not required to receive services. In fact, almost 60% of sexually active girls use public clinics, such as Title X clinics, as their primary source of reproductive health care.[5] This is significant as one in three adolescent girls have engaged in sexual intercourse by age 16, and by 18, two in three have initiated intercourse.[6] Additionally, based on data from the 2002 National Survey of Family Growth, the incidence of statutory rape at first sex is 13%. This number has remained consistent from 1995 when the incidence was 14%.[7] The average age difference between partners in a statutory rape classification is 5.1 years; for non-statutory rape situations the difference is 1.5 years.[7]

PL 91-572, Title X of the Public Health Service Act, is the national family planning program of the United States. The goals of the program are to provide services to help prevent unintended pregnancy, reduce the number of abortions, lower rates of sexually transmitted infections, and improve overall reproductive health.[8, 9] Services take place in a network of almost 5,000 clinics throughout the United States; these clinics are housed at state and local health departments, hospitals, community and migrant health clinics, Planned Parenthoods, and independent clinics.[10]

Providers are typically nurse practitioners and nurses, although some larger clinics will employ physicians and physician assistants.

The Title X Program Guidelines establish the rules for agencies that accept Title X family planning funding. The Program Guidelines include a detailed list of items that care providers must address during the history collection component of the client's visit. Two of these items to include when gathering information on the client's sexual history are sexual debut and sexual behavior, including information about the client's partner(s). Responses to these two questions may lead to the discovery of statutory rape among minor clients. Statutory rape is sexual intercourse between a minor and an adult; often this is defined by state laws determining age cut-points for both a minor and an adult, as well as age differences between the minor and adult.[11, 12]

The Title X Program Guidelines also note that client confidentiality must be assured and safeguards must be provided to guard against invasion of personal privacy. In regard to protecting adolescent confidentiality, the Guidelines note that adolescents must be given assurances that counseling sessions are confidential. Requiring parental consent for provision of services is not allowed, nor can parents/guardians be given information about services received.[1, 13, 14]

The Program Guidelines have a section that specifically addresses care for adolescent clients. Adolescent clients must be given age appropriate information, and while providers are encouraged not to assume that every adolescent in the clinic is sexually active, adolescents are to be informed of all contraceptive methods, including abstinence.[13] The Guidelines specify that providers should encourage minor clients to include their family in the decision to seek family planning services as well as to "provide counseling to minors on resisting attempts to coerce minors into engaging in sexual activity."[13] It is within this section of the Program Guidelines that the language from the 1998 mandate about sexual coercion is incorporated.

In 1998, new language addressing sexual coercion among minors was created for the Title X program. Providers were encouraged to counsel minors about sexual coercion, which the providers correctly interpreted to mean a stronger emphasis on identifying statutory rape.[11] In North Carolina, N.C. General Statute §7B-301 declares that any person or institution that has cause to suspect child physical, sexual (including statutory rape), and/or emotional abuse must report this case to the Director of the Department of Social Services.[15] N.C. General Statute §7B-310 notes that no privilege is grounds for failure to report except in the case of attorney-client privilege.[11] While approximately 31 states have specific statutes regarding failure to report, North Carolina is not one of them.[11] Therefore, while providers are mandatory reporters of statutory rape, if it is found that they did not report suspected abuse, they will not necessarily be held liable or charged by the Attorney General.

Although asking questions about a client's age or gathering information about her partner was not a new concept for family planning counseling, inclusion of this specific sexual coercion counseling guideline now became more directly tied to funding. This created a need for training to ensure that providers were including required information in family planning visits so that state funding was not jeopardized. Previous research has shown that a provider's experience in family planning and continuing education training can have a positive impact on knowledge levels and counseling behaviors of providers.[16-18] North Carolina offers a number training options for their providers on clinical care, adolescent health, and service provision.

The state of North Carolina also receives free one-day training workshops for its family planning providers from the training center in federal region IV, namely, The Emory University Regional Training Center. This agency created a curriculum entitled, *Preventing Sexual Coercion Among Adolescents: A Training Guide for Family Planning Providers,* that was nationally disseminated and implemented in 1999 and revised in 2003.[1] The curriculum covers: adolescent health and sexuality

(including many aspects of sexual violence); state-specific laws on statutory rape and mandatory reporting; counseling skills; and methods for creating policies regarding the handling of statutory rape cases. Between August 2003 and December 2004, 18 training workshops were conducted across North Carolina, with over 450 providers participating; however, only half of these participating trainees are part of the North Carolina Title X system.

Study Goals

To date, there is no previous research on knowledge of Title X providers, so it is unknown if they have the appropriate level of information needed to address the special needs of adolescent family planning clients. Medical and nursing education covers all aspects of care, but may not be in-depth in many subjects, such as reproductive health care unless advanced or specialized education is obtained. To address this gap, the goals of the study were to examine family planning providers' knowledge regarding important laws and regulations for working with adolescent family planning clients in the health departments of North Carolina. Specifically, the study surveyed Title X providers to determine their level of knowledge regarding: 1) statutory rape laws; and 2) federal Title X regulations. The study also examined whether there were differences in knowledge level by the providers' family planning experience, including type of provider and years in the family planning clinic, type of community in which they work, and participation in continuing education workshops.

Method

Sample

To be eligible to participate in the study, a provider must have worked in one of the 99 North Carolina county health department family planning clinics that receive Title X funding and must see adolescent patients for counseling/intake and/or clinical services. The providers did not have to be staff members solely dedicated to the family planning clinic, as many smaller health departments

have providers who rotate throughout multiple clinics in the health department. Clinic size impacts service delivery style in North Carolina health departments. Many small clinics use all of their clinical providers in all of the health department clinics, so that if there are four nurses on staff, all four were in the family planning clinic as opposed to one designated family planning nurse. In the more urban clinics, there was more liklihood of dedicated family planning staff members, but all counties had multiple providers.

The Title X providers were recruited with the help of the North Carolina Department of Health and Human Services, Women and Children's Health Branch. As there was no master list of county providers, the first step used to identify the names of all eligible providers was to send an email from the Women's and Children's Health Branch Director asking the county family planning manager to email the names of providers to me. The next step was to call each of the non-responding counties to gather a complete list of names. The final mailing list included 618 eligible study participants, including nurses, nurse practitioners, physicians, physician assistants, social workers and health educators.

Instrument

A self-administered instrument was created to examine knowledge of statutory rape laws and Title X regulations among family planning providers who work with adolescent clients in the family planning clinic. The instrument was pilot tested in Louisville, Kentucky with Title X providers who had various levels of experience both in the clinic and the Title X system, making them professionally similar to the North Carolina providers. Information gathered from the pilot study was used to revise the final instrument. There were no difficulties identified with question comprehension, and some demographic question response categories were expanded to be more inclusive of provider characteristics. The final instrument contained 50 questions and was

estimated take between 20 and 30 minutes to complete. It was mailed to the eligible Title X providers in the Spring of 2005.

This instrument, containing both open- and close-ended questions, asked questions on four areas: 1) knowledge of state statutory rape laws; 2) knowledge of federal Title X regulations; 3) provider characteristics; and 4) clinic characteristics. This study has two outcomes of interest; knowledge of state statutory rape laws and knowledge of federal Title X regulations.

The first outcome of interest, knowledge of state statutory rape laws, was measured on a scale from zero to four. One point was given for each correct answer; each question was in a multiple choice format. The first two questions focused where to file a mandatory report of statutory rape and the state age of consent for sexual activity. The final question focused on the two categories related to age differences between partners that would constitute statutory rape. One question was used, with two response options being correct and two incorrect response options.

The second outcome of interest, knowledge of federal Title X regulations, was also measured on a scale from zero to four. Four questions were used, each with true/false response options, and one point was given for each correct answer. The questions focused on information provided on contraceptive options to adolescents, whether it is permissible to require parental permission for family planning services, and the final two questions focused on whether it is permissible to notify parents prior to or after an adolescent has requested and received family planning services.

Demographic data collected included gender, race, Hispanic ethnicity, religion, and education. Other provider characteristics that were examined in this study were experience, community setting, and training. Experience consisted of two items used to indicate a provider's clinical experience in the family planning setting. The first item was type of clinical provider: nurse practitioner, registered nurse, or non-nurse. The second item was years working in a family

planning clinic, with a provider considered to have a high level of experience if they had worked in a family planning clinic for three or more years.

Participants were asked whether the clinic where they work at is located in a rural, urban, or mixed urban-rural community. Provider's training was measured on a scale from zero to four, based on four types of continuing education offered throughout the year. A point was assigned for each of the following types of training workshops: 1) general health counseling skills; 2) sexual health counseling skills; 3) coercion counseling training skills from a general workshop; and 4) coercion counseling training skills from their specific clinic.

The instrument asked participants whether their clinic had a policy for instances when a client discloses sexual abuse; if so they were then asked if this was a written policy and whether they had a copy of the written policy. The instrument then asked participants whether their clinic had a policy for instances when a client discloses statutory rape, with similar follow up questions regarding whether the policy was written and if the participant had a copy. Participants were also asked questions regarding provision of the following services for adolescent family planning clients: pregnancy testing, birth control, STI testing, and PAP testing. Providers were first asked which of the four services are available at their clinic for adolescent clients and then were asked to identify the most commonly requested of the four services by adolescent family planning clients.

Data Collection

Dillman's Tailored Design Method was used for data collection.[19] Each participant received a pre-letter providing information about the study and inviting them to participate. Four days later, a package containing an informed consent letter, survey instrument, return envelope (with postage) and pen were sent. Subjects who chose not to participate were instructed to return the instrument blank. Ten days after the second mailing, a postcard was mailed to all participants to thank those who had responded as well as to remind those that had yet to return the survey instrument to do

so. A final mailing was sent a month after the original mailing only to those participants who had not yet responded; this mailing included another letter regarding the study, a new copy of the survey instrument and a postage paid return envelope. Approximately 50% of the mailing list received this final mailing.

Analysis

All responses were entered into a database using EpiInfo,[20] and analyses were conducted using SAS 8.2 ©. Univariate analyses were used to determine frequencies of clinic and provider characteristics. Bivariate analyses were used to examine each knowledge question by provider's experience level and training received. Additionally, mean scores for statutory rape knowledge and Title X knowledge were calculated for the total group and examined by experience and training characteristics. P-values were generated using regression analysis which adjusted for interclass correlation by health department. An alpha of .05 was considered significant for all analyses. The data analysis for this research study was generated using PROC SURVEYFREQ, PROC SURVEYMEANS and PROC SURVEYREG SAS software, Version 8.2 of the SAS System for Windows. Copyright 199-2001 SAS Institute Inc. SAS and all other product or service names are registered trademarks of SAS Institute Inc., Cary, NC, USA.

Human Subjects

This project was approved by the University of North Carolina Office of Human Research Ethics, Public Health Institutional Review Board.

Results

This study achieved a 64.2% completion rate. Every health department had at least one provider respond; there were no differences in completion rate by area of the state or by size of health department. Among participants, 95% were women and 85% were Caucasian. Only 0.5% noted they were of Hispanic ethnicity (Table 1.1). The majority of providers in the study were either

registered nurses (63%) or nurse practitioners (25%). Of non-nurse providers, 4.5% were physicians, 3.8% were physician assistants and the remaining 1% were social workers and health educators. The majority of the respondents (78.1%) had worked in family planning clinics for more than three years, with 21.9% having less than three years experience. Among those with three or more years of experience, 38.2% had ten or more years of family planning clinic experience.

Table 1.1 presents information regarding clinic characteristics. Over half of the participants (56%) worked in a clinic based in a rural county; 28% were based in mixed urban-rural counties, while those based in urban counties made up the smallest group (14.1%). Over 83% of all participants stated that the primary reason for adolescent visits to the clinic was for birth control, with the remaining reasons including pregnancy testing, STI testing, and Pap Smear test. Fifty-eight percent of providers stated their clinic had a policy on sexual abuse disclosure; among those with a policy, 73% stated it is a written policy, and 57% of participants who were aware of the written policy have a copy of this policy. Slightly less than half of participants (49%) stated their clinic had a policy regarding statutory rape disclosure; 75% of participants who knew of a policy stated it was written, and 55% of those providers had a copy of this written policy.

Table 1.2 shows that participants correctly answered a mean of 1.94 (se=0.05) of the four statutory rape knowledge questions. Overall, only 5.8% (n=21) of providers correctly answered for all four statutory rape questions.

The majority of the sample (86.0%) correctly identified that if a case of statutory rape is suspected, they should file a mandatory report of abuse to the Department of Social Services. However, fewer participants (66.0%) were able to correctly identify that the age of consent for sexual intercourse in North Carolina is 16. The two questions regarding age differences for determining statutory rape had the fewest correct responses, with 20.4% able to correctly identify

cases of statutory rape when the victim is between the ages of 13 and 15, and 19.8% being able to identify cases of statutory rape when the victim is less than 13 years of age.

The differences in knowledge levels by provider characteristics are displayed in Table 1.2. Years of experience working in the family planning was significantly associated with knowledge scores; those providers with fewer than three years of experience had a mean score of 1.74 compared to 2.00 for those with three or more years (p=.01). The association between the number of training courses a provider attended and knowledge level of statutory rape laws was also statistically significant. Participation in training courses showed a gradient in mean scores from those with no participation having a mean score of 1.78, to those in the mid-range of courses (2 courses) having a mean score of 1.99, and those who participated in four courses having a mean score of 2.11, the greatest mean score among all the independent variables (p=.02).

There were no statistically significant differences by provider type, although registered nurses and nurse practitioners had a greater mean score (1.97, 1.93 respectively) than non-nurses (1.86), which include physicians, physician assistants, and social workers. There was no statistically significant difference in knowledge levels by clinic setting, although those participants who worked in urban locations had the lowest mean score at 1.79 while those from rural or mixed urban-rural communities had a mean score of 1.95 and 1.98 respectively.

Table 1.3 shows the results of the linear regression model for statutory rape knowledge levels. The model included the following variables: provider type, clinic experience, community setting, and training workshop attendance. Only training workshop attendance was statistically significant, and it explained approximately 22% of the variance in provider knowledge of statutory rape laws.

Table 1.4 shows that knowledge of the federal Title X regulations was higher than knowledge of state statutory rape laws among participants. The participants correctly answered a mean of 3.51 (se=0.04) of the four Title X questions and 59% (n=226) correctly answered all four questions.

There were three questions that at least 94% of participants correctly identified, including: 1) informing adolescents of all types of available contraception (98%); 2) it is not permissible to notify parents prior to providing an adolescent services (96%); and 3) it is not permissible to notify parents after providing an adolescent services (94%). The question that posed the most difficulty focused on the ability of clinics to require written parental consent for services with 62.9% identifying the correct answer.

Table 1.4 shows that none of the characteristics examined were significantly associated with knowledge level. Similar to the results for statutory rape laws, non-nurses had lower mean scores ($\bar{x}$=3.38) compared with registered nurses ($\bar{x}$=3.51) and nurse practitioners ($\bar{x}$=3.54). Again, those with fewer than three years of experience scored lower ($\bar{x}$=3.43) than those with three or more years of experience ($\bar{x}$=3.53) in the family planning clinic setting. The type of community showed the smallest range of variance in the mean scores with urban providers having a mean score of 3.47 compared to rural providers ($\bar{x}$=3.50) and those from mixed rural-urban communities ($\bar{x}$=3.51). Unlike statutory rape knowledge scores, a gradient was not seen regarding the amount of training received.

Table 1.5 shows the results of the linear regression model for Title X knowledge levels. The model included the following variables: provider type, clinic experience, community setting, and training workshop attendance. This analysis showed no independent effect of any of the characteristics on level of Title X knowledge.

Discussion

This study examined family planning providers' knowledge levels for two key concepts: state statutory rape laws and Title X regulations. Knowledge of state statutory rape laws was relatively low. More years of experience in the family planning setting and a higher number of training

workshops attended were significantly associated with higher knowledge levels. Those newer to the family planning system may not have had as many training opportunities to learn and/or have this important information reinforced. However, with a mean score of less than two correct response (out of four), all providers should be offered the opportunity to increase their knowledge of state laws. Training has been shown to impact knowledge level,[18] and therefore additional training for all state providers could help continue to raise knowledge of state laws. If workshops cannot be conducted, supplemental materials can be created specifically on this topic and disseminated from the state level to each county for their providers.

Knowledge of the Title X regulations was higher than knowledge of statutory rape – the majority of participants had a high knowledge score on key concepts related to providing services. Participants knew that parents (or guardians) could not be notified prior to, during, or after the receipt of family planning services. In addition, all were aware of the importance of informing clients of all methods of contraception. However, participants were not as knowledgeable concerning written consent for family planning services. One reason for this confusion may be the need for parental permission for other health department services, such as providing care for the common cold and school physicals. Knowledge of written consent rules should be reinforced to be sure all providers are aware of these important regulations. Trainings provided should include this information if addressing family planning service delivery.

It is interesting to note the consistently high Title X knowledge scores and larger ranges for statutory rape knowledge by the type of community a provider works within, given the dramatic differences in operations between large and small health departments. In larger health departments, there are dedicated family planning staff members that include nurses, nurse practitioners, as well as physicians, social workers and/or health educators. It would be expected that these staff members would have high knowledge levels given that family planning is their main

role in the clinic. In small clinics where there are fewer clinicians for the entire health department, these nurses and nurse practitioners rotate through a variety of clinics throughout the week. Given that the health department may only hold family planning clinics one to two times a week, it would not be expected that the clinicians have high knowledge of detailed regulations or state laws since they have to be highly knowledgeable on a wide range of populations and health concerns relating to their community's health care. However, while the differences were small with regard to Title X knowledge (mean score range 3.47-3.51), they were greater for statutory rape knowledge (range 1.79-1.98). Surprisingly, those urban providers had the lowest mean scores for both knowledge scores, which was the opposite of what would be expected. It is unknown why this occurred, but something that should be addressed in future research.

The majority of providers in this study, and in public family planning clinics, are nurses – either registered nurses or nurse practitioners. For the most part, clinical training focuses primarily on clinical care. Like most other health practitioners, legal knowledge can be limited to the information provided by an individual's employer or continuing education opportunities. There are some potential reasons for this study's finding that providers had greater ease with Title X regulations when compared with state statutory rape laws. The legal intricacies are very difficult to understand and are written for those with legal expertise. Therefore, it can be difficult for public health providers to understand and be able to correctly interpret these laws and how they apply to provision of clinic services for adolescents. The Title X regulations are written specifically for this population, which may explain the provider's ease of comprehension of the regulations and their ability to correctly identify and interpret them with regard to adolescent service provision.

There are some limitations of this study. First, although the completion rate was acceptable, there may have been differences between respondents and non-respondents that would influence the results of the study. Those who either did not respond (approximately 25% of the sample) or

chose to send back the survey instrument blank (approximately 10%) may have had different levels of knowledge than the overall sample; for example, these providers may have been newer to the Title X system and worried about not knowing the answers so chose to either return the survey instrument blank signifying they did not want to participate or to not return the survey instrument at all. It could also be that those with higher knowledge we assigned to more client care and therefore did not have the time to respond to the survey instrument. Also, the method for gathering the names of all state providers could inadvertently have left some off the list, which could create selection bias. Although we attempted to ensure that all providers were included, it was up to each county representative to provide the names. There may have been providers left off the mailing list; whether or not this is true cannot be determined.

This study helped to identify training needs for those who work with adolescents in public health department family planning clinics in the areas of sexual coercion and statutory rape. This is important for all clinics, regardless of size and whether staff is dedicated to the family planning clinic or rotates through various clinics. State laws can be difficult to understand so training should be offered, including materials that clearly explain the impact of health care delivery with young family planning clients. Cross training among health providers on legal concerns related to adolescent clients is integral to ensuring the best health care.

It is also important to ensure that confidentiality regulations are understood to ensure that appropriate health care is provided. While North Carolina providers have a high knowledge level, taking steps to ensure that both new and seasoned providers continue to receive training will help to keep knowledge levels high among providers. Confidentiality is integral in gaining the trust of clients of all ages when working in sensitive areas such as family planning. Ensuring confidentiality can help to keep clients coming back in for regular health visits, and help women plan the families

they want. Gaining the trust of young clients is especially important as they begin to understand and experiment with their sexuality and begin to need regular reproductive health care.

Table 1.1. Characteristics of Family Planning Providers and the Clinics in Which They Work

PROVIDER CHARACTERISTICS	**%**	**n**
Gender		
Female	95	376
Male	3	12
# Missing=9		
Race		
Caucasian	85	337
African-American	9	34
Native American/American Indian	2	8
Asian/Pacific Islander	1	5
Other	<1	2
# Missing=11		
Occupation		
Registered Nurse	63	244
Nurse Practitioner	25	97
Physician	5	18
Physician Assistant	4	15
Health Educator/Social Worker	1	4
# Missing=6		
CLINIC CHARACTERISTICS		
Location of Clinic		
Rural	56	221
Mixed Urban/Rural	28	112
Urban	14	56
# Missing=8		
Primary Reasons for Adolescent Family Planning Visit		
Birth Control	83	285
Pregnancy Test	9	32
Other	7	25
# Missing=55		
Clinic Has a Policy on Sexual Abuse Disclosure		
Yes	58	229
*Written Policy**	*73*	*168*
*Provider has a copy**	*57*	*96*
Clinic Has a Policy on Statutory Rape Disclosure		
Yes	49	186
*Written Policy**	*75*	*140*
*Provider has a copy**	*55*	*77*

*Only those answering 'yes' to the previous item were asked the follow-up questions
n=397

Table 1.2. Mean Scores, Percentage and Number of Family Planning Providers Who Correctly Answered Questions Regarding North Carolina State Statutory Rape Laws

	File mandatory report with Dept. of Social Services	North Carolina age of consent = 16 years of age	If victim is 13-15 years old, perpetrator is >6 years older	If victim is <13 years old, perpetrator is >4 years older)	Mean number of items correct	P-value **
	% (n)*	% (n)*	% (n)*	% (n)*	$\bar{X}$ (SE)	
Total Participants	86.0 (331)	66.0 (254)	20.4 (77)	19.8 (75)	1.94 (.05)	
Type of Provider						p=0.85
Non-Nurse	83.3 (35)	47.8 (22)	25.0 (10)	22.5 (9)	1.86 (.16)	
Nurse Practitioner	86.2 (81)	70.2 (66)	19.2 (18)	17.0 (16)	1.93 (.07)	
Registered Nurse	86.2 (206)	67.8 (160)	20.1 (47)	21.4 (50)	1.97 (.06)	
# Missing=10						
Years of Family Planning Clinic Experience						**p=0.01**
Low: <3 years	83.5 (71)	57.7 (49)	12.4 (10)	19.8 (16)	1.74 (.07)	
High: ≥3 years	86.7 (260)	68.3 (205)	22.6 (67)	19.9 (59)	2.00 (.06)	
#Missing=0						
Type of Community						p=0.87
Urban	76.5 (39)	55.6 (30)	20.8 (11)	17.0 (9)	1.79 (.15)	
Rural	85.1 (183)	66.8 (143)	20.3 (42)	21.3 (44)	1.95 (.07)	
Mixed	91.9 (102)	69.7 (76)	18.2 (20)	18.2 (20)	1.98 (.07)	
# Missing=8						
Total Training Received						**p=0.02**
0 Courses	87.8 (64)	58.4 (45)	16.4 (12)	9.6 (7)	1.78 (.11)	
1 Courses	86.9 (53)	51.6 (32)	21.1 (12)	19.3 (11)	1.77 (.13)	
2 Courses	85.6 (77)	69.0 (60)	17.1 (15)	23.9 (21)	1.99 (.09)	
3 Courses	83.3 (75)	69.7 (62)	26.7 (24)	22.2 (20)	2.00 (.11)	
4 Courses	86.7 (52)	79.3 (46)	18.6 (11)	23.7 (14)	2.11 (.11)	
# Missing=14						

Sample Size n=397

*= Percentage and number correctly answering the question

**= P-values were generated using regression analysis which adjusted for interclass correlation by health department.

Table 1.3. Modeling the Association Between Provider Characteristics and Statutory Rape Knowledge, n=353

	β	95% CI
Nurse Practitioner*	-0.08	-0.27, 0.10
Non-Nurse*	-0.18	-0.49, 0.13
High Clinic Experience	0.19	-0.01, 0.39
High (3-4) Training Courses	**0.22**	**0.02, 0.41**
Urban Community**	-0.13	-0.45, 0.19
Mixed Urban-Rural Community**	0.07	-0.13, 0.26

BOLD indicates p <0.05
CI = Confidence Interval
*=Referent is Registered Nurse
**=Referent is Rural Community

Table 1.4. Mean Scores, Number and Percentage of Family Planning Providers Who Correctly Answered Questions Regarding Federal Title X Regulations for Adolescent Service Provision

	Must inform adolescents about all methods of contracep-tion	It is not permissible to notify parents prior to receiving services	It is not permissible to notify parents after receiving services	Unable to require written parental consent for services	Mean number of items correct	P-value **
	% (n)*	% (n)*	% (n)*	% (n)*	$\bar{X}$ (SE)	
Total Participants						
	98.2 (385)	95.9 (372)	94.1 (368)	62.9 (244)	3.51 (.04)	
Type of Provider						p=0.34
Non-Nurse	93.2 (41)	91.1 (41)	86.9 (40)	66.7 (30)	3.38 (.16)	
Registered Nurse	99.2 (239)	96.7 (231)	95.4 (230)	60.5 (144)	3.51 (.05)	
Nurse Practitioner	97.9 (95)	96.8 (91)	94.7 (89)	66.3 (63)	3.54 (.08)	
# Missing=10						
Years of Family Planning Clinic Experience						p=0.34
Low: <3 years	98.9 (86)	95.3 (81)	91.9 (79)	58.1 (50)	3.43 (.08)	
High: ≥3 years	98.0 (296)	96.0 (291)	94.8 (289)	64.2 (194)	3.53 (.05)	
# Missing=0						
Type of Community						p=0.86
Urban	96.4 (54)	94.6 (52)	94.6 (53)	61.8 (34)	3.47 (.11)	
Rural	99.5 (217)	94.5 (206)	91.1 (203)	62.8 (135)	3.50 (.06)	
Mixed	96.4 (106)	99.1 (106)	95.4 (104)	61.8 (68)	3.51 (.06)	
# Missing=8						
Total Training Received						p=0.50
0 Courses	92.4 (76)	93.6 (73)	91.0 (71)	57.7 (45)	3.40 (.11)	
1 Courses	96.8 (60)	96.7 (59)	95.2 (59)	67.2 (41)	3.54 (.09)	
2 Courses	96.0 (86)	96.6 (83)	96.7 (87)	62.9 (56)	3.53 (.08)	
3 Courses	100 (90)	96.7 (87)	93.3 (84)	62.9 (56)	3.52 (.07)	
4 Courses	100 (61)	95.0 (57)	93.3 (56)	61.7 (37)	3.49 (.11)	
# Missing=14						

Sample Size n=397

*= Percentage and number correctly answering the question

**= P-values were generated using regression analysis which adjusted for interclass correlation by health department.

Table 1.5. Modeling the Association Between Provider Characteristics and Title X Knowledge, n=368

	β	95% CI
Nurse Practitioner*	0.02	-0.16, 0.19
Non-Nurse*	-0.14	-0.46, 0.18
High Clinic Experience	0.07	-0.11, 0.25
High (3-4) Training Courses	0.03	-0.11, 0.17
Urban Community**	-0.04	-0.28, 0.20
Mixed Urban-Rural Community**	0.02	-0.16, 0.19

BOLD indicates p <0.05
CI = Confidence Interval
*=Referent is Registered Nurse
**=Referent is Rural Community

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FAMILY PLANNING PROVIDERS COMFORT WITH COUNSELING ADOLESCENTS ABOUT SEXUAL VIOLENCE

Abstract

The purpose of this study was to explore Title X family planning providers' perceptions regarding their comfort with counseling adolescents on sexual behavior, including adolescents' disclosure of sexual abuse and statutory rape. A mailed survey instrument was used with a 64% completion rate. Participants included 397 family planning providers (88% registered nurses and nurse practitioners) who provide clinical care to adolescent clients from 99 health department based family planning clinics in North Carolina. Two four-point indices, along with one open-ended question, were used to measure providers' comfort level when counseling adolescent family planning clients. Provider characteristics examined included provider type, years of family planning clinic experience, the community setting in which they worked, and attendance a training workshop on family planning service delivery. Providers had high levels of comfort when counseling adolescents concerning general health and sexual health, with mean scores of 3.44 and 3.35, respectively (with 4 equaling the highest level of comfort). Comfort dropped significantly among providers when counseling a client who discloses sexual abuse (2.86 out of 4.00) or discloses statutory rape (2.69 out of 4.00). Providers also had high levels of comfort in asking ten questions commonly posed to a new client in the clinic (history gathering). When asked for reasons regarding potential counseling discomfort, providers stated issues related to adolescent cognitive development (including attitude and information comprehension), need for additional training, and a fear of being seen as judgmental. Overall, this research found that providers are generally comfortable providing standard family planning counseling. However, when extremely sensitive topics arise, including sexual abuse and statutory rape, comfort levels

significantly decrease. Additional training on counseling skills would benefit family planning providers to ensure they have the tools needed to provide the highest level of care for extremely sensitive situations.

Introduction

PL 91-572, Title X of the Public Health Service Act, is the national family planning program of the United States that provides a variety of reproductive health services to both adults and adolescents. The goals of the program are to provide services to help prevent unintended pregnancy, reduce the number of abortions, lower rates of sexually transmitted infections, and improve women's health overall.[1, 2] Services are provided within a network of almost 5,000 clinics throughout the United States. These clinics are housed at state and local health departments, hospitals, community and migrant health clinics, Planned Parenthood clinics, and independent clinics.[3] Family planning providers are typically nurse practitioners and registered nurses, although some larger clinics will employ physicians and physician assistants to work with family planning clients.

The Title X Program Guidelines establish rules for agencies that accept Title X family planning funding, including both service plans and protocols that the clinics must follow. In addition to the services addressed within the Title X regulations, including contraceptive care and STI/HIV prevention and treatment, clinics may provide other services that are intended to promote reproductive and general health care for their clients.[4] Almost 60% of sexually active girls use public clinics, such as Title X clinics, as their primary source of reproductive health care.[5] Given that approximately 30% of Title X clients are under the age of twenty, the Guidelines have a specific section to address care for adolescent clients.[3] Additionally, based on data from the 2002 National Survey of Family Growth, the incidence of statutory rape at first sex is 13%. This number has remained consistent from 1995 when the incidence was 14%.[6] The average age difference between partners in a statutory rape classification is 5.1 years; for non-statutory rape situations the difference is 1.5 years.[6]

Confidentiality is integral in working with adolescent clients and Title X has a long history of protecting client confidentiality, including that of their minor clients.[7, 8] The Guidelines note that client confidentiality must be assured and safeguards provided to guard against invasion of personal privacy. Parental consent for provision of services is not allowed, nor can parents/guardians receive information on services received.[4, 9, 10]

Anecdotal evidence suggests that many family planning providers are uncomfortable counseling adolescents on sexually sensitive matters, especially when clients are under the age of consent, which is currently 16 in North Carolina.[11] In 1998, new language addressing sexual coercion among minors was created for the Title X program. Providers were encouraged to counsel minors on preventing sexual coercion, which the providers correctly interpreted to mean a stronger emphasis should be placed on the discovery statutory rape.[12] Statutory rape is sexual intercourse between a minor and an adult; often this is defined by state laws determining age levels for both the minor and adult.[12, 13] Family planning providers may be uncomfortable discussing sexual coercion because such conversations could lead to the discovery of statutory rape, as well as other serious health issues such as previous sexual abuse. In fact, the Program Guidelines include a detailed list of items that providers address during the intake interview (history gathering) component of the client's visit that may lead to the identification of statutory rape or sexual abuse. Two items that must be included are information on the client's sexual history, including sexual debut and behavior, as well information on the client's partner(s). Some providers, due to their lack of training or experience, may not be equipped to handle in-depth counseling on these sensitive topics and may therefore may not adequately address this portion of the patient history.[7, 14] Two previous studies gathering knowledge and counseling information from family planning providers found a lack of training and lack of experience to be important predictors in reproductive health knowledge level and counseling behaviors.[15, 16]

Counseling Adolescents on Sexually Sensitive Matters

Providers who work with adolescents are in a unique position to address and affect adolescent sexuality and the consequences of adolescent sexual behaviors.[7, 17] For adolescents who are not receiving appropriate guidance from their parents, the messages sent by health care providers about sex and relationships are particularly important. Family planning providers are in the unique position of being able to assist vulnerable adolescents by consistently teaching about factors which provide the possibility of protection in potentially coercive situations.[7, 12] Such counseling may require skills that are not always provided in medical and nursing training.[7] However, attending family planning skills training sessions can be helpful in improving providers' family planning counseling behaviors.[18]

Study Goals

The goal of this study was to gather information from North Carolina Title X family planning providers' to examine their characteristics and their perceptions regarding their comfort level with counseling adolescent family planning clients. Sociodemographic characteristics examined included gender, race/ethnicity, and education. Provider characteristics examined included type of provider, years of experience in the clinic setting, type of community a provider works in, and number of training workshops attended. Information was gathered to examine providers' comfort levels with various types of counseling to determine if comfort level varied by type of counseling. Additionally, information was gathered concerning the providers' levels of comfort when asking clients various types of questions that must be asked during the intake/history portion of the clinic visit. Information was gathered on potential reasons for discomfort when counseling clients in the family planning setting.

Method

Sample

To be eligible to participate in the study, a provider must have worked in one of the 99 North Carolina county health department family planning clinics that receive Title X funding. In addition, the provider must have seen adolescent patients for counseling/intake and/or clinical services. Providers who did not work directly with clients at the time of the study were not included. The providers did not have to be staff members solely dedicated to the family planning clinic, as many smaller health departments have providers who rotate throughout multiple clinics in the health department.

The Title X providers were recruited with the help of the North Carolina Department of Health and Human Services, Women and Children's Health Branch. As there is currently no master list of county providers, the first step used to identify the names of all eligible providers was to send an email from the state asking the county family planning manager to email the names of providers to the study leader. The next step was to call each of the non-responding counties individually to gather a list of names. The final mailing list included 618 eligible study participants, including registered nurses, nurse practitioners, physicians, physician assistants, and social workers.

Instrument

A self-administered questionnaire was created to assess family planning providers who work with adolescent clients in the family planning clinic. The instrument was pilot tested in Louisville, Kentucky with Title X providers who had various levels of experience both in the clinic and the Title X system, making them professionally similar to the North Carolina providers. Information gathered from the pilot study was used to revise the final survey instrument. There were no difficulties identified with question comprehension, and some demographic question response categories were expanded to be more inclusive of provider characteristics. The final instrument

contained 50 questions and was estimated take between 20 and 30 minutes to complete. It was mailed to the eligible Title X providers in the Spring of 2005.

This instrument, containing both open- and close-ended questions, asked questions concerning six areas: 1) demographic characteristics 2) provider characteristics; 3) clinic characteristics; 4); provider comfort with four types of counseling; 5) provider comfort with questions common to the intake interview/history gathering portion of the visit; and 6) reasons for provider discomfort when counseling adolescents.

Demographic data collected included provider gender, race, Hispanic ethnicity, religion, and education. Other provider characteristics that were examined in this study were experience, community setting, and training. Experience consisted of two variables used to indicate a provider's clinical experience in the family planning setting. The first was type of clinical provider: nurse practitioner, registered nurse, or non-nurse. The second was years working in a family planning clinic, with a provider considered to have a high level of experience if they had worked in a family planning clinic for three or more years.

Participants were asked about the clinics in which they worked. They were asked whether the clinic they work at is located in a rural, urban, or mixed urban-rural community. They also were asked participants whether their clinic had a policy for instances when a client discloses sexual abuse; if so they were then asked if this was a written policy and whether they had a copy of the written policy. Participants were also asked questions regarding adolescent service provision. There are four services that are appropriate for adolescent family planning clients: pregnancy testing, birth control, STI testing, and PAP testing. Providers were first asked which of the four services are available at their clinic for adolescent clients and then they were asked to identify the most commonly requested of the four services by adolescent family planning clients.

Four questions were used to determine a provider's level of training, which was measured on a scale from zero to four, based on four types of continuing education offered throughout the year. A point was assigned to each positive response selected to one of the following types of training workshops: 1) general health counseling skills; 2) sexual health counseling skills; 3) coercion counseling training skills from a general workshop; and 4) coercion counseling training skills from their specific clinic.

Four questions were used to assess comfort level when counseling in the family planning clinic. The four questions addressed a specific type of counseling common to the family planning setting: general health, sexual health, sexual abuse disclosure, and statutory rape disclosure. Each of these questions asked the provider to choose how comfortable they felt conducting a each type of counseling session. A four-point Likert scale was used with the response options ranging from 1=very uncomfortable and 4=very comfortable.

Ten questions was used to assess providers' comfort level with questions common to the intake interview, or history gathering portion, of the clinic visit. Participants were given a hypothetical scenario stating: "*A 15-year-old is in the family planning clinic. She reports that she is sexually active and would like to go on regular contraception*." Participants then were asked to imagine that they were attending to this client and circle the level of comfort asking each of the ten questions using a scale of 1=very uncomfortable to 4=very comfortable. Questions focused on reason for clinic visit, desired and current contraceptive care, sexual behavior, and sexual partner information.

One open-ended question was used to follow-up this scenario and the counseling questions for participants to respond to. Providers were asked, "*What are the reasons, if any, for <u>your</u> discomfort when you are counseling minor clients on sexually sensitive matters?*" Instead of providing a possible list of answers, the question was open-ended in order to ensure that no potential reasons were excluded from the data collection.

Study Procedures

Dillman's Tailored Design Method was used for data collection.[19] Each participant received a pre-letter providing information about the study and inviting them to participate. Four days later, a package containing an informed consent letter, survey instrument, return envelope (with postage) and pen was sent. Subjects who chose not to participate were instructed to return the survey instrument blank. Ten days after the second mailing, a postcard was mailed to all participants. This postcard thanked those providers who had responded to the request while also reminding those providers that had yet to return the survey instrument to do so. A final mailing was sent a month after the original mailing only to those participants who had not yet responded; this mailing included another letter regarding the study, a new copy of the survey instrument and a postage paid return envelope. Approximately 50% of the mailing list received this final mailing.

Analysis

All quantitative survey instrument responses were entered into a database using EpiInfo[20]. The data analysis for this research study was generated using PROC SURVEYFREQ, PROC SURVEYMEANS, PROC SURVEYREG, and PROC FACTOR SAS software, Version 8.2 of the SAS System for Windows. Copyright 199-2001 SAS Institute Inc. SAS and all other product or service names are registered trademarks of SAS Institute Inc., Cary, NC, USA. Descriptive analyses were conducted to examine frequencies for provider and clinic characteristics. Frequencies were determined for the comfort level of the four types of counseling common to the family planning clinic: general health, sexual health, sexual abuse disclosure, and statutory rape disclosure. Bivariate analysis on these counseling variables was then conducted using the three main provider characteristics of provider type, community setting and training participation. Rao-Scott chi-square analysis[21] was used to determine whether there were significant differences in counseling comfort by provider characteristics while adjusting for interclass correlation by health

department; a pre-set criteria of $p < 0.05$ was used. Exploratory factor analysis was then conducted to determine if there were any underlying constructs among these four counseling variables. The principal factor method was used to extract the factors, and this was followed by a promax (oblique) rotation.[22] To determine the level of comfort for the ten questions of the hypothetical scenario of the intake interview, both frequencies and mean scores were derived. P-values are based on regression analysis which adjusted for interclass correlation by health department.

To establish a list of the most common reasons for counseling discomfort, qualitative analysis was conducted. Qualitative responses were transcribed verbatim into Microsoft Word © and then imported into Atlas.TI[23] for analysis. Using the transcribed information, a list of codes was generated based on common reasons stated. Each statement was then coded using this list of generated codes. Each time a code was matched to text, the code box recorded the frequency; at the conclusion of the coding, these frequencies were used to determine the most common reasons stated by providers for counseling discomfort.

Human Subjects

This project was approved by the University of North Carolina Office of Human Research Ethics, Public Health Institutional Review Board.

Results

Over 64% of the overall sample completed the questionnaire. Every health department had at least one provider respond; there were no differences in response by area of the state or by size of health department. Table 2.1 shows that 94.7% of the survey participants were women and 84.9% were Caucasian. Only 0.5% noted they were of Hispanic ethnicity. The majority of providers in the study were either registered nurses (63.1%) or nurse practitioners (25.1%). Of non-nurse providers, 4.5% were physicians, 3.8% were physician assistants and the remaining 1% were

social workers and health educators. The majority of the sample (78.1%) had worked in family planning clinics for more than three years, with 21.9% having less than three years experience. Among those with three or more years of experience, 38.2% had ten or more years of family planning clinic experience.

Table 2.1 also presents information on the providers' clinics. Over half of the participants (56%) were from a rural county, 28% were from mixed urban-rural counties, while those from urban counties make up the smallest group (14.1%). Over 83% of all participants stated that the primary reason for adolescent visits to the clinic was for birth control, with the remaining reasons including pregnancy testing, STI testing, and Pap Smear tests. Fifty-eight percent of providers stated their clinic had a policy on sexual abuse disclosure; among those with a policy, 73% stated it is a written copy and 57% had a copy of this policy. Slightly less than half of participants (49%) stated their clinic had a policy regarding statutory rape disclosure; 75% of the participants who knew of a policy stated that it was a written policy, and 55% of those providers had a copy of this written policy.

Table 2.2 presents information concerning the practitioners' levels of comfort concerning the four types of counseling common to the family planning clinic. With regard to general health counseling, 98.0% of providers felt either very comfortable or comfortable. Similarly, for sexual health counseling, 95.7% were either very comfortable or comfortable with this type of counseling. No providers selected "very uncomfortable" for either of these questions. However, when asked about counseling an adolescent who has disclosed sexual abuse, the percent of providers who felt comfortable fell to 70.9%, and for disclosure of statutory rape, 61.1%.

Bivariate analysis on the counseling variables was conducted using the following characteristics: experience, clinic location, and training received (Table 2.2). Due to many providers choosing one of the "comfortable" response options for both general and sexual health counseling, there were limited statistically significant differences seen by the providers' characteristics. Those with more

experience were significantly more comfortable conducting counseling sessions on general health topics (χ^2=7.77; p<0.005) and sexual health (χ^2=18.97; p<0.0001). Additionally, those from urban counties were significantly less comfortable conducting general health counseling sessions (χ^2=9.26; p<0.01).

Among providers, nurse practitioners had significantly higher comfort levels than registered nurses and non-nurses for both sexual abuse disclosure counseling (χ^2=7.18; p<0.03) and statutory rape disclosure counseling (χ^2=12.48; p<0.002). Those with more than three years of experience in the family planning clinic also had significantly higher comfort levels for sexual abuse disclosure counseling (χ^2=7.89; p<0.005) and statutory rape disclosure counseling (χ^2=5.34; p<0.02). Finally, the more training workshops a provider attended was significantly associated with higher comfort level for sexual abuse disclosure counseling (χ^2=23.10; p<0.0001) and for statutory rape disclosure counseling (χ^2=13.51; p<0.009). However, the type of community a provider works in was not significantly associated with comfort with sexual abuse disclosure counseling (χ^2=2.33; p<0.31) or statutory rape counseling (χ^2=1.33; p<0.27).

Based on the results of the bivariate analysis for the four types of counseling, exploratory factor analysis was conducted, showing two underlying constructs: “standard family planning counseling” and “disclosure counseling”. (Table 2.3) A scree test suggested two meaningful factors, so only these factors were retained for rotation. In order to interpret the rotated factor pattern, an item was said to load on a given factor if the factor loading was .40 or greater for that factor, and was less than .40 for the other. Using these criteria, two items were found to load on the first factor, which was named “standard family planning counseling.” Two items also loaded on the second factor, which was named “disclosure counseling.” Questionnaire items and corresponding factor loadings are presented in Table 2.3. Coefficient alpha reliability estimates all exceeded .70, with the

following estimates: general health counseling .84, sexual health counseling .81, sexual abuse counseling .79, and statutory rape counseling .82.

Ten questions were used for providers to rate their comfort level with regard to common questions used to collect a client's history at the beginning of a clinic visit. Table 2.4 shows that overall most providers had high comfort levels with these history gathering questions; mean scores ranged from 3.60 to 3.84 out of 4.00. Providers were most comfortable with questions related to reason for visit and type of contraception desired. As the questions became more detailed regarding sexual behavior, comfort level decreased. Those in the mid-range of comfort level included questions on pregnancy/STI protection and number of partners (past and present). The two questions that had the lowest level of comfort among providers addressed engaging in non-consensual sexual behavior and age of partners; these would be the questions that lead to sexual abuse and statutory rape disclosure.

There were a number of significant differences among the mean scores of the history gathering questions by provider characteristics (Table 2.4). In nine out of ten questions, nurse practitioners were significantly more comfortable asking client questions about her sexual history than registered nurses and non-nurses. The only question without statistical significance was in regard to asking about previous sexual violence, although nurse practitioners still had a higher mean score than other providers. When mean scores were examined by years of experience in the family planning setting, those with more experience were significantly more comfortable asking clients about previous sexual abuse. The number of training workshops attended by providers was statistically significant only one question, with those who had attended a higher number of workshops more comfortable with addressing the age of a client's partners.

Among those who responded to the open-ended question (n=233) regarding reasons for discomfort when counseling adolescent clients, 83 (36%) stated they were not uncomfortable

counseling adolescents. A few providers stated multiple reasons for discomfort. There were 183 remaining reasons for discomfort; the most common responses can be found in Table 2.5. Reasons stated included issues related to adolescent cognitive development (including attitude and information comprehension), need for additional training, mandatory reporting rules, fear of being seen as judgmental, demographic differences between client and provider. Less commonly stated reasons included a lack of experience with adolescent clients, feeling like the questions were overly intrusive, a provider's personal, religious or moral beliefs, needing to deal with the adolescent client's parents, and having children of similar age to the clients.

Discussion

Family planning providers can play important roles in protecting adolescents' reproductive health. Young adolescents use public clinics, such as Title X clinics, because of the accessible and confidential services offered. However, this is a population that may have specialized needs with regard to sexuality, including being at increased risk for engaging in risky behaviors and becoming involved with older partners.[8, 10] For that reason, it is important for a family planning provider to be comfortable counseling not just on general health and sexuality matters, but also with sensitive matters such as sexual abuse and statutory rape disclosure.[12]

The majority of the providers (over 85%) in this study were nurses or nurse practitioners. While these providers are well trained in gathering medical information through standardized questions and providing clinical services, many may not have the counseling education and skills needed to address some sensitive subjects in the family planning clinic. This was most evident when the questions were examined by provider characteristics, primarily with nurse practitioners being more comfortable with almost all of the history gathering questions when compared to registered nurses and non-nurses. However, providers had very high comfort levels with regard to general family planning information including sexuality, contraception and STI protection, and addressing general

health. On the other hand, when the questions appeared to be extremely personal, such as number and/or ages of partners, or involve information that had legal ramifications, such as discovery of statutory rape or sexual abuse, providers were less comfortable. These are subjects that often require specialized counseling techniques, taught mostly to social workers and other counselors who may not be employed by smaller health departments. This breakdown between the two types of counseling was most evident when the factor analysis was performed. While disclosure of statutory rape and/or sexual abuse does not occur with all clients, enough providers were concerned about their counseling abilities that it is a matter that should be addressed.

Looking at the provider characteristics with regard to disclosure counseling, there were some significant differences that have implications for future training needs. Nurse practitioners had a significantly higher comfort level with disclosure counseling than registered nurses and non-nurses. Also, those with more years of experience in the family planning setting also had significantly higher rates of comfort. Finally, among training levels, a gradient was seen. As number of training courses increased, comfort level significantly increased with disclosure counseling. This final finding reinforces the need for increased training opportunities among state family planning providers.

With this adolescent population come additional challenges not seen with adult clients. Adolescents are in a developmental stage which involves changes that affect both attitude and ability to comprehend information in an appropriate manner; this can make counseling and clinic education more difficult than with adult clients. Additionally, there were concerns among providers that family members are often more involved than the adolescent would prefer and a number of providers noted difficulties in dealing with adolescent client's parents. Providers felt that they needed additional experience working with this adolescent population and many providers requested additional training.

Providers were worried about being viewed as judgmental by their adolescent clients, as they knew this could be detrimental to creating a good working relationship with the client. Many providers noted that their personal and religious beliefs are important to them, but that these beliefs must stay out of clinic practice and it is important to them that their clients do not feel affected by them. Those who are parents to adolescents and young children noted that they often struggled with their "inner parent voice." The providers knew they could not use a tone that sounded "parental" with the young clients, but often felt that young clients needed to feel supported by an adult. Many providers noted their concerns stemmed from an important quality: the desire to be the best provider and to provide the best service possible.

North Carolina's family planning program receives free training through their federal family planning training center and courses can be offered, and if needed created, to meet the needs of the state's health department staff.[24] The qualitative data gathered regarding the reasons for discomfort while counseling can be used to ensuring that the workshops are covering the appropriate material. All of the comments made by providers were noted to be important as they wanted to be sure they were doing the best they could for this vulnerable population. Many providers noted that they hoped that by stating their needs, they would be provided with the tools needed to ensure they continue to provide the highest level of care possible.

There are some limitations of this study. First, although the completion rate of 64% was acceptable, there may have been differences between respondents and non-respondents that would influence the results of the study. Those who either did not respond (approximately 25% of the sample) or chose to send back the survey instrument blank (approximately 10%) may have had different levels of comfort than the overall sample. With sensitive topics, social desirability may play a role in both choosing to participate and in the answers provided which can skew the results relating to comfort level when asking about perceptions of an individual's work-related skills. Also,

the method for gathering the names of all state providers could inadvertently have left some off the list, which could create selection bias. Additionally, this instrument was created specifically for this study and has not been used elsewhere; there may have been measurement issues within the instrument.

Public health departments, including the family planning clinic, see many clients in one day. They are often the main source of health care for a county's citizens; therefore it is integral that they provide the best quality of care possible. Similar to previous studies,[7, 15, 16] the providers in this study, primarily nurses and nurse practitioners on the front lines of care, displayed through their comments a true desire to provide a high quality of care. These providers are often required to provide counseling to young adolescents on topics that they may not be fully trained to address, but feel that it is important to be trained so that they can deal appropriately with all that arises during a family planning visit. They stated in many ways their strong connection to the clients they serve and their need to guide adolescents into a healthy reproductive life as an adult. In order to do so, additional training must be provided to enhance their counseling skills, especially for situations when a minor discloses previous sexual abuse or statutory rape. Counseling is a special skill, and while nurses and nurse practitioners are trained in gathering sensitive information, many need additional training on how to counsel on sensitive topics such as sexual violence and statutory rape. Making additional training regarding working with minor clients available to staff throughout North Carolina's health department will ensure that the providers are able to work with their clients at a high level and that these vulnerable clients continue to come to the health department for quality reproductive health care.

Table 2.1. Characteristics of Family Planning Providers and the Clinics in Which They Work

PROVIDER CHARACTERISTICS	**%**	**(n)**
Gender		
Female	95	(376)
Male	3	(12)
# Missing=9		
Race		
Caucasian	85	(337)
African-American	9	(34)
Native American/American Indian	2	(8)
Asian/Pacific Islander	1	(5)
Other	<1	(2)
# Missing=11		
Type of Provider		
Registered Nurse	63	(244)
Nurse Practitioner	25	(97)
Physician	5	(18)
Physician Assistant	4	(15)
Health Educator/Social Worker	1	(4)
# Missing=6		
CLINIC CHARACTERISTICS		
Location of Clinic		
Rural	56	(221)
Mixed Urban/Rural	28	(112)
Urban	14	(56)
# Missing=8		
Primary Reasons for Adolescent Family Planning Visit		
Birth Control	83	(285)
Pregnancy Test	9	(32)
Other	7	(25)
# Missing=55		
Clinic Has a Policy on Sexual Abuse Disclosure		
Yes	58	(229)
*Written Policy**	*73*	*(168)*
*Provider has a copy**	*57*	*(96)*
Clinic Has a Policy on Statutory Rape Disclosure		
Yes	49	(186)
*Written Policy**	*75*	*(140)*
*Provider has a copy**	*55*	*(77)*

n=397

*Only those answering 'yes' to the previous item were asked the follow-up questions

Table 2.2. Percent and Number of Providers Comfortable with Four Types of Family Planning Counseling Stratified By Provider Characteristics

	Comfortable With General Health Counseling % (n)*	Comfortable With Sexual Health Counseling % (n)*	Comfortable With Sexual Abuse Disclosure Counseling % (n)*	Comfortable With Statutory Rape Disclosure Counseling % (n)*
Total Participants	98.0 (386)	95.7 (377)	70.9 (278)	61.1 (238)
Type of Provider				
Nurse Practitioner	100 (97)	100 (97)	81.4 (79)†	78.1 (75)†
Registered Nurse	97.1 (235)	94.2 (228)	67.1 (161)	55.7 (133)
Non-Nurse *# Missing=10*	97.8 (44)	95.6 (43)	66.7 (30)	56.8 (25)
Years of Family Planning Clinic Experience				
Low: <3 years	94.3 (82)†	87.4 (76)†	59.3 (51)†	51.8 (44)†
High: ≥3 years *#Missing=0*	99.0 (304)	98.1 (301)	74.2 (227)	63.8 (194)
Type of Community				
Rural	99.1 (217)†	95.4 (209)	69.3 (151)	59.2 (129)
Urban	92.9 (52)	92.9 (52)	66.1 (37)	60.0 (33)
Mixed *# Missing=8*	98.2 (109)	97.3 (108)	76.4 (84)	66.7 (72)
Total Training Received				
0 Courses	93.6 (73)	88.5 (69)	53.3 (41)†	48.7 (37)†
1 Courses	98.4 (62)	93.7 (59)	69.8 (44)	54.0 (34)
2 Courses	98.9 (88)	97.8 (87)	68.5 (61)	61.4 (54)
3 Courses	98.9 (90)	98.9 (90)	75.8 (69)	63.6 (56)
4 Courses *# Missing=14*	100 (61)	100 (61)	88.3 (53)	78.3 (47)

n=397

*=Percent and number choosing either response option "3= comfortable" or "4= very comfortable" for each type of counseling

†=Differences by provider type are statistically significant ($p<0.05$), based on chi-square analysis.

Table 2.3. Inter-factor Correlations

Survey Instrument Item	Factor 1: "Standard Family Planning Counseling"	Factor 2: "Disclosure Counseling"	Communality Estimates
I feel _____[a] conducting a general health counseling session with an adolescent client.	**.80**	.29	.72
I feel _____ conducting a session on topics of sexuality with adolescent clients.	**.79**	.38	.76
I feel _____ counseling an adolescent who has disclosed sexual abuse.	.36	**.78**	.73
I feel _____ counseling an adolescent who has disclosed statutory rape.	.29	**.77**	.69

[a] On a scale of 1-4; 1= very uncomfortable and 4= very comfortable

Table 2.4. Providers' Comfort Level Asking the Following Questions to a 15-year Old Family Planning Client. Mean Scores on a Scale of 1=Very Uncomfortable and 4=Very Comfortable by Provider Characteristics

	Why are you in the clinic today?	What type of contraception are you interested in?	How long have you been sexually active?	What protection against pregnancy and STIs have you been using?	How many sexual partners have you ever been with?
Total Participants	3.84	3.82	3.78	3.77	3.72
Type of Provider					
Nurse Practitioner	3.94*	3.90*	3.90*	3.89*	3.86*
Registered Nurse	3.81	3.79	3.74	3.74	3.67
Non-Nurse *# Missing=10*	3.82	3.80	3.73	3.76	3.76
Years of Family Planning Clinic Experience					
Low: <3 years	3.83	3.80	3.73	3.71	3.66
High: ≥3 years *#Missing=0*	3.85	3.82	3.79	3.79	3.74
Total Training Received					
0 Courses	3.81	3.77	3.73	3.70	3.64
1 Courses	3.77	3.81	3.74	3.76	3.68
2 Courses	3.89	3.81	3.78	3.78	3.74
3 Courses	3.87	3.87	3.82	3.79	3.78
4 Courses *# Missing=14*	3.82	3.80	3.75	3.79	3.70
	How many sexual partners do you have right now?	**Have you talked to you parents about using contraception?**	**How often do you have sex?**	**Have you engaged in sexual activity when you did not want to?**	**What are the age(s) of your current partner(s)?**
Total Participants	3.72	3.69	3.68	3.65	3.60
Type of Provider					
Nurse Practitioner	3.85*	3.78*	3.86*	3.76	3.73*
Registered Nurse	3.67	3.66	3.63	3.60	3.57
Non-Nurse *# Missing=10*	3.69	3.64	3.64	3.67	3.47
Years of Family Planning Clinic Experience					
Low: <3 years	3.66	3.64	3.58	3.52*	3.52
High: ≥3 years *#Missing=0*	3.73	3.70	3.71	3.68	3.62
Total Training Received					
0 Courses	3.62	3.69	3.58	3.58	3.53*
1 Courses	3.66	3.55	3.65	3.56	3.50
2 Courses	3.74	3.69	3.64	3.66	3.55
3 Courses	3.76	3.71	3.76	3.64	3.64
4 Courses *# Missing=14*	3.72	3.73	3.74	3.75	3.70

n=397

(Range of scores from 1= very uncomfortable to 4=very comfortable)

*=Statistically significant at p<0.05

Table 2.5. Reasons Stated by Family Planning Providers for Potential Discomfort when Counseling Adolescent Clients

	# Times Mentioned
Issues related to adolescent cognitive development such as attitude and comprehension of information	24
Providers need or desire additional training	22
Worried about the need to file a mandatory report to the authorities	19
Fear of coming off as judgmental while talking to the adolescent	17
Differences in demographics, such as age or race between provider and client	14
Lack of experience counseling minor clients	11
The questions required feel like invasion of privacy	11
A provider's personal, religious, or moral beliefs	11
Issues related to adolescent client's parents desire for information/intervention	9
The provider is currently the parent of teens or younger children	9

n=150*

*Providers may have noted multiples reasons

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CONFLICT BETWEEN FAMILY PLANNING PROVIDERS' MANDATORY REPORTING OF STATUTORY RAPE AND PROTECTION OF ADOLESCENT CONFIDENTIALITY

Abstract

The goal of this study was to describe Title X providers' opinions about the impact of mandatory reporting of statutory rape on the protection of confidentiality for young family planning clients. A self-administered questionnaire was mailed to providers who conduct counseling sessions and/or administer clinical care to adolescent clients in public family planning clinics located in the 99 county health department-based Title X family planning clinics in North Carolina. We obtained a 64% completion rate. Results showed that providers were evenly divided on their views of whether mandatory reporting impacted confidentiality. Those providers who did not feel that mandatory reporting impacted the receipt of confidential care noted reasons such as their role is to protect/advocate for the client, the fact that reporting is the law, and their belief that reporting is in the best interest of the client. Reasons for viewing mandatory reporting as having a negative impact on provision of confidential care included the need for honesty from clients, worry that clients would avoid future clinic visits, and care provider's inability to control confidentiality of others outside the family planning clinic. The viewpoints were often related to the family planning providers' individual definition of statutory rape.

Introduction

Adolescents need access to high quality family planning services in order to maintain health during adolescence and into adulthood. Confidentiality is integral in working with adolescent clients; those who feel that their confidentiality will be breached may either delay or avoid seeking services for reproductive health care, potentially resulting in long term health repercussions.[1-4] For many adolescents, Title X services are the best option for contraceptive care, due in part to the facts that parental consent is not required to receive Title X services and sliding scale fees are available.[5, 6]

The national family planning program of the United States is PL 91-572, Title X of the Public Health Service Act. The goals of the Title X program are to provide services to help prevent unintended pregnancy, reduce the number of abortions, lower rates of sexually transmitted infections, and improve overall reproductive health.[6, 7] Services take place in a network of almost 5,000 clinics throughout the United States; these clinics are housed at state and local health departments, hospitals, community and migrant health clinics, Planned Parenthoods, and independent clinics.[8] The Program Guidelines have a specific section to address care for adolescent clients, which is important since approximately 30% of clients are under the age of twenty.[8] Almost 60% of sexually active girls use public clinics, such as Title X clinics, as their primary source of reproductive health care.[9] Additionally, based on data from the 2002 National Survey of Family Growth, the incidence of statutory rape at first sex is 13%. This number has remained consistent from 1995 when the incidence was 14%.[10] The average age difference between partners in a statutory rape classification is 5.1 years; for non-statutory rape situations the difference is 1.5 years.[10]

Title X has a long history of protecting client confidentiality, including that of their minor clients.[11] The Program Guidelines note that client confidentiality must be assured and that safeguards must

be in place to guard against invasion of privacy. The disclosure of information by project staff regarding services received by clients is prohibited without written permission, except as required by law.[5] In regard to confidentiality, the Guidelines note that adolescents must be given assurances that counseling sessions are confidential. Parental consent for provision of services is not allowed, nor can parents/guardians receive information on services received.[1, 5, 12]

The Title X Program Guidelines lay out the rules for those agencies that accept Title X family planning funding. Two items that must be included in patient history taking are sexual partner history and sexual behavior history; responses to these two items may lead to the discovery of statutory rape. Statutory rape is sexual intercourse between a minor and an adult; often this is defined by state laws determining age levels for both a minor and an adult.[13, 14] In 1998, new language was instituted for the Title X program addressing sexual coercion against minors. Clinicians were encouraged to counsel minors regarding sexual coercion, which the clinicians correctly interpreted to mean a stronger emphasis on the discovery of statutory rape.[13] In most states, including North Carolina, discovery of statutory rape by a clinician is a mandatory reportable offense.[15, 16] This results in a potential conflict between client confidentiality and statutory rape reporting when working with minor clients.

The Title X regulations do not directly address the conflict between confidentiality and mandatory reporting for statutory rape. Title X acknowledges that it is important to abide by state laws, thereby acknowledging awareness of the conflict, yet offers no guidance on how to work with this conflict. Thus, there is a potential dilemma regarding the reporting of statutory rape versus protecting confidentiality when working with adolescent clients. To report may require breaking the trust of the adolescent, which could lead to the client becoming reluctant to use health care or to her giving inaccurate answers during the health history interview.[17]

Only one study has previously looked at the conflict presented in the Title X clinics by statutory rape reporting. The study took place in 1997 (prior to the mandated change in the funding language) among Kansas family planning program managers.[18] This study utilized a 14-item structured instrument to gather clinicians' opinions regarding the exemption of reproductive health workers from child abuse reporting requirements, the effect of mandatory reporting outcomes on the emotional and/or financial support of the adolescent, and public and personal support for the enhancement of statutory rape reporting.[18] The results from the study showed that the managers (who may not provide direct services) strongly supported aggressive enforcement of statutory rape laws, while remaining unclear on the potential impact of mandatory reporting on their adolescent clients. Concern over protecting confidentiality was high, and was often noted as a reason for choosing not to report. Similarly, age differences between the client and her partner also impacted the intent to report a case of statutory rape, where the greater the age difference, the more likely the clinician was to file a report.[18]

Adolescents who come to the family planning clinics need to feel that they can be honest with their provider and that they will receive confidential services that protect their reproductive and overall health. This study will allow us to delve into family planning providers' opinions by gathering information from North Carolina Title X providers regarding whether they feel that there is a conflict between the state statutory rape laws and the federal Title X regulations regarding protection of confidentiality. This includes gathering information on whether providers feel that mandatory reporting hampers their clinical ability to provide confidential care, as well as providers' opinions on the impact of mandatory reporting on adolescent reproductive health.

Method

Sample

To be eligible to participate in the study, a provider must have worked in one of the 99 North Carolina county health department family planning clinics that receive Title X funding. In addition, the provider must see adolescent patients for counseling/intake and/or clinical services. Providers who did not work directly with clients at the time of the study were not included. The providers did not have to be staff members solely dedicated to the family planning clinic, since many smaller health departments have providers who rotate throughout multiple clinics in the health department.

The Title X providers were recruited with the help of the North Carolina Department of Health and Human Services, Women and Children's Health Branch. As there was no master list of county providers, the first step used to identify the names of all eligible providers was to send an email from the Women's and Children's Health Branch Family Planning Nurse Consultant asking the county family planning manager to email the names of providers to the lead investigator of the study. The next step was to call each of the non-responding counties to gather a list of names. The final mailing list included 618 eligible study participants, including registered nurses, nurse practitioners, physicians, physician assistants, and social workers.

Instrument

A self-administered instrument was created that contained both open- and close-ended questions focused on demographic information on the family planning providers, clinic information, the providers' knowledge of statutory rape laws and Title X regulations, and the providers' opinions concerning the potential conflict between mandatory reporting and the protection of confidentiality. The instrument was pilot tested in Louisville, Kentucky with Title X providers who had various levels of experience both in family planning clinics and within the Title X system, making them professionally similar to study providers. Information gathered from the pilot study was used to

revise the final survey instrument. There were no difficulties identified with question comprehension, and some demographic question response categories were expanded to be more inclusive of provider characteristics. The final instrument contained 50 questions and was estimated take between 20 and 30 minutes to complete. It was mailed to the eligible Title X providers in the Spring of 2005.

Demographic information was collected on the providers including gender, race, Hispanic ethnicity, religion and education. Other provider characteristics that were examined in this study were experience, community setting, and training. Experience consisted of two variables used to indicate a provider's clinical experience in the family planning setting. The first was type of clinical provider: nurse practitioner, registered nurse, or non-nurse. The second was years working in a family planning clinic, with a provider considered to have a high level of experience if they had worked in a family planning clinic for three or more years. Participants were asked to self-define the community setting in which they practice: rural, urban, or mixed urban-rural community. Providers' training was assessed by assigning a point for each of the training workshops the providers attended concerning general health counseling skills, sexuality counseling skills, and coercion counseling training skills from either a state workshop or from their individual clinic. Possible provider training scores ranged from 0-4 points.

Participants were asked whether their clinic had a policy for those instances during which a client disclosed sexual abuse; if so, they were asked if it was a written policy, and whether they had a copy of it. Next, they were asked whether there was a policy for statutory rape disclosure policy, including whether it was a written policy and if they had a copy of this policy. Participants also were asked about family planning services that are available to adolescent clients, including birth control, pregnancy testing, sexually transmitted infection testing and PAP tests.

Three variables were used to assess the providers' knowledge: knowledge of statutory rape laws, knowledge of Title X regulations, and total knowledge. Knowledge of statutory rape laws was created from a series of four items, with each correct response assigned one point, for a possible knowledge score of zero to four. The questions focused on: age of consent, where to file a mandatory report of abuse, and the two separate age-related situations that would constitute statutory rape. The Title X regulation knowledge set was created in a similar manner to the previous variable, where a series of four questions was used; each correct response equaled one point for a range of zero to four correct. The Title X regulation questions focused on delivery of family planning services for adolescent clients including: informing clients about all methods of contraception, the inability to require written consent for services, that it was not permissible to notify parents (or guardians) prior to receipt of family planning services and that it was not permissible to notify parents (or guardians) after the receipt of family planning services. These two variables were combined to create a total knowledge score which had a range of zero through eight.

This study used both quantitative and qualitative data to address the main study question regarding the potential conflict between mandatory reporting and protection of confidentiality. For the quantitative aspect of the study, one variable, conflict between mandatory reporting and protecting confidentiality, was based on the question: "*As a clinician, I believe that being a mandatory reporter of statutory rape hampers my ability to guarantee minor clients confidential services.*" The four response options were strongly agree, agree, disagree, and strongly disagree.

Following this quantitative question, space was given to allow providers to explain their responses this conflict item. This section provided data for the first portion of the qualitative analysis. The second portion of the qualitative analysis was based on a second question that

asked participants "*As a Title X clinician, what are your opinions on mandatory reporting for all sexually active clients under the age of consent (e.g. statutory rape)?*"

Data Collection

Dillman's Tailored Design Method[19] guided the data collection. Each participant received a pre-letter providing information about the study and inviting them to participate. Four days later, a package containing an informed consent letter, survey instrument, return envelope (with postage) and pen were sent. Subjects who chose not to participate were instructed to return the survey instrument blank. Ten days after the second mailing, a postcard was mailed to all participants to thank those who had responded as well as remind those that had yet to return the instrument to do so. A final mailing was sent a month after the original mailing only to those participants who had not yet responded; this mailing included another letter regarding the study, a new copy of the survey instrument and a postage paid return envelope. Approximately 50% of the mailing list received this final mailing.

Analysis

All quantitative survey instrument responses were entered into a database using EpiInfo.[20] The data analysis for this research study was generated using PROC SURVEYFREQ, PROC SURVEYMEANS and PROC SURVEYREG SAS software, Version 8.2 of the SAS System for Windows. Copyright 199-2001 SAS Institute Inc. SAS and all other product or service names are registered trademarks of SAS Institute Inc., Cary, NC, USA. Frequencies were determined for provider and clinic characteristics, knowledge scores, and the conflict item. Mean scores of the conflict item were then generated for the sample. Additionally, mean scores were examined by both provider characteristics and knowledge scores. P-values were generated using regression analysis which adjusted for interclass correlation by health department. An alpha of .05 was considered significant statistically for all analyses.

Qualitative data were transcribed verbatim into Microsoft Word ©. Analyses were conducted using Atlas.TI[21] to identify themes found among the responses. Codes were created by the principal investigator after reading through the transcripts. The first qualitative question was linked to the quantitative conflict item, and therefore the codes were created to also include whether the participant had chosen "agree" or "disagree" options from the item. The second question, which focused on general opinions related to mandatory reporting, was analyzed using codes created based solely on providers' qualitative responses. The codes were matched to the comments within the transcripts by the same individual who created the code system. Code and retrieve analysis was then conducted using the most common themes found within the text.

Human Subjects

This project was approved by the University of North Carolina Office of Human Research Ethics, Public Health Institutional Review Board.

Results

Over 64% of the overall sample completed the survey instrument. Every health department had at least one provider respond; there were no differences in response by area of the state or by size of health department. Table 3.1 shows that among participants, 95% were women and 85% were Caucasian. Less than 1% noted they were of Hispanic ethnicity. The majority of providers in the study were either registered nurses (63%) or nurse practitioners (25%). Of non-nurse providers, 5% were physicians, 4% were physician assistants and the remaining 1% were social workers and health educators. The majority of the respondents (78%) had worked in family planning clinics for more than three years, with 22% having less than three years experience. Among those with three or more years of experience, 38% had ten or more years of family planning clinic experience.

Table 3.1 also presents information regarding clinic characteristics. Over half of the participants (56%) worked in a clinic based in a rural county, 28% were based in mixed urban-rural counties,

while those based in urban counties made up the smallest group (14%). Fifty-eight percent of providers stated their clinic had a policy on sexual abuse disclosure; among those with a policy, 73% stated it was a written copy and 57% of participants who were aware of the written policy had a copy of this policy. Slightly less than half of participants (49%) stated their clinic had a policy regarding statutory rape disclosure; 75% of participants who knew of a policy stated it was written, and 55% of those providers had a copy of this written policy.

Figure 3.1 shows the distribution of providers' responses to the conflict item concerning whether mandatory reporting hampers the ability to provide confidential services were divided. Almost 9% did not respond to this question, although half of those participants provided qualitative responses regarding why they were unable to choose a response; another 2% created their own category for "agree-disagree". Of those who did respond to the question, 7.3% strongly agreed that mandatory reporting hampers the ability to provide confidential services and about a third either agreed (35.8%) or disagreed (35.8%) with the statement. The remaining 10.8% strongly disagreed that mandatory reporting hampered the ability to provide confidential services with this statement.

Table 3.2 shows the mean scores of the conflict item for the total sample, and by provider characteristics and knowledge scores. Overall, providers had a mean score of 2.55 to the conflict item showing that on average providers leaned slightly more towards the idea that mandatory reporting did not hamper the ability to provide confidential services. There were no statistically significant differences in the mean conflict score by the provider characteristics. Nurse practitioners ($\bar{x}$=2.65) were slightly more likely to feel that mandatory reporting did not hamper confidentiality compared to registered nurses ($\bar{x}$=2.53) and non-nurses ($\bar{x}$=2.51); those providers with more than three years ($\bar{x}$=2.57) were slightly more likely to feel that mandatory reporting did not hamper protection of confidentiality than those with less experience (2.51). Providers based in

mixed urban rural communities ($\bar{x}$=2.57) and rural communities ($\bar{x}$=2.58) had somewhat higher mean scores on the conflict item than those in urban communities (2.46). Finally, those who had attended all four training workshops were somewhat more likely to feel that mandatory reporting did not hamper protection of confidentiality ($\bar{x}$=2.76) versus those with less training, with mean scores ranging from 2.39 to 2.57.

The mean conflict item score was also compared among those who had high versus low knowledge for both the statutory rape laws and the Title X regulations; none of these comparisons were statistically significant. Those who had a mean knowledge score of two or more questions correct, which is above the mean of 1.94 questions correct (out of a possible four), had a slightly lower mean conflict item score, 2.56, than those who answered less than two questions correct ($\bar{x}$=2.58). Overall, participants had a higher mean knowledge score for the Title X regulations, 3.51 questions correct out of 4. Those providers who answered all four questions correctly were slightly less likely ($\bar{x}$=2.54) than those scoring below the mean knowledge level ($\bar{x}$=2.59) to feel that mandatory reporting did not hamper protection of confidentiality. Finally, those providers whose total knowledge score was above the mean of 5.45 correct questions out of 8 had a slightly higher mean score on the conflict item ($\bar{x}$=2.57) than those answering less questions correctly ($\bar{x}$=2.55).

Views on the Conflict between Mandatory Reporting and Protection of Confidentiality

Participants were asked to provide qualitative information regarding their responses to the question on the possible conflict between mandatory reporting and protection of confidentiality. Response to this question was high, with 78.6% of participants answering the open-ended portion of the question. Many participants stated multiple reasons for their opinion on the potential conflict between mandatory reporting and protection of confidentiality.

For those who thought that mandatory reporting did *not* impact confidentiality, a number of reasons were provided. The top six responses given, beginning with the most common, were: a family planning provider's role is to protect and/or advocate for the client; it's not the providers' choice to make since it is the law; the provider informs the client of the mandatory reporting obligation at beginning of the interview so they are aware of the limits of confidentiality; it's for the young clients' own good/in the young clients' best interest; the perpetrator needs to be stopped from dating young girls and/or punished; and it helps get the client needed services, such as counseling . For example, regarding protecting/advocating for clients, one nurse practitioner from a rural county stated: *"Mandatory reporting increases my ability to help protect our youth."* Another registered nurse from a rural county stated: *"I would feel I wasn't doing a patient justice or being a good patient advocate if I didn't report these situations."* With regard to following the law, a registered nurse from a rural county stated: *"If it's required for me to report, then I report. I will still maintain confidentiality within the clinic and the community."*

Many felt that informing patients ahead of time about reporting would not hamper confidentiality, with a registered nurse from a mixed urban-rural county stating: *"By reporting statutory [rape], I explain to the patient why I am reporting it in hopes that she will understand I am thinking of her best interest. Informing the patient that the people I inform are all trying to help her."* Finally, when providers wrote about needing to report, as it was in the best interest of the client, they noted comments similar to this nurse practitioner from a mixed urban-rural county: *"… I agree it is in the best interest of the child for such an occurrence to be reported and followed-up on. The benefit here would outweigh the risk."*

On the other side of the spectrum, a number of reasons were given as to why mandatory reporting *may* conflict with providing confidential services. The top six reasons given by providers were: need for a patient to be truthful/honest regarding her behaviors; fear that clients would avoid

coming to the clinic; reporting would compromise expected confidentiality; provider's inability to guarantee the confidentiality of others; reduces clinician trust; and issues related to the adolescent's partner, such as lying about his age or other methods of protecting him. Others topics that were less frequent, but mentioned ten or more times included issues with how the Department of Social Services (DSS) handles the report, that most of the behavior they see is consensual sex, and that they fear the repercussions to the adolescent client when the information gets out.

One registered nurse from a rural county, when talking about the need for patients to be honest and future clinical care said, *"I feel that the minor will lose confidence in me and will not be honest on future visits and will tell others. This will compromise the care that she receives on future visits if she even decides to return."* A social worker from an urban county noted similar feelings stating, *"… I feel, however, that word would get out and girls would begin to lie about the age of their partner or they would decide not to use the services of the clinic at all."* A registered nurse from an urban community worried about the impact of sharing information with others noted: *"As I have very little control over the sequelae of the reporting, I have concerns that the patients will be unwilling to return to the clinic should they need services in the future."*

Providers were then asked to state their opinions on mandatory reporting for all sexually active clients under the age of consent; 79.8% provided an answer for this question. Similar to the previous question, many of the responses centered on related themes: the potential increase in adolescent pregnancy and STI rates, reporting is the only way to protect/advocate for the client, that it was appropriate to report all cases of underage sexual behavior, clients would avoid future care if reported, most cases are consensual behavior so should not report, it is important for the clinician to be able to use clinical discretion to determine whether to report and that reporting so many clients would be cumbersome to the provider and would overwhelm DSS.

Many of the comments addressed multiple themes. One registered nurse from a rural community, addressing the possible increase of negative consequences and lack of future care, stated: *"Clients would lose the trust they have in us if they knew there was mandatory reporting. The girls wouldn't use our facilities, incorrect information would be obtained from friends and teenage STD's and pregnancy would increase."* A rural-based registered nurse addressed protection of the client, stating: *"I believe that reporting statutory rape is essential to the protection, health, and mental health of sexually active minors."* Similarly, another rural-based registered nurse stated, *"In an ideal world, ALL statutory rape should be reported – for the protection of our children – but the medical, legal systems, DSS, Mental Health is not equipped to handle all referrals that would be made… Reporting should be case by case – 'will reporting be helpful or destroy some families?'"*

Discussion

Based on the limited previous research, this study aimed to delve deeper into the topic of statutory rape reporting and to gather information about family planning providers' opinions about the potential conflict between mandatory reporting of statutory rape reporting and protection of client confidentiality. We found that the providers who participated in this study were divided on their views of this potential conflict. Half of the participants felt that mandatory reporting negatively impacted the ability to provide confidential care and the other half felt that it had no impact. Regardless of the direction of their opinions regarding reporting, many providers stated that these opinions were based their strong desire to be a good clinician, provide top clinical care, and to do what is best for the client's long term health.

Also notable is that the views of the providers tend to depend on how they personally viewed statutory rape. The majority of providers who stated that the disagreed that mandatory reporting hampered protection of confidentiality had follow up comments that displayed their definition of

statutory rape was strictly by the sense of the law, where any client under the age of consent is a victim of statutory rape; they frequently used terms such as 'victim' and 'perpetrator'. Additionally, these providers noted that if confidentiality was broken, it was in the best interest of the young client. These providers repeatedly stated that they view themselves as protectors and advocates for a client who may be too young and/or vulnerable to address sexual situations. Even if the sexual behavior is stated to be consensual, the view was that these girls are too young to understand that they are being taken advantage of, and that reporting will help get them the needed services.

For those providers who felt that mandatory reporting would negatively impact the ability to provide confidential care, these providers often felt that the sexual activity was consensual and primarily normal adolescent behavior. They also felt that reporting the young client, including involving the authorities, would do more harm than good. These providers worried that if the family planning clinic was known as a place where everyone would be reported, adolescent clients would either avoid the clinic for contraceptive care or would lie about their age and/or their partner's age. The need for gathering truthful information, gaining client trust, and ensuring clients had access to contraceptive care was of higher importance than the need to report all adolescents. These providers also worried that while they could maintain confidentiality, once the report was in, the provider could not guarantee the client that others, such as Department of Social Services or the Police Department, would keep the information confidential; this was especially so in smaller communities. The long-term impact that these providers were worried about was unplanned pregnancy and sexually transmitted infections.

There are several limitations of this study. First, although the completion rate of 64% was acceptable, there may have been differences between respondents and non-respondents that would influence the results of the study. Those who either did not respond (approximately 25% of

the sample) or chose to send back the survey instrument blank (approximately 10%) may have had different levels of comfort than the overall sample. With sensitive topics, social desirability may play a role in both choosing to participate and in the answers provided which can skew the results relating to comfort level when asking about perceptions of an individual's work-related skills. Also, the method for gathering the names of all state providers could inadvertently have left some off the list, which could create selection bias. Additionally, a little over 20% of participants who responded to the survey instrument chose not to respond to each of the qualitative questions. This may be due to a lack of time while in the clinic, or because of the sensitive nature of the questions. It is unknown whether these providers may have had differing options than those providers who did submit qualitative information.

Despite these limitations, the results of this research have implications for family planning practices and policies. Standards for practice need to be set and stated for providers who work with adolescent family planning clients. Providers were divided on whether mandatory reporting hampers protection of confidentiality; the creation or revision of clinic policies must include all providers and ensure that the policies follow the proper rules while also being cognizant of the potential reproductive health impacts on adolescents. Those on both sides of the debate felt strongly that using provider discretion on when to report was more beneficial than lumping all cases into one standard practice of care. Being able to choose the process of care that will ensure the most benefit, while decreasing the potential harm was the desired protocol by many providers.

Training can also help providers understand the state laws and federal regulations, thereby ensuring that they understand what steps must be taken when working with adolescent clients. Ensuring that young family planning clients have access to care to prevent unwanted pregnancies and infections, and have a safe place to go to receive care and services was a top priority. Finally,

regardless of their viewpoints, wanting to make available the best care possible was the top priority for providers.

Table 3.1. Characteristics of Family Planning Providers and the Clinics in Which They Work

PROVIDER DEMOGRAPHICS (N=397)	**%**	**n**
Gender		
Female	95	376
Male	3	12
# Missing=9		
Race		
Caucasian	85	337
African-American	9	34
Other	6	26
# Missing=11		
Provider Type		
Registered Nurse	63	244
Nurse Practitioner	25	97
Physician	5	18
Physician Assistant	4	15
Health Educator/Social Worker	1	4
# Missing=6		
Years of Family Planning Clinic Experience		
Low: < 3 years	22	87
High: ≥ 3 years	78	310
#missing=0		
CLINIC CHARACTERISTICS		
Location of Clinic		
Rural	56	221
Mixed Urban/Rural	28	112
Urban	14	56
# Missing=8		
Clinic Has a Policy on Sexual Abuse Disclosure		
Yes	58	229
*Written Policy**	*73*	*168*
*Provider has a copy**	*57*	*96*
Clinic Has a Policy on Statutory Rape Disclosure		
Yes	49	186
*Written Policy**	*75*	*140*
*Provider has a copy**	*55*	*77*

*Only those answering 'yes' to the previous item were included in the follow-up questions

Table 3.2. Mean Scores on the Conflict Item, by Provider Characteristics and Knowledge Scores, n=356†

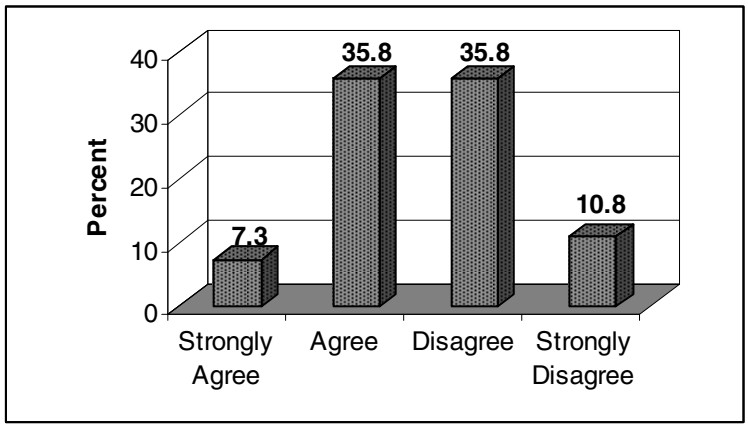
Conflict Item: "As a clinician, I believe that being a mandatory reporter of statutory rape hampers my ability to guarantee minor clients confidential services". (1=Strongly Agree, 4=Strongly Disagree)		
	Mean Score (SE)*	**p-value****
All Providers	**2.55 (0.04)**	
Type of Provider		0.26
Non-Nurse	2.51 (0.13)	
Registered Nurse	2.53 (0.05)	
Nurse Practitioner #missing=10	2.65 (0.09)	
Years of Family Planning Clinic Experience		0.58
Low: < 3 years	2.51 (0.09)	
High: ≥ 3 years #missing=0	2.57 (0.04)	
Type of Community		0.82
Urban	2.47 (0.09)	
Mixed Urban-Rural	2.57 (0.07)	
Rural #missing=8	2.58 (0.05)	
Total Training Received		0.10
0 Courses	2.55 (0.09)	
1 Courses	2.39 (0.10)	
2 Courses	2.53 (0.10)	
3 Courses	2.57 (0.07)	
4 Courses #missing=14	2.76 (0.11)	
Statutory Rape Knowledge Level		0.78
Below Mean Score (<2 correct)	2.58 (0.08)	
Above Mean Score (≥2 correct) #missing=73	2.56 (0.04)	
Title X Knowledge Level		0.62
Below Mean Score (≤3 correct)	2.59 (0.07)	
Above Mean Score (4 correct) #missing=57	2.54 (0.06)	
Total Knowledge Level		0.75
Below Mean Score (≤5 correct)	2.55 (0.07)	
Above Mean Score (>5 correct) #missing=87	2.57 (0.06)	

† 1.8% (n=7) of participants checked both "agree" and "disagree"; 4.3% (n=17) did not answer the question, but did provide qualitative explanation; 4.3% (n=17) did not answer question at all.

*SE=standard error of the mean

**= p-values were generated using regression analysis which adjusted for interclass correlation by health department

Figure 3.1. Distribution of Responses to the Conflict Item: "As a clinician, I believe that being a mandatory reporter of statutory rape hampers my ability to guarantee minor clients confidential services."



n=356†

† 1.8% (n=7) of participants checked both "agree" and "disagree"; 4.3% (n=17) did not answer the question, but did provide qualitative explanation; 4.3% (n=17) did not answer question at all.

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DISCUSSION

In 1998, new language for the Title X Family Planning Program was introduced. This new language was closely tied to funding and therefore failure to follow the rules could result in loss of state funding. The new language addressed encouraging adolescent clients to include their families in the decision to seek contraception, and encouraged family planning providers to counsel adolescents on sexual coercion.[1] It was this second component of the new language that concerned providers, as it was apparent that there was a strong desire to find, and therefore report, cases of statutory rape, which may present a conflict with protecting patient confidentiality. Title X language states that a provider must abide by state laws, including mandatory reporting of statutory rape, while also protecting client confidentiality.[2] Anecdotal evidence showed that providers were concerned about the implications of this language on the health of their adolescent clients as well as on their clinic's funding. However no data had been collected to verify the views of those on the front line until this study.

The goal of this study was to gather information from North Carolina health department based Title X providers on their: 1) knowledge of state statutory rape laws; 2) knowledge of federal Title X regulations related to adolescent service provision; 3) perceptions of counseling comfort when working with adolescent family planning clients; and 4) perceptions on the possible conflict between state mandatory reporting laws and federal protection of confidentiality. Information gathered can help inform both family planning research and clinic practice in North Carolina and the rest of the United States Title X programs.

We found that providers had a high level of knowledge regarding Title X regulations related to adolescent health care delivery, and that there were there were no significant differences in knowledge by provider characteristics. However, knowledge of state statutory rape laws was much lower, and providers with three or more years of experience in family planning and those who had attended a greater number of related training workshops were significantly more likely to have scored higher on these legal questions.

Providers had high levels of comfort for both general and sexual health counseling; both common types of counseling when working with family planning clients. However, providers were significantly less comfortable when an adolescent client discloses either previous sexual violence or statutory rape situations. Reasons for discomfort included the desire for additional training, dealing with potential legal situations such as mandatory reporting, and fear of appearing judgmental by clients.

The final portion of the study focused on the potential conflict between mandatory reporting and protection of confidentiality when working with adolescent family planning clients. Providers were evenly divided as to whether they felt mandatory reporting had a positive or negative impact on protection of confidentiality. Reasons given for feeling reporting was a good thing included the need to advocate and protect clients and the importance of following the law. Those who felt that mandatory reporting hampered the ability to offer confidential services stated that clients would not provide honest answers to questions or that they would not come to the clinic for services, both which could lead to increased cases of adolescent pregnancy and sexually transmitted infections. All providers stressed the importance of doing what was right as a provider and what was best for the client.

Overall, these findings show that there is a need to address family planning provider's concerns about their knowledge levels, their ability to counsel on difficult topics, as well as their views on the

conflict between mandatory reporting and protecting confidentiality. Providers need the proper tools in order to give adolescent family planning clients the best possible services. Many requested training through the open-ended questions so that they could better serve their clients.

Future research

Because this was the first study since the language change to address the concerns surrounding statutory rape reporting in the Title X system, more research needs to be conducted to determine if similar results will be seen throughout the United States. Other southeastern states operate similarly to North Carolina, with the State Health Office receiving the state dollars and the vast majority of funding being sent to health departments.[3] These seven states (Alabama, Florida, Georgia, Kentucky, Mississippi, South Carolina, Tennessee) have similar health concerns and receive similar training workshops; therefore, it would be interesting to see if the findings would be replicated in these states. Outside of the southeast, operations are different, with funding going to health departments, Planned Parenthood clinics, and other specialty clinics.[4] It is unknown whether these other areas of the country or other types of clinics (non-health departments) might also see similar findings with regard to knowledge levels and counseling perceptions.

Providers noted in their concerns related to mandatory reporting that it would have an effect on adolescent health. Determining the number of adolescents who visited the family planning clinics prior to and after the language change would be important to see if adolescents are less likely to come into the clinic for reproductive health care. Also it would be important to track adolescent pregnancies and births, as well as sexually transmitted infections, both before and after the language change was implemented. This would help determine if more adolescents are going without needed reproductive care since the language change, as reducing unmet need is an important aspect of Title X. Following the data on family planning visits and negative outcomes could begin to determine if the language change is having an effect on adolescent health. Another

indicator that should be tracked is the number of mandatory reports for statutory rape, both before and after the language change, and whether these reports were coming from the Title X system or from outside entities such as schools and youth programs. Finally, an important group needs to be included in future studies – sexually active adolescents. Information needs to be gathered from them to determine if the language change is affecting their behavior with regard to clinic visits and access to contraceptive care.

Public Health Implications

There are a number of public health implications emanating from this study. First, there is a greater need for training for all family planning providers across North Carolina on statutory rape laws and counseling when adolescents disclose either sexual violence or statutory rape. The majority of providers in this study were nurses, nurse practitioners and physicians, who may not have the in-depth counseling skills needed for working with some adolescent family planning clients. Training is currently available to North Carolina providers, and it would be highly beneficial for family planning providers to attend these training workshops.

Clinic policy can be addressed based on the information found. Approximately 60% of providers thought their clinic had a policy on disclosure of sexual abuse; it was less than 50% for statutory rape. However, there were discrepancies found among providers from similar clinics. Regardless, if clinics have a policy on either type of disclosure, they need to be sure their providers are aware of it, and have a copy of the written document(s). If there is not a policy in place, the clinics should work to create one so that providers have a clear directive on how to handle cases of disclosure when working with adolescent clients. Provider input, on either creating a new policy or revising a current one, could be invaluable to a clinic since the providers are on the front line of care and know what is needed to provide appropriate care to young adolescent clients.

In addition, adolescents' fear over a lack of confidentiality at the family planning clinic can have negative consequences to their health. Many adolescents use public family planning clinics because of the confidentiality provided; even those who have insurance coverage through their parents choose to go the public family planning clinic for contraceptive services. Without the option of the public clinic, many would not seek care if their only choice was their family doctor.[5] For those adolescents worried about either being reported themselves, or having their partner reported, forgoing care does not mean that they are forgoing sexual activity. Therefore, there may be an increased chance of pregnancy or sexually transmitted infection among those adolescents who would not seek care if it were not confidential. Young adolescents who become pregnant are at increased risk of lower educational attainment, child abuse to their child, and poverty.[6] For those who contract an infection, the health implications are large. Many bacterial infections can go undetected, which can lead to infertility; HIV can lead to death.[7]

It is important for the adolescent family planning clients' health that confidentiality is maintained at a level that will ensure they can attain services without fear of the repercussions of mandatory reporting. Additionally, if adolescents know that providers can be fully trusted to act in their best interest, more may come in and accept help to leave possible coercive/unhealthy situations, whether by finding counseling assistance or agreeing to police/social services intervention if deemed appropriate.

These implications for training and clinic policy go beyond North Carolina. Many of the states in the southeast operate similarly, and can look at the results from North Carolina when planning their annual training calendar, as well as look into their clinic policies on disclosure. States outside of the southeast can also benefit by ensuring their training needs are appropriate and that clinics have policies in place, either at the state or county level. At the federal level, Office of Population Affairs, which oversees Title X, can ensure that federal training centers have enough funding to

provide appropriate training, given that this topic is one of their top priorities.[2, 4] They can offer state health offices guidance in creating clinic policy that meets the funding guidelines, so as not to put any future funding in jeopardy.

Finally, clear clinic policy combined with adequately trained providers will benefit the health of North Carolina's adolescent population. The goal is to ensure that sexually active adolescents can access contraception in order to delay pregnancy until they are ready for parenthood and to prevent sexually transmitted infections. Ensuring that policies are in place and that the providers have all the tools needed to work with this population will enhance the services provided to family planning clients, especially those with greater needs such as adolescents. Preventing pregnancy and infection has long term health and financial implications. Helping adolescents navigate to adulthood successfully is a role the family planning providers of North Carolina can play.

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Appendix I:

Survey Instrument

Family Planning Clinician's Perceptions of Counseling Adolescents

This study is looking into family planning provider opinions regarding counseling adolescents in the clinic setting. This research is being conducted by Deb Risisky, a Doctoral Student in the department of Maternal and Child Health at the University of North Carolina School of Public Health.

You are being asked to participate in this study because you work in a Title X supported family planning clinic in North Carolina. I am asking that you complete this one survey; there will be no additional tasks to participate in. This survey should take about 30 minutes to complete. If necessary, you may be contacted for further information regarding clarification of responses.

The only risks associated with this study are related to the potential breach of confidentiality, which could result in your identity being linked to the information you provide. However, to protect your privacy, a unique identification number will be used for each document and will not include your name anywhere on the questionnaire form. The researchers will not be able to link your identification number to your identity.

While there is no direct benefit to you from participating in this study, the results from the survey will contribute valuable information about family planning counseling of adolescents, and will help direct training and policy development for Title X, both in North Carolina and possibly at the federal level. You may request a copy of the final results on the last page of this questionnaire. It will be kept separately from all questionnaires, and can not be linked to the information you provide.

Your participation is voluntary. Your decision whether or not to participate in this study will not affect your employment. You may decline to answer particular questions. You also may choose not to be in the study or to end your participation at any time. If you choose not to participate, please return the questionnaire blank so that we may remove you from follow-up mailings.

This research has been reviewed and approved by the Public Health Institutional Review Board of the Office of Human Research Ethics. If you have any questions about this study, you may call Deb Risisky (919 414 1177), or Dr. Sandy Martin, Ms. Risisky's Faculty Advisor (919 966 5973), 9:00 a.m. to 5:00 p.m. Monday through Friday. You may call collect.

Thanks in advance for your assistance in this research effort.

Please detach and retain this cover page for future reference.

For the following questions, please check the appropriate boxes. For open-ended questions, write in the appropriate information. If you need more space, feel free to use the back of the page. Thank you for your participation.

First we will begin with your experience as a family planning provider:

1. How long have you been a family planning provider at this clinic?
   - ☐ Less than 1 year
   - ☐ 1-2 years
   - ☐ 3-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

2. How long were you a family planning provider at another clinic prior to this one?
   - ☐ Less than 1 year
   - ☐ 1-2 years
   - ☐ 3-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years
   - ☐ I have not been a family planning provider at another clinic

3. How many continuing education trainings do you attend per year?
   - ☐ None, I do not attend (*skip to question 12*)
   - ☐ 1-2 per year
   - ☐ 3-5 per year
   - ☐ 6-8 per year
   - ☐ 8 or more per year

4. Where do you typically attend continuing education trainings?
   - ☐ Conferences
   - ☐ Local workshops (at district/county/city health department)
   - ☐ State workshops
   - ☐ Other: _____

5. What are the topics of trainings that you typically attend (*check all that apply*):
   - ☐ Adolescent health
   - ☐ Administrative/clinic management
   - ☐ Clinical care
   - ☐ Counseling
   - ☐ STIs/HIV
   - ☐ Other: _____

6. I have received training on general counseling skills for working with adolescent clients.
   - ☐ Yes
   - ☐ No

7. I have received training on sexual health counseling skills for working with adolescent clients.

- ☐ Yes
- ☐ No

8. I have attended training regarding counseling adolescents on preventing sexual coercion.

- ☐ Yes
- ☐ No

9. If yes, what month/year? _____

10. Have you received training from your specific clinic on sexual coercion?

- ☐ Yes
- ☐ No

This section will focus on regulations related to adolescent sexual behavior:

11. What is the age of consent for sexual intercourse for minors in North Carolina?

- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ Don't Know

12. Which of the following are considered statutory rape by North Carolina law? (*Check <u>all</u> that apply*)

- ☐ Vaginal intercourse with a person under age 13 when actor is at least 3 years older
- ☐ Vaginal intercourse with a person under age 13 when actor is at least 4 years older
- ☐ Vaginal intercourse with a person age 13 through 15 when the actor is at least 6 years older
- ☐ Vaginal intercourse with a person age 14 through 16 when actor is at least 4 to 6 years older

13. If you suspect a minor client is the victim of statutory rape, North Carolina state law requires you to report this case to:

- ☐ Department of Juvenile Justice
- ☐ Department of Social Services
- ☐ Department of Health
- ☐ No one

14. Adolescents seeking contraceptive services must be informed about all methods of contraception.

- ☐ True
- ☐ False

15. It is permissible for Title X projects/clinics to require written consent of parents or guardians for the provision on services to minors in some circumstances.

- ☐ True
- ☐ False

16. It is permissible for parents (or guardians) to be notified before a minor has requested and received Title X family planning services.

- ☐ True
- ☐ False

17. It is permissible for parents (or guardians) to be notified after a minor has requested and received Title X family planning services.

- ☐ True
- ☐ False

The next questions are about counseling in the clinic setting:

18. I feel _____ conducting a general health counseling session with an adolescent client.

- ☐ Very comfortable
- ☐ Comfortable
- ☐ Uncomfortable
- ☐ Very uncomfortable

19. I feel _____ conducting a counseling session on topics of sexuality with adolescent clients.

- ☐ Very comfortable
- ☐ Comfortable
- ☐ Uncomfortable
- ☐ Very uncomfortable

20. I feel _____ counseling an adolescent who has disclosed sexual abuse.

- ☐ Very comfortable
- ☐ Comfortable
- ☐ Uncomfortable
- ☐ Very uncomfortable

21. I feel _____ counseling an adolescent who has disclosed statutory rape.

- ☐ Very comfortable
- ☐ Comfortable
- ☐ Uncomfortable
- ☐ Very uncomfortable

22. Does your clinic have a policy or protocol regarding adolescents who disclose sexual abuse?

- ☐ Yes
- ☐ No **SKIP TO 25**
- ☐ Don't Know **SKIP TO 25**

23. Is the policy regarding adolescents who disclose sexual abuse a written policy?

- ☐ Yes, it is written
- ☐ No, it is not written **SKIP TO 25**
- ☐ Not sure if it is a written policy **SKIP TO 25**

24. Do you have a copy of this policy regarding adolescents who disclose sexual abuse?

- ☐ Yes, I do
- ☐ No, I do not

25. Does your clinic have a policy or protocol regarding adolescents who identify statutory rape?

- ☐ Yes
- ☐ No **SKIP TO 28**
- ☐ Unsure **SKIP TO 28**

26. Is the policy or protocol regarding adolescents who identify statutory rape a written policy?

- ☐ Yes, it is written
- ☐ No, it is not written **SKIP TO 28**
- ☐ Not sure if it is a written policy **SKIP TO 28**

27. Do you have a copy of this policy or protocol regarding adolescents who identify statutory rape?

- ☐ Yes, I do
- ☐ No, I do not

28. Imagine you are attending to the client mentioned below. Circle the answer that is closest to how you feel about asking the following questions.

A 15 year old is in the family planning clinic. She reports that she is sexually active and would like to go on regular contraception.

	Very Comfortable	**Comfortable**	**Uncomfortable**	**Very Uncomfortable**
a. Why are you in the clinic today?	1	2	3	4
b. How long have you been sexually active?	1	2	3	4
c. How often do you have sex?	1	2	3	4
d. What type of contraception are you interested in?	1	2	3	4
e. How many sexual partners have you ever been with?	1	2	3	4
f. How many sexual partners do you have right now?	1	2	3	4
g. What are the age(s) of your current partner(s)?	1	2	3	4
h. Have you talked to your parents about using contraception?	1	2	3	4
i. Have you engaged in sexual activity when you did not want to?	1	2	3	4
j. What protection against pregnancy and STIs have you been using?	1	2	3	4

The next set of questions will ask for you to write out your opinions. Please take all the room you need, as your opinions on clinic matters are very important to us. This is the first time clinician's opinions are being gathered and can be vital for creating clinic policy in the future. Again, your opinions will <u>not</u> be able to be attributed to you directly in the final report.

29. As a clinician, I believe that being a mandatory reporter of statutory rape hampers my ability to guarantee minor clients confidential services.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Please explain:

_____

_____

_____

_____

_____

_____

_____

_____

30. As a Title X clinician, what are your opinions on mandatory reporting for all sexually active clients under the age of consent (e.g. statutory rape)? Please write in your opinions – you may use the back of the page if needed.

31. What are the reasons, if any, for <u>your</u> discomfort when you are counseling minor clients on sexually sensitive matters? (Use back of page if need more room)

_____

_____

_____

_____

_____

_____

_____

The next section focuses on occupational information:

32. What is your highest level of education?
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Medical Degree
- ☐ Doctorate (non-medical Degree)
- ☐ Other _____

33. What is your title at this clinic? (ex: Staff Nurse, Nursing Director, Social Worker)

_____

34. What is your job specialty (*check one*)?
- ☐ Nurse
- ☐ Physician
- ☐ Physician's Assistant
- ☐ Health Educator
- ☐ Social Worker
- ☐ Other _____

35. What is your highest level of nursing education?
- ☐ Professional/technical school
- ☐ ADN
- ☐ BSN
- ☐ MSN
- ☐ *Not a nurse*
- ☐ Other _____

36. Are you a registered nurse (RN)?

- ☐ Yes
- ☐ No
- ☐ *Not a nurse*

37. Are you a nurse practitioner (NP)?

- ☐ Yes
- ☐ No
- ☐ *Not a nurse*

The next section focuses on your clinic:

38. Is the area where your clinic is located primarily:

- ☐ Rural
- ☐ Urban
- ☐ A mixture of rural and urban

39. On average, about how many family planning clients are seen at your clinic in a typical day?

_____ CLIENTS

40. On average, about how many adolescent family planning clients are seen at your clinic in a typical day?

_____ CLIENTS

41. On average, about how many adolescent family planning clients do **you** see in a typical day?

_____ CLIENTS

This section will focus on services at your clinic:

42. What services are available to adolescent family planning clients at your clinic? (*Check <u>all</u> that apply*)

- ☐ Pregnancy Test
- ☐ Birth Control
- ☐ STI test
- ☐ PAP test
- ☐ Other: _____

43. What is the most common reason that an adolescent would come to your clinic? (*Check <u>one</u>*)

- ☐ Pregnancy Test
- ☐ Birth Control
- ☐ STI test
- ☐ PAP test
- ☐ Other: _____

44. What, if any, family planning services offered at your clinic are not available to adolescent clients?

_____

45. If a service is not available at your clinic for adolescents, how often do you refer them to other community agencies?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Please tell us about you:

46. Are you:

- ☐ Male
- ☐ Female

47. Are you:

- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Asian/Pacific Islander
- ☐ Native American/American Indians
- ☐ Other _____ (*please specify*)

48. Are you:

- ☐ Hispanic
- ☐ Non-Hispanic

49. What is your religious affiliation?

- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Christian (*if yes, please specify one of the following below*)
  - ☐ Catholic
  - ☐ Protestant
- ☐ Other _____ (*please specify)*

Thank you very much for taking time to respond to this survey.

I would like to receive the final report, which includes the results, of this project. You may email the document to me at the following address:

_____