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School Nurses' Awareness and Attitudes Towards Commercial Sexual Exploitation of Children: A Mixed Methods Study

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SCHOOL NURSES' AWARENESS AND ATTITUDES TOWARDS COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN: A MIXED METHODS STUDY

A Dissertation Presented

by

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ABSTRACT

SCHOOL NURSES' AWARENESS AND ATTITUDES TOWARDS COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN: A MIXED METHODS STUDY

May 2017

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Human trafficking is a global problem and a multi-billion dollar industry. Most victims are women and girls and more than half are children. In the United States, many at risk youth continue to attend school with school nurses on the frontlines. Using the Peace and Power Conceptual Model, a mixed methods study was conducted to explore their awareness, attitudes, and role perceptions in prevention of commercial sexual exploitation of children (CSEC). Two factors related to increased awareness, and positive attitudes and role perceptions to prevent of CSEC included prior exposure to working with vulnerable students, and prior education about CSEC. Two factors that inhibited identification of CSEC included an uncertainty in identifying CSEC, and a lack of collaboration with colleagues in schools. Four sub-themes were identified; 'exposure/knowledge, 'collaboration', 'role boundaries', and 'creating respite space'. Future research should target the multidisciplinary school team. Simultaneous policy efforts should focus on improving practice conditions for school nurses to support their role in identification and intervention to prevent CSEC among at risk youth.

Keywords: human trafficking, school nurses, attitudes, awareness, knowledge, commercial sexual exploitation, children, victims

DEDICATION

This dissertation is dedicated to my loving husband Jeremy and my three wonderful children Cameron, Ellary, and Gabriel. Thank you, Jeremy, for being my rock and my source of encouragement. Your steadfast love and belief in me pushed me forward. You put your hopes and dreams on hold to support mine- thank you. To my sons, Cameron and Gabriel, and my daughter Ellary, your smiles and love for me encouraged me to keep going. Thank you, my sweet hearts, for keeping a calendar, *'When Mommy Finishes Her PhD'*, so that I had no choice but to keep my promise to you.

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LIST OF ABBREVIATIONS AND ACRONYMS

AAP..... American Academy of Pediatrics
CSEC.....Commercial Sexual Exploitation of Children
DCF.....Department of Children and Families
DOJ ..... Department of Justice
ECS ..... Education Commission of the States
FBI .....Federal Bureau of Investigation
HCP.....Health Care Providers
HHS..... U.S. Department of Health and Human Services
HIV .....Human Immunodeficiency Virus
HPV.....Human Papilloma Virus
IHTPTF .....Interagency Human Trafficking Policy Task Force
IOM.....Institute of Medicine
LGBTQ ..... Lesbian, Gay, Bisexual, Transgender, or Questioning
MA ..... Massachusetts
NASN..... National Association of School Nurses
NCMEC ..... National Center for Missing and Exploited Children
NGO.....Non-Governmental Organization
NIJ..... National Institute of Justice
MSNO.....Massachusetts School Nurses' Organization
PEACE..... Praxis, Empowerment, Awareness, Cooperation, Evolvement
PPCM.....Peace and Power Conceptual Model
STI..... Sexually Transmitted Infections
TVPA ..... Trafficking Victims Protection Act
U.S .....United States

CHAPTER 1

THE PROBLEM

Background

According to the National Center for Missing and Exploited Children (NCMEC) (2014) approximately 1 in 5 girls and 1 in 10 boys are sexually abused or experience sexual assault prior to adulthood. Commercial sexual exploitation of children (CSEC), a term interchanged with sex trafficking of minors, is considered child abuse and is both a global and national health problem (Greenbaum, 2014). CSEC involves a commercial sex act by force, fraud or coercion, or involves a person who is under the age of 18 years forced to perform such acts (Trafficking Victims Protection Act [TVPA], 2000). Children are inherently vulnerable to commercial sexual exploitation by nature of being children because they are still developing cognitively and emotionally and are typically physically dependent on adults (Cole & Sprang, 2015).

Significance

It is estimated that approximately 244,000 – 360,000 children in the United States (U.S.) are at risk for CSEC annually where a majority of children in the U.S. are trafficked by their family or close friends (National Institute of Justice [NIJ], 2007). Estes and Weiner (2001) estimate upwards of 199,000 incidences of CSEC occurring in the U.S. annually. Gender inequalities exist in that girls are at an increased risk compared to

boys with estimates as high as 69% of CSEC female victims and 14% under the age of 15 years (Department of Justice [DOJ], 2004). Other identified risk factors include marginalized populations including ethnic minorities, low-income, urban backgrounds, and living in identified high-risk communities (Kruger, Harper, Harris, Sanders, Levin, & Meyers, 2013). The national average age of entry into the commercial sex industry is 12-15 years, and the most vulnerable include teenage girls with a history of childhood physical, emotional, and sexual trauma (Grace, Starck, Potenze, Kenney, & Sheetz, 2012).

The U.S. Federal Bureau of Investigation's (FBI) (2015) Operation Cross Country, part of a larger joint Innocence Lost National Initiative, has sounded the alarm regarding the growing nationwide problem of sex trafficking of minors. The FBI has been working in conjunction with U.S. states and international countries to map the paths of trafficking networks with Massachusetts (MA) identified as one of many nationwide trafficking hubs (FBI, 2015). Sexual exploitation of youth occurs across the Commonwealth; however, no statewide data on prevalence or incidence is available due to the hidden nature of the crime (Office of the Attorney General, 2013). The Child Advocacy Center of Suffolk County (2012) released a multi-agency report noting that hundreds of Boston youth have been drawn into child sex trafficking and countless more are currently at risk. In response, the MA Interagency Human Trafficking Policy Task Force (IHTPTF) was formed to address the problem of CSEC and other forms of trafficking across the state. Key goals of the task force include targeting victim identification, increasing victim services, reducing demand for sex, holding traffickers and buyers accountable, and addressing the problem of low awareness among the people

most likely to be able to identify and address it. Professionals identified in MA as likely to be able to identify CSEC victims include all law enforcement, health care providers (including school nurses), first responders, victim service providers, and educators throughout the Commonwealth (MA IHTPTF, 2013).

Purpose of Research Study

School nurses in the U.S. are considered primary sources of healthcare for children in schools across the country (Grace et al., 2012). Adams and Shineldecker (2013) point out that the school nurse health office needs to be a place where students meet a positive, caring, nonjudgmental school nurse. Each visit of a student to the school health office is an opportunity for the nurse to provide health, self-care teaching, and information about safety. The school nurse may be the last point of possible prevention and intervention for at-risk youth who may be at risk of dropping out of school, becoming truant, running away, and becoming victimized through commercial sexual exploitation. Diaz (2014) proposed the notion that the role of the school nurse is integral in increasing awareness, advancing understanding, and supporting efforts to prevent, identify and respond to CSEC. Grace et al. (2012) argue that school nurses may lack awareness, hold stigma towards CSEC, and/or deny that CSEC occurs. Furthermore, Cole, Sprang, Lee, and Cohen (2014) point out that providers consistently describe CSEC victims as "challenging clients", thus presenting a critical need to focus efforts on assessing attitudes towards CSEC victims. As leaders and facilitators of health and wellness, school nurses have three potential responsibilities: 1) to be aware of both the dangers of CSEC threatening school youth, 2) to be able to shift inner attitudes and perceptions

towards CSEC, and 3) to actively raise awareness of CSEC among teachers, school administrators, parents, and the local community in which the school is embedded.

Study Aims

Recently published preliminary studies have explored health care provider (HCP) awareness and attitudes towards CSEC in the U.S., and a limited number of studies report findings from interventional studies measuring the effectiveness of education interventions targeting HCPs. There are no available studies which include school nurses specifically and no studies address MA precisely despite the pervasive problem of trafficking in this state. Understanding awareness and attitudes towards CSEC among MA school nurses is a first and necessary foundational step to inform future development of interventions using the role of the school nurse targeting at risk youth. Furthermore, we do not currently know MA school nurses' perceived roles and responsibilities regarding prevention of CSEC or how this may feasibly fit into the role of the school nurse. Use of participatory research approaches will be an important means of understanding the current state of the science surrounding the scope and breadth of this problem, to empower MA school nurses and help to inform future research programs targeting youth at risk for CSEC within MA schools. Therefore, the specific aims of this study were to examine awareness and attitudes towards CSEC among school nurses in MA and to understand their perceived roles and responsibilities surrounding this problem.

CHAPTER II

LITERATURE REVIEW

Context of CSEC

CSEC occurs among youth who are on the margins of society such as those who have been neglected and abused (a high risk factor); live in foster care or juvenile detention centers; homeless, runaways (leave home by choice), or throwaways (told to leave home); as well as youth who identify as lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) and are rejected by their families (Institute of Medicine [IOM], 2013). Recent estimates reveal that 1 in 6 runaways become victims of CSEC, where 68% of children exploited are under the care of state social services and/or are living in foster care at the time of running away (NCMEC, 2014). Furthermore, large gaps exist between prevalence of CSEC, or populations at risk, and children who are identified as victims, presenting a crucial area for research (U.S. Department of Health and Human Services [HHS], 2009). Inaccurate estimates of CSEC in the U.S. are thought to be due to the nature of where and how the crime occurs – behind closed doors, and with low public visibility, limiting potential for intervention.

Constellation of Risk Factors

Sexually exploited youth can face barriers to accessing health services. The most pressing reason includes an inability to both access and utilize health services due to the nature and context of how sexual exploitation occurs, whereby victims are not free to do so unless allowed by their exploiter (Greenbaum, 2014). A multitude of negative health sequelae affect children who are commercially exploited, warranting a need for prompt attention and intervention from the health care community. For instance, youth experience perpetual violence, which often goes unreported due to fear of retaliation including both physical and sexual violence (Grace et al., 2012). Furthermore, reproductive health issues occur including anogenital trauma, unplanned pregnancy, untreated sexually transmitted infections (STIs), exposure to HIV, Human Papilloma Virus (HPV), and Hepatitis B, C and D (Cole & Sprang, 2015; Diaz, 2014; Grace et al., 2012; Greenbaum, 2014; Greenbaum & Crawford-Jakubiak, 2015; Kruger et al., 2013; McMahon-Howard & Reimers, 2013). Substance use and abuse has also become a paramount health concern among exploited youth who either turn to substances as a means to cope with the situation of chronic violence, fear and degradation or are forced to take substances from their exploiters as a means of ensuring total compliance (Grace et al., 2012). Substance abuse, whether used as a means to numb reality or by force, leads ultimately to addiction. Significant mental health illnesses are of great concern among exploited youth including anxiety, dissociative disorder, self-destructive behaviors, suicide attempts, and clinical depression (Cowell, 2014; Diaz, 2014; Grace et al., 2012; Greenbaum, 2014; Greenbaum & Crawford-Jakubiak, 2015). Grace et al. (2012) also identify the psychological phenomenon of Stockholm syndrome as prevalent among

CSEC victims, a phenomenon previously known among prisoners of war where the youth identify with their captors as a means of emotional and physical survival. A further health concern surrounds the notion that at-risk youth often live within dangerous communities, experience stressed relationships affecting their ability to form intimate relationships and resilience (Kruger et al., 2013). This is consistent with Grace et al. (2012) who report that victims of CSEC experience a profound sense of aloneness, and experience isolation without access to resources and support.

Risks Facing Youth Attending Schools

According to the U.S. Department of Justice (DOJ) (2010), the threat of U.S. children becoming a victim of CSEC is serious and a pressing concern in terms of barriers to intervention and prevention targeting at-risk youth where inadequate education and awareness of providers who come into contact with CSEC perpetuates the problem. According to Grace et al. (2012), many at-risk youth continue to attend school despite being commercially sexually exploited, albeit low or sporadic school attendance. Grace et al. (2012) specifically identified Boston, Massachusetts (MA) as a hot-spot of CSEC where the face of trafficking has changed within the last ten years to "going indoors" as opposed to previously out in the open on the streets. Children can be exploited through internet sites (i.e. Craigslist.com and Backpage.com), social media and text messaging, and experience systematic targeting where the exploiters (pimps) spend time isolating children with a goal of increasing his or her dependence on the exploiter for material and emotional sustainment (Grace et al., 2012).

Health Care Providers (HCPs)

HCPs are among a limited number of professionals identified as likely to interact with victims of sexual exploitation yet consistently report limited familiarity with CSEC, a lack of understanding what their role is with at-risk youth, and a lack of training opportunities as barriers to effective practice with this vulnerable population (Beck et al., 2015; Cole & Sprang, 2014; Edinburgh, Richtman, Marboe, & Saewyc, 2012; Ferguson et al., 2009; Grace et al., 2014; Isaac et al., 2011; McMahon-Howard & Reimers, 2013; Titchen et al., 2015; Wong, Hong, Leung, Yin, & Steward, 2011). Ahn et al. (2013) conducted a systematic review of the literature targeting available human trafficking educational resources for HCPs, reporting significant gaps in general. School nurses in particular are on the front lines interacting with youth routinely given that the majority of U.S. states require by law a minimum of 180 school days per year (Educational Commission of the States [ECS], 2013). However, limited research exists regarding school nurses' awareness and attitudes towards CSEC. Furthermore, limited research exists on the role of the school nurse in the prevention of CSEC.

School Nurse-Driven Interventions

Recent evidence has shown the effectiveness of school nurses in implementing prevention interventions targeting at-risk youth in schools. Promising results are evident highlighting the role of the school nurse in prevention interventions targeting obesity, tobacco use, adolescent mental health, and dating violence. Morrison-Sandberg, Kubik, and Johnson (2011) suggest that school nurses are well positioned to provide childhood obesity prevention interventions. Speroni, Earley and Atherton (2007) conducted a promising 12-week after-school fitness intervention program to prevent obesity in school-

aged youth implemented by school nurses noting the ideal environment of the school and trusted position of the school nurse (Speroni et al., 2007). Freeman, Rosenbluth, and Cotton (2012) identify school nurses as the first adults that adolescents confide in when experiencing unhealthy relationships. The authors implemented a training intervention with school nurses to increase their awareness and attitudes towards dating abuse, sexual coercion and youth exposure to dating violence (Speroni et al., 2007). Castleman, Novak, and Sposetti (2005) focused on training school nurses to screen and implement a brief intervention given identified time constraints school nurses face in their day-to-day role to prevent tobacco use among students. Targeting the role of school nurses was identified as a more sustainable and effective approach to prevention of tobacco use in school-aged youth given a realization of the optimal position of the school nurse as a frontline, trusted figure within schools (Castleman et al., 2005). A similar approach taken by Hootman, Houck, and King (2002) specifically focused on improving student academic success, and decreasing school-based violence among students with mental health issues by targeting the role of the school nurse. The approach centered on providing school nurses with information and knowledge that could help them effectively identify at-risk youth in order to implement sustainable early interventions to prevent further student risk (Hootman et al., 2002). The researchers have shown that in several key areas of risk for youth school nurses have played an important role in risk reduction.

The Role of School Nurses in Prevention of CSEC

According to the National Association of School Nurses (NASN) (2011) and the American Academy of Pediatrics (AAP) (2008), the school nurse is the best leader in the school community to coordinate school health policies and programs, providing expertise

and oversight in the provision of school health services and health promotion education. The scope of practice of the school nurse includes supporting student success through the provision of health care, addressing the physical, mental, emotional, and social health needs of students (AAP, 2008; NASN, 2011). The amount of time children spend in school presents a window of opportunity for school nurses to identify children at-risk for exploitation. School nurses may be the only health care provider interacting with youth if they are still attending schools, and thus the only hope to identify and prevent commercial sexual exploitation of school children.

School Nurse Awareness and Attitudes Towards CSEC

Awareness and attitudes of school nurses towards CSEC is poorly understood. In the context of CSEC, the philosophical worldview of school nurses potentially interacting with children at-risk of CSEC can present potentially misinformed judgment-laden care versus context-sensitive care. For example, school nurses may provide care that is framed by the opinions of others without context of the multifactorial lives of students. In contrast, school nurses may provide care in context, rejecting pre-set opinions of who students are. In order to formulate context-sensitive care inward, intentional reflection is warranted in formulating attitudes and consciously reflexive awareness of the realities of CSEC. This is consistent with the provision of socially just, morally pluralistic nursing care. A middle ground is sought between moral absolutism (truth if fixed) versus moral relativism (truth is socially constructed within individuals) (Bleazby, 2009; Hoskins, 2005; Snelling, 2003). There are a limited number of studies reporting HCP awareness and attitudes towards CSEC overall and none specifically targeting school nurses.

Instrument Measuring Awareness and Attitudes Towards CSEC

Attitudes, knowledge, or skills in clinical practice are frequently measured using survey instruments (Cook & Beckman, 2006). Ferguson et al.'s (2009) investigator-developed survey was the only instrument identified to have adequate validity and reliability to measure CSEC. Ferguson et al. (2009) developed adequate psychometrics on the survey by collecting responses with a non-probability convenience sample of professionals likely to interact with high-risk families in high-risk areas from 230 U.S. cities identified as high-risk for CSEC. Participants included individuals from Non-Governmental Organizations (NGO) (including social workers), law enforcement officials, and prosecutors and had a high survey response rate (92%). The instrument was modified to address knowledge, skills, attitudes, and awareness employing focus groups and pilot testing. Content experts and sex trafficked survivors contributed to the survey development and revisions, strengthening both content and construct validity. Additionally, the Ferguson et al. (2009) instrument was evaluated as having good instrument reliability (Cronbach's alpha awareness pretest = .93 posttest = .89; Cronbach's alpha attitudes pretest = .94; posttest = .92). Furthermore, Ferguson et al. (2009) utilized the theoretical foundations of Bloom's Taxonomy and the Andragogical Model of Adult Learning to guide curriculum development. The instrument demonstrated an increase in awareness and attitudes post-education intervention suggesting it is an effective method of measuring an education intervention.

Discussion

School nurses have a pivotal role in helping exploited youth move beyond invisibility towards a path of safety and support (Grace et al., 2012). Grace et al. (2012)

argues that school nurses may lack awareness, hold internal stigma towards, or outright deny that CSEC is occurring. Given that the most common identified means of obtaining help is through disclosure to a trusted adult, Grace et al. (2012) suggests school nurses utilize open door policies, invest in forming trusting relationships with school children and identify victims through students' disclosures. Greenbaum (2014) identified pertinent risk factors of CSEC across individual, family, community, and societal domains. Potential indicators of CSEC were identified, such as initial clinical presentation, historical factors, and a physical exam suggestive of potential risk and need for further interviewing (Greenbaum, 2014). Furthermore, an evidence-based interview-screening tool for HCPs that is sensitive to the complex situation of CSEC victims or those at-risk for exploitation may be relevant for future use in interventional studies with school nurses. Greenbaum (2014) includes definitions of common street terms used among those involved with CSEC; i.e. "kiddie stroll" refers to an area of sex work involving victims less than age sixteen years. The importance of attitude towards CSEC connected to HCPs perceptions and misjudgments that a youth is engaging in sex work has been discussed throughout the literature (Adams & Shineldecker, 2013; Cowell, 2014; Diaz, 2014; Greenbaum & Crawford-Jakubiak, 2015; Todres & Clayton, 2014). Findings include recommending that school nurses focus first on children at risk of child abuse and who are identified as abused as a population at greater risk of CSEC (Cowell, 2014). This is consistent with Diaz (2014) who points out that understanding CSEC as a form of child abuse can help HCPs change their attitudes and acknowledge the critical role they play in recognizing risk and providing assistance to victims. Greenbaum and Crawford-Jakubiak (2015) reference HCPs working in institutions (i.e.; schools) the

important role they play in identifying and intervening with youth at risk of CSEC. Todres and Clayton (2014) discuss HCP awareness in many settings (emergency rooms, urgent care centers, adolescent clinics, school clinics, shelters, specialty clinics, community health centers, health department clinics, freestanding Title X clinics, Planned Parenthood, and dental clinics) strongly suggesting that raising awareness is a first step in formulating a response to CSEC.

Positive findings are reported within available studies measuring HCP awareness and attitudes towards CSEC and provide insight in framing future study with school nurses. Attitudes and awareness were measured in the context of education interventions designed to raise awareness and change attitudes towards CSEC. Effectiveness of interventions were evaluated through pre-test and post-test surveys soliciting self-reported data, where training increased HCPs overall awareness and attitudes towards CSEC (Beck et al., 2015; Edinburgh et al., 2012; Ferguson et al., 2009; Grace et al., 2012; McMahon-Howard & Reimers, 2013; & Titchen et al., 2015). Furthermore, HCPs reported increased knowledge and confidence in identifying at-risk youth as well as attitude shifts were evident from perceiving children as sex workers to perceiving children as victims of CSEC (Beck et al., 2015; Edinburgh et al., 2012; Ferguson et al., 2009; Grace et al., 2014; McMahon-Howard & Reimers, 2013; & Titchen et al., 2015). Grace et al. (2014) report promising results in the delivery of a short 25-minute education intervention for HCPs. Results indicated a potential means of intervention delivery targeting busy HCPs yet maintaining the same effectiveness of longer educational trainings. Titchen et al. (2015) highlight the importance of training HCPs during their foundational education and present promising results in medical student and medical

resident awareness of CSEC, specifically their ability to identify victims and how to intervene. Overall, HCPs reported both a desire and need for future training opportunities in order to provide high quality care to at-risk youth and victims of CSEC, indicating important implications for application with school nurses.

Conceptual Model

Chinn and Falk-Rafael's (2015) Peace and Power Conceptual Model (PPCM) was used to guide this study and was chosen for its relevant premise on feminist philosophical thought and activism, critical emancipation and community peace-building processes. Chinn (2013) describes feminist philosophical thought built upon valuing the ideas and contributions of women, fundamental human rights for all and a rejection of the privileged condition (Chinn, 2013). *Power* results in emancipatory knowing-doing as school nurses take actions for change leading to freedom from oppression. The model is structured on *Peace* and *Power* as both a process and an outcome fueled by a dialectic struggle involving critical emancipatory knowing and doing.

Emancipatory Knowing-Doing

The model concepts (Figure 1) of emancipatory knowing-doing include the overarching conceptual acronym PEACE (*Praxis*, *Empowerment*, *Awareness*, *Cooperation*, and *Evolvement*). PEACE refers to the overall idea of *Peace*, with each letter representing pertinent concepts relevant to this proposed study. *Praxis* is defined as both knowing and doing, involving thoughtful reflection and action occurring synchronously (Chinn, 2013). School nurse awareness (*knowing*) of CSEC as a community problem will trigger critical reflection (reshaping perceptions) leading to protective action and care (*doing*). *Empowerment* involves the idea of growth in personal

strength, power and ability to act intentionally with love and respect for others, or choosing to act in solidarity with others (Chinn, 2013). As school nurses become aware of CSEC and are able to identify children at risk, they may be empowered to reject externally and internally shaped misperceptions of youth at risk. *Awareness* is defined as an active, always growing knowledge of the self and others in the community context, seeing beyond the present and integrating the past and future in order to intentionally transform the experience of minority and marginalized groups (Chinn, 2013). The model concept of *Awareness* is of particular importance to this study given its premise on the idea that transformative, conscious awareness can shape perceptions towards students at risk for CSEC. Misperceptions that school nurses may have can be shaped by long-held structures and systems in societies, which define, shape, and create the undermined experience of those who are marginalized (Chinn, 2013). *Cooperation* involves an active commitment to solidarity and work towards community cohesiveness (Chinn, 2013). School nurses are in a position of power within schools to provide leadership among school staff and administrators guiding efforts to work as a cohesive whole to intervene and protect youth at risk. *Evolvement* is defined as the commitment to transformative growth and change (Chinn, 2013). School nurses can intentionally become aware of CSEC and risks students may face through a commitment to continuing their own education. Thus, school nurses can position themselves towards transforming the lives of students within their school as well as provide leadership and education to school staff, families, students and the surrounding local school communities, consistent with the scope of the school nurse role.

Power

The process of *Peace-Power versus Power-Over Power* inevitably will cause conflict and struggle, consistent with the experience of change (Flaherty, 2010). Chinn (2013) defines *Power* as energy fueled from conscious and deliberate actions within the self that are the output of the *Peace-Power versus Power-Over* process. The model concepts of *Peace-Power* and *Power-Over* explain an inner struggle between the emancipatory will versus the individual will of school nurses shaped by societal hierarchal ideals. *Power-Over* refers to power used for the benefit of the individual, where retaining power becomes the ultimate goal at any cost to the other (Chinn, 2013). In the context of this study, students at-risk for CSEC are the marginalized group, whereas school nurses are in a position of power. It is assumed that awareness and attitudes of school nurses are internally and externally shaped, influencing the process and outcome of *Peace* when caring for students at risk. In turn, those in power within society externally shape attitudes and awareness of school nurses, which can internally shape perceptions and reactions towards youth who may be at risk. *Peace-Power* stems from a power of love for the other, where harmony with one another becomes the priority (Chinn, 2013). It involves emancipatory power which rejects the dominant use of hierarchal structural power and institutional systems in societies. Institutional barriers involve a form of oppression which adopts cultural assumptions of the dominant group, where practices of the group are viewed as the "norm" to which all others should conform to (Jenkins, Johnson, Bungay, Kothari, and Saewyc, 2015). Jenkins et al. (2015) note that it is important to explore how contextual aspects of individual lives influence health outcomes, where context is situated within structural, social and individual

features affecting health. Chinn and Falk-Rafael (2015) draw in these concepts defined as the synergistic relationship between the private and public realm of student lives. Poland et al. (2006) note that social structures shape, constrain, and reproduce human thoughts and behavior, where these structures can be specific to neighborhoods, towns, and regions. The private realm of students can present structural and/or institutional relationship barriers between students at risk and school nurses, where structural prejudice and/or racism may be present at the unconscious level of the school nurse due to a lack of awareness of CSEC. Gender, sexual identity, family background, financial strain within the family, poor family relationships, history of violence within the family unit, abuse, substance misuse, mental health issues, involvement with foster care and/or Department of Children and Families (DCF), and involvement with the Juvenile Justice System are examples of factors within the private lives of youth which can set up relationship barriers at the out-set of interactions. Inequality, the media, public policies, community violence and poverty, institutional practices at the local school, community level, and regional levels can synergistically act to further the oppressed condition of students at risk for CSEC. More importantly, it involves how students at risk for CSEC are perceived in the nursing care relationship and whether or not CSEC is recognized as a potential threat. Recognition leads to emancipation through identification, protection, and intervention, yet the inability to recognize a student at risk results in a missed opportunity that may be the last.

Peace-Power Versus Power-Over Powers

Chinn (2013) also discusses several peace-powers and their counterpart power-over powers in framing how individuals function within groups. Group norms are shaped

by the overall group culture. School nurses practice within the greater school community and culture of the multidisciplinary school team. Understanding the dynamic of group interactions and how school nursing practice is shaped in this context may influence perceptions about students at risk and their care decisions. For example, school nurses may reflect power of consciousness versus power of expediency when approaching care decisions with students. Power of consciousness takes into context the holistic view of students, the totality of their experience, what is seen and unseen. Power of expediency may be reflected in care decisions with students at risk that rely on what is most practical to manage in the moment. School nurses may practice in hierarchal settings reflecting power of division where power and knowledge belong to a set few. Power of the whole may be reflected as school nurses work to build nurturing helping networks with colleagues. School nurses may also sense actions that are based on perceptions of the totality of student lives and experiences, reflecting power of intuition. Power of causality may also be reflected as school nurses rely on a set of standards or procedures during care interactions without regard to consequences carried over into the future. Power of trust may be reflected as school nurses foster genuine human relationships with students at risk. In contrast, school nurses may approach care interactions reflecting power of fear with high risk students as decisions are controlled by fear and uncertainty. School nurses may critically understand that student lives are to be cherished and respected, reflecting power of nurturing. In contrast, school nurses may accept a diminished and under-resourced role within schools, reflecting power of use. School nurses may also approach care decisions that fit each unique student and situation, reflecting power of creativity. In contrast, power of rules may be reflected as school nurses rely solely on following pre-set

policies and expectations without regard to context while making care decisions. Table 1 presents six peace-powers and their counterpart power-over powers identified in the context of how school nurses may navigate practice within the school setting and across the school team.

The Dialectic Between Peace-Power Versus Power-Over

One major construct identified within Chinn and Falk-Rafael's (2015) (PPCM) model operationalized in this study is emancipatory knowing (*awareness of CSEC*). Another construct of importance in this study is *attitude* about CSEC and is embedded within the model concept of *Power* (*Peace-Power* and *Power-Over*). The model concept *dialectic* theoretically signifies an internal and external struggle within school nurses, fueled by awareness of personal and family factors in the private lives of youth and public influences acting as risk factors that further maintain their marginalized condition. The *dialectic* struggle influences care delivered within a *Peace-Power* or *Power-Over* nursing framework. Furthermore, the *dialectic* struggle acts as a tension between learned habits of *power-over* versus the emancipatory ideal of *peace-power*. Awareness through knowledge of CSEC acts as a powerful force behind the ability of school nurses to experience critically reflexive inner attitude shifts, resulting in deliberate choices and actions towards emancipatory knowing-doing. The *dialectic* struggle within school nurses involves knowledge of a constellation of risk factors that youth may present within a school nurse health office. Knowing and recognizing risk of CSEC, or not knowing and the potential for having misperceptions about students at risk for CSEC is at the heart of the *dialectic* struggle. Reflexive conscious awareness of the synergistic interaction between the *private realm* (family history, personal history and friendships) and *public*

realm (societal, social, economic and local political factors) can lead to identification of children at risk for CSEC. Reflexivity involves an ongoing examination of the meaning of interactions with at-risk youth. *Power* through emancipatory knowing-doing follows as school nurses become aware of the oppressive conditions of CSEC negatively affecting health, leading to empowered decision-making and action of the school nurse on behalf of youth at risk for CSEC (Figure 1).

School nurse *awareness* and *attitudes* are shaped either externally or with intentionality. The dialectic struggle represents how school nurses must reflect on how perceptions of students at risk for CSEC are shaped. In turn, this critically reflexive awareness shapes and influences how school nurses approach students at risk for CSEC under their care; either a *Peace-Power* or *Power-Over* school nursing approach. Awareness of CSEC along with the private and public influences perpetuating student risk can lead to changes in attitudes about CSEC. An emancipatory caring approach will allow students to feel valued, retain hope, and be more likely to trust their school nurse (Adams & Shineldecker, 2013). The PPCM can guide school nurses' approach to intervening among students at risk for CSEC; however, it is important to assess school nurses' awareness of CSEC.

PPCM Constructs of Interest

Awareness represents an active, growing knowledge of self and others within the world (Chinn, 2013). Awareness encompasses the ability to see beyond the present moment and in order to integrate the past and future (Chinn, 2013). Awareness is reflective of a transformative knowing, keeping in mind the experiences of marginalized

groups. Awareness further encompasses a conscious process whereby what is defined as normal by structural and institutional systems are accepted as abnormal.

Attitudes represent individual values consciously chosen, either consistent with *Peace-Power* or *Power-Over*. Attitudes are reflective of how internal values are lived and where messages are conveyed (Chinn, 2013). It is accepted that attitudes are shaped and reflective of our conscious awareness of internal values informing our actions (Chinn, 2013). Attitudes take shape externally and internally from our own thinking and ideas and can be either negative or positive. Attitudes can be reshaped and changed through awareness, experiences and actions in the context of relationship preservation and respect for others (Chinn, 2013).

Role Perceptions in Prevention of CSEC can be shaped by the dialectic struggle through awareness of CSEC and shifting attitudes towards students at risk. Role perceptions towards prevention of CSEC is reflected in either *Peace-Power* or *Power-Over* school nursing care, fueled by the dialectic struggle. Through awareness of CSEC and the private and public realm risk factors students may face, attitudes shape emancipatory knowing/doing, reflecting action and a commitment to emancipation, social justice, identification, intervention and prevention of CSEC.

Summary

Given noted success within studies measuring HCP awareness and attitudes towards CSEC, relevance for school nurses as a provider group has been considered. School nurses can gain an understanding of a constellation of risk factors synergistically interacting within the private and public realms of youth which either buffer or fuel risk for CSEC. School nurses' intentional awareness of academic and social school

experiences of students, as well as their personal, family histories, and community context can guide nurses towards identification of demographics of families at risk. Furthermore, awareness of local school policies and practices influencing sustained risk for students can impact how school nurses shape their leadership role within schools and in the local community. The intentional reflexive awareness of school nurses can lead to a shifting of more positive attitudes towards students who may be at risk for CSEC, seeing them as potential victims rather than participants in the sex trade. Attitudes and awareness of school nurses can inevitably shape how children at risk will be conceptualized and how care is delivered, where attitudes and awareness will ultimately lead to *Peace-Power* rather than *Power-Over* school nursing practice with students at risk for CSEC.

CHAPTER III

METHODOLOGY

Study Design

A descriptive, two-phased mixed methods study with a sequential, explanatory design was conducted. The target population was school nurses in Massachusetts (MA) given the Commonwealth of MA has been identified as a "hot spot" for CSEC, especially in the city of Boston (Grace et al., 2012). A sequential explanatory design was selected, guided by the PPCM through conceptual linkages in the literature and through research question development. Awareness and attitudes of MA school nurses towards CSEC have not been formally examined before and the concepts within the PPCM were explored further in-depth (Figure 2).

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Phase one consisted of revising the Ferguson et al. (2009) survey instrument for school nurses. In order to ensure the stem of each question was appropriately directed to school nurses. Administration of the *Assessment of School Nurse Awareness and Attitudes Toward CSEC* survey was completed to collect baseline data regarding awareness, attitudes, and role perceptions school nurses in MA have about CSEC. Quantitative data was then analyzed in order to inform and develop questions that would be asked of the school nurses qualitatively during the second study phase. A qualitative participant selection model was used to purposefully select participants from the

quantitative arm for phase two--focus group study (Creswell & Plano Clark, 2007). Qualitative data was analyzed after completion of focus groups. Interpretation of qualitative results helped to further explain and interpret findings from the quantitative component of the study (Creswell & Plano Clark, 2007). Emphasis was given to the qualitative component of the study in order to capture MA school nurses' awareness, attitudes, and role perceptions towards CSEC and potential prevention measures.

Phase One – Quantitative Phase

Target Population and Sampling Frame

A cross-sectional quantitative survey method was used for this phase of the study to measure school nurses' awareness and attitudes using the *Assessment of School Nurse Awareness and Attitudes Toward CSEC* survey. The population targeted for the phase one arm included school nurses in Massachusetts (MA). The Massachusetts School Nurses' Organization (MSNO) membership formed the sampling frame. The current listed membership of MA school nurses is 800 members (Marie DeSisto, Executive Director, MSNO, personal communication September 2, 2016). MSNO sent the survey electronically to the entire MA membership. MSNO's policy is to not give researchers access to member names or contact information but rather they facilitated study recruitment by sending emails to its members.

Sampling Design

Sampling steps included electronic survey recruitment to the entire population of MA MSNO members (current membership 800). Participants were recruited through MSNO beginning in October of 2016. This phase of the study consisted of piloting the *Assessment of School Nurse Awareness and Attitudes Toward CSEC* survey. At this

stage in the science school nurses have not been studied, therefore we cannot ascertain power calculations to guide targeted sample size, however, it was a goal to over-recruit in order to obtain a final sample size of at least 150 MA school nurses to be able to draw statistical conclusions. During phase one, participants were asked if they are willing to be contacted after the survey for future study purposes, and if so they provided their email and preferred phone contact information.

Quantitative Data Collection

Collection and management of data occurred through online survey administration using the Qualtrics survey software tool. Qualtrics is widely known for its ease of use and for its stability across web platforms and computer systems and ease of use for data analysis purposes. Participants may be more familiar with Qualtrics versus another survey software platform since MSNO utilizes Qualtrics for their annual member surveys (NASN, 2016). MSNO distributed the survey to its members by email containing the study recruitment letter and link to enter the survey. In order to increase survey response rate and avoid non-response and incomplete surveys, participants were given an incentive to enter their names into a raffle for an Apple iPad drawing upon completion of the survey. Respondent information associated with the raffle drawing was kept separate from survey data. After completion of data collection through Qualtrics, survey data was transferred to Microsoft Excel, de-identified and assigned an identification number and uploaded. Participant contact information for the Apple iPad drawing was housed in a second Microsoft Excel file and assigned a number, and a third Microsoft Excel file contained the contact information of participants who indicated willingness to be contacted for phase two of the study. All files were housed on a locked,

password-protected computer. Data was encrypted using Apple FileVault encryption software provided by the University of Massachusetts Boston Instructional Technology (IT) department in order to protect all participant data.

The Survey

The *Assessment of School Nurse Awareness and Attitudes Toward CSEC* survey was used and was adapted from the Ferguson et al. (2009) survey instrument (Appendix A). Permission was obtained to revise the survey (Dr. Kristin Ferguson-Colvin, personal communication February 3, 2016). Revisions included altering the question stems to fit the population of interest (school nurses), to develop additional questions targeting school nurse role perceptions, and to measure the constructs of interest from the conceptual framework (Appendix A). Evaluation of face validity was conducted with a Pediatric and Family Nurse Practitioner as content experts with experience in school health. Following assessment of face validity, the *Assessment of School Nurse Awareness and Attitudes Toward CSEC* survey was comprised of sixty-six questions, including demographic data and measurement of awareness and attitudes of CSEC. Questions included descriptive characteristics of school nurses and the school setting. The last survey question was open-ended and asked if there was anything they would like to add. Likert scales (5-point) were used and values treated as continuous reflecting awareness and attitudes measuring levels of agreement (1= not at all; 2= somewhat; 3= average; 4= above average; 5= very much). Higher scores indicated higher levels of awareness and attitudes.

Awareness. Awareness was measured as three parts: awareness of student vulnerability, definition of CSEC, and understanding the impact of CSEC. Questions included awareness of the broader problem and scope of CSEC as well as about prior training

activities regarding human trafficking and/or CSEC. Four items measured awareness of the impact of CSEC (e.g., How strongly do you agree that victims can still be students attending school?). Questions also included awareness of student vulnerability (e.g., How familiar are you with the academic achievement levels of students under your care?). These questions were derived from the PPCM to measure school nurse awareness of student private (family history, personal history and friendships) and public realm (societal, social, economic and local political) risk factors. Four items measure awareness of CSEC specifically (e.g., How familiar are you with the term Commercial Sexual Exploitation of Children?).

Attitudes. Attitudes toward CSEC were measured by two factors: pathways/precursors to CSEC and victim identification. Questions were developed to address research question two and were derived from the PPCM to measure school nurse attitudes towards students at risk for CSEC (e.g., How strongly do you agree that students who run away are difficult to work with?).

Role Perceptions. Questions assessed the school nurse's perceptions regarding their role in victim identification and engagement (e.g., How strongly do you agree that time is a barrier for school nurses to identify CSEC?). This measure includes items developed to address research question three in order to inform a future study with school nurses.

Quantitative Research Questions

1) What is the awareness of MA school nurses related to CSEC?
2) What are the attitudes of MA school nurses related to CSEC?
3) What are the perceived roles of MA school nurses regarding prevention of CSEC?

4) Is there a relationship between school nurses and their school setting in regard to demographic characteristics and their awareness, attitudes, and role perception regarding CSEC?

Quantitative Data Analysis Plan

Power analysis was also conducted to estimate sample size for pilot studies (Viechtbauer et al., 2015). Survey completion and response rates were calculated and reported. STATA version 14 statistical software was used to analyze descriptive and inferential statistics based on a set parameter, sample mean, standard deviation, sampling error, set at a 95% confidence interval. Descriptive statistics was utilized to examine demographic and school setting characteristics by using frequency distributions, means, standard deviations, and ranges. The last survey question was open-ended asking (*Do you have anything else to add?)* and was analyzed using content analysis and straight qualitative descriptive methods. Each scale section measuring *awareness, attitudes,* and *role perceptions* were tabulated and added together for total scale scores. Inter-item reliability was conducted using Cronbach's α correlation coefficient with a range of 0 to 1, a score greater than 0.7 was used as a cutoff point and considered acceptable. Bivariate analysis was conducted to examine the strength of association between the *awareness, attitudes* and *role perception* scales using Pearson's *r* correlation coefficient. Inferential statistics were used to explore data from the following measures: Student Vulnerability Awareness, Definition of CSEC, Understanding the Impact of CSEC, Pathways/Precursors to CSEC, and Victim Identification. Exploratory multiple linear regression analysis was conducted to explore the continuous outcome variables

awareness, *attitudes*, and *role perceptions* and respondent demographics, school, community and student factors identified through the PPCM.

Phase Two – Qualitative Phase

Qualitative Methodology

Qualitative description was utilized as a qualitative methodology for study phase two. Qualitative description is a method in which researchers stay close to their data. Qualitative descriptive studies may begin with an underlying theoretical framework from which to collect and analyze data (Sandelowski, 2010). The variables specific to CSEC employed within PPCM were discovered through the literature review and were further tested with MA school nurses in the qualitative study phase. As Sandelowski suggests, an open-mindedness to preconceptions and theoretical leanings derived from the literature was maintained regarding fit of the PPCM through the responses that the MA school nurses provided. Descriptive qualitative methods allowed for greater conceptualization of school nurse attitudes and awareness towards CSEC and their role, allowing for greater depth of meaning connected to quantitative study results.

Sampling Design

Purposive sampling methodology was used for the qualitative arm. Purposive sampling is a nonprobability sampling method used when the intention is to select participants for a specific purpose or unique position (Schutt, 2012). School nurses in MA are the population of interest, considered 'key informants' regarding investigating their awareness and attitudes towards CSEC and their perceptions regarding their role in prevention. Purposive sampling includes purposefully selecting participants who elected to be contacted after completing the on-line survey. The investigator purposefully

selected 6-8 participants per focus group from rural, suburban and urban areas in order to further understand perspectives of school nurses living in different geographical areas of MA and their attitudes and awareness towards CSEC. Participants were also selected from differing school settings: private/public, elementary/middle/high school, and special education. Three focus groups and one in-depth individual interview were conducted. The investigator attempted to over-recruit by two participants per focus group in order to account for risk of no-shows. Recruited participants were contacted one week before the scheduled focus group by email, followed by a reminder call the night before.

Qualitative Data Collection

Qualitative data was collected using a focus group approach employing a semi-structured interview guide (Appendix B). Questions were developed from the results of the survey as well as from the PPCM. Questions were developed to understand awareness and attitudes among MA school nurses, which may shape the dialectic struggle of the PPCM: *Peace-Power* versus *Power-Over* school nursing practice. The investigator and a nurse researcher with qualitative research expertise served as co-moderators, guiding the group discussion in keeping with the research questions. Focus groups were held in order to allow for semi-structured discussion among participants and to allow for the group dynamic of interaction and expression of ideas shared relating to the constructs under study (Polit & Beck, 2008). It was anticipated that discussion among participants would prompt greater depth of understanding regarding school nurses' awareness, attitudes and role perceptions towards addressing CSEC. Focus group data also provided insight into participants' perceptions regarding their experiences taking the survey as well as input into the survey questions for future development. Focus groups were held in

easily accessible locations in MA in order to limit participant burden in traveling. Focus group duration was targeted at approximately ninety minutes and light refreshments were provided. Participants gave informed consent to both participation and audiorecording prior to commencing the focus groups. The focus group audiorecordings were transcribed verbatim. The investigator took careful analytical field notes during and immediately after the focus groups, noting participants' demeanor and behaviors during the groups. At the completion of each focus group, participants were given a gift card in the amount of $25.00 for their participation.

Qualitative Research Questions

1) What factors influence MA school nurse levels of awareness and attitudes regarding CSEC?
2) What factors influence MA school nurses' role perceptions regarding CSEC prevention?
3) What are the barriers and facilitators to CSEC prevention within the role of the MA school nurse?

Qualitative Data Analysis Plan

Two individuals analyzed the qualitative data and then met to compare their coding. A third individual reviewed the transcripts and developed codes. Qualitative data were analyzed using thematic coding analysis approach to search for common patterns and themes that emerged from focus group data. The NVivo software program was used as a tool to organize and analyze qualitative data. Participant statements or phrases essential to the experience of school nurses were highlighted and pulled out with sensitivity to both the group and individual levels in how themes emerged as well as how

they reflected on field note data. Focus group data was integrated with the survey results and interpreted within the context of the PPCM, with particular attention to the peace-power and power-over powers (Table 1).

Descriptive and interpretive validity was sought in the research process using qualitative description methodology (Sandelowski, 2000). Maxwell (1992) describes descriptive validity as an accurate accounting of events that most people would agree upon if observing the same event, whereas interpretive validity involves an accurate accounting of the meanings participants attribute to those events, and the participants would agree that the meanings were accurate (Maxwell, 1992). Munhall (2007) also notes the value of theoretical validity, credibility, confirmability and transferability, which are essential components in establishing rigor in qualitative research. Theoretical validity was sought in terms of further testing the concepts developed in the PPCM and their theoretical linkages with school nurses themselves. Credibility was sought through engagement with school nurses through multiple focus groups and connecting to the pilot survey results. Confirmability was evaluated during analysis of qualitative data, specifically looking for repeated themes and evidence of saturation. Findings were evaluated for transferability or whether or not findings could be transferred to the broader population of school nurses in MA and perhaps other geographic regions.

Human Subjects Protection

Institutional Review Board (IRB) approval was obtained in March 2016 from University of Massachusetts Boston (UMB). Participants recruited for study phase one provided informed consent consistent with recommendations of the UMB Office of Research and Sponsored Programs with an option to select “agree” or “disagree” prior to

commencing the survey. It was assumed that informed consent was obtained for participants who completed the online survey. Prior to commencing the phase two focus groups, informed consent was received for both participation and audio-recording of the groups. Participation in the study was voluntary and confidentiality was maintained. Survey data was de-identified and participants were assigned numbers. Participant names and contact information for the phase one Apple iPad incentive drawing was housed in a separate excel file. All data was kept on a locked, password-protected computer with all data encrypted. Data was encrypted using Apple FileVault encryption software provided by the University of Massachusetts Boston Instructional Technology (IT) department. Participant names and contact information of those who agreed to be contacted after survey completion was also housed in a separate excel file. Qualitative data, including the digital audiofiles, was stored on a locked, password-protected computer and all data were encrypted. Three members of the research team reviewed the focus group and interview transcripts.

CHAPTER IV

RESULTS

The purpose of this chapter is to present results of a mixed methods study conducted to understand awareness, attitudes and role perceptions of Massachusetts school nurses towards CSEC. Most respondents completed the full survey, with few leaving blank responses or incomplete surveys. Missing data were evaluated for trends and no significant trends were noted among respondents who left blank response items compared to those who completed the survey in full.

Phase One - Quantitative Phase

Study Sample

Power. Viechtbauer et al. (2015) describe calculating sample size in pilot studies when the true probability of detecting differences within a study sample is unknown in general practice. Sample size was estimated using Viechtbauer et al.'s (2015) recommendations using a chosen 95% confidence level and significance level of $p \leq 0.05$ to detect meaningful changes in attitudes, awareness and role perceptions among respondents. A sample of at least 59 school nurses was needed to draw statistically significant conclusions. A final sample of 112 respondents exceeded the minimum sample size needed.

Normality Analysis. Kernal density plot of residuals and quantile-quantile (Q-Q) plots were conducted to test for normality of the study sample (Rosner, 2010). Q-Q plots and kernel density plots of residuals confirmed the study sample followed a normal distribution. Given a normally distributed study sample and continuous outcome variables of awareness, attitudes and role perceptions, exploratory analysis using multiple linear regression was selected. This approach was also consistent with analysis methodology in the Ferguson et al. (2009) study.

The MSNO sent the survey electronically by email and posting a link on their member discussion board targeting the 800 MA school nurse members who had previously indicated willingness to be contacted for research purposes. Four respondents reported that they were not practicing in a school setting; therefore they were removed from the analysis. A total of 124 MSNO members responded to the survey during the month of October, 2016 and a total of 112 nurses completed the survey, yielding an overall survey response rate of 16% and a completion rate of 90%, respectively. Recruitment of this study population was challenging and initial response was low prompting a total of four email reminders sent throughout the month of October. Previous study targeting the MSNO members met similar challenges in soliciting responses to electronic surveys, with approximately 240 members responding on average across a period of several months (Marie DeSisto, MSN, RN, NCSN, Executive Director MSNO, personal communication September 18, 2016).

Survey Analysis

Descriptive statistics of the survey respondents were compiled using STATA 14 to explore respondent demographics and responses to survey items.

Demographics

Respondent demographics are presented in Table 2. Almost all school nurse respondents (98%) reported currently practicing as a registered nurse in a school setting in MA, with a mean of 12.92 years in that capacity (SD 7.21). The number of years in school nursing practice ranged from 0.5-29 years; baccalaureate or masters-prepared are 44.64% and 43.75% respectively, and a few school nurses reported education preparation at the associates or post-master's levels, at 3.57% and 8.04% respectively. Just over half of respondents (56.25%) reported that they are not required by their employer to have school nurse service credentialing. All respondents were female, with an age range of 24-68 years, M=53 (SD 9.68).

School Setting Characteristics

School setting characteristics are presented in Table 3. School setting questions were asked in order to gain insight into what types of school settings respondents were working in as well as how many students the nurses are responsible for. Approximately 60% of respondents reported working with elementary age students, whereas 26% reported working in high schools, 12% in middle schools, and less than 1% (0.89%) in a post-high school special education transition program. Most respondents (85%) reported working in traditional public schools, while 5% reported working in public charter schools, 6% in private schools, and 3.6% in special education designated schools. The mean number of students that nurses reported being responsible for daily and/or directly providing nursing care to was approximately 586 students (range 50-4000, SD 544.42). Respondents also reported large variability in the total number of students that they are responsible for in their entire school district (range 80-7100, M=627 students, SD

808.59). There were four respondents who reported that they were not responsible for any students directly and after analyzing their responses to the last open-ended survey question (*do you have anything else to add?*) all four indicated that they work as school nurse administrators and do not directly provide nursing care in their roles. Responses to survey items addressing total student responsibility and direct care numbers were recoded to missing for nurse administrators who responded "0" to these questions to avoid skewed results. Most respondents (62%) reported working in a suburban location in MA, with 26% working in urban areas, and 12% working in rural areas. Only 17.86% reported working in a district that has a school-based health clinic.

School Community and Student Risk Factors

School community demographics and additional respondent answers to student risk factors are presented in Table 4. Respondents were asked questions about the greater school community and additional student risk factors identified through the PPCM. Questions were asked about the geographic location and diversity of the schools. Questions about community crime, joblessness, and student arrival to school were also asked. Under a fourth of respondents (18.75%) reported that the surrounding local school community is unsafe, 36.61% felt that their local school community is somewhat safe, whereas just under half of respondents felt that their local community is safe (44.64%). Poverty was reported as somewhat of a problem by 40% of the nurses, whereas 39.29% reported working in more affluent communities, and 20.54% reported working in impoverished communities. Questions about community diversity were also asked given that the literature review showed that minorities are at higher risk of CSEC. About one-third (37.5%) reported that their schools were diverse, where as 14.29% of reported no

diversity in their school setting. Most respondents (63%) indicated that students arrive to school via a school bus. Some respondents (14%) indicated students arrive via private car, and 5% stated students arriving via public transportation. Also, 5.36% of respondents indicated that they are unsure how students arrive to school.

Respondents were asked if they care for special education students. The majority of respondents reported that they do care for special education students (93.75%) with a few respondents reported that they are unaware if they do or not. Respondents were asked a second question regarding their involvement in the Individualized Education (IEP) or a 504B team processes, which federally mandate that students with any disability, including learning disabilities are protected underneath the Office of Civil Rights (OCR) and the Americans with Disabilities Act (ADA), and must be accommodated to access educational curriculum, social-emotional wellbeing commensurate with grade-level peers, and access to the full school and surrounding community (United States Department of Education, 2009). These questions were asked given students with learning and/or medical disabilities are a vulnerable population at risk for CSEC and it is poorly understood what role school nurses play in the legal IEP/504B team process. Most respondents reported that they are involved in the IEP/504B team process for special education students (89%), however level of involvement was not assessed in the survey and was addressed in the qualitative phase of the study.

Reliability of Awareness, Attitudes and Role Perception Scales

Cronbach's α was used to determine reliability of the scales (Table 5). Scores were correlated for each item with the total score for each respondent and results were compared to the variance for each item score. The awareness scale included fifteen

items (M=46.05; SD 9.07). The resulting alpha test-scale coefficient was 0.87 indicating overall high-scale reliability. The attitudes scale included sixteen items (M=46.25; SD 6.62). The resulting alpha test-scale coefficient was 0.74, indicating overall scale reliability. The role perceptions scale included twelve items (M=34.34; SD 3.83). The resulting alpha test scale coefficient was 0.70, indicating adequate scale reliability. All items were retained for all three of the scales as no one particular item appeared to significantly decrease the alpha if deleted.

Univariate Analysis of Awareness, Attitudes and Role Perceptions

Awareness. The CSEC awareness score range was 23-67 (M = 46.05 SD 9.07) (Table 6). Just under half of respondents reported that they are aware of student achievement levels on average (42.86%). When asked about familiarity with student tardiness and absences, just under half of respondents (40.18%) reported high levels of awareness. Respondents were asked questions about their awareness of family, peer, and dating relationships of students. Just under half of respondents reported that they are aware of student family relationships and student peer relationships. Over half of respondents reported somewhat to no awareness of student dating relationships (*somewhat* 25.89%; *not at all* 30.36%).

Respondents were also asked about their awareness of the social, emotional, and mental health status of students. Approximately half of respondents reported high levels of awareness of the social emotional status of students (*above average* 48.21%; *very much* 12.50%). When asked about student learning and/or medical disability diagnoses of students, over three-fourths of the nurses (76.79%) reported high levels of awareness. A question was asked regarding familiarity with students who are living in foster care

and/or DCF custody and approximately half of respondents reported high levels of awareness (53.57%).

Respondents were also asked about their familiarity with the term *throwaway* kids. Just under half of respondents reported low to no awareness of the term *throwaway kids* (*somewhat 28.57%*; *not at all* 11.61%). Lastly, respondents were asked four items about their awareness of CSEC. When asked about awareness of human trafficking in general, approximately half of respondents reported low to no awareness of human trafficking (*somewhat* 31.25%; *not at all* 13.39%). Likewise, approximately half of respondents (*somewhat* 25.89%; *not at all* 16.96) reported low to no awareness of the CSEC term. Similar results were found when respondents were asked questions about the multiple forms of CSEC, the scope of the CSEC problem locally and nationally, and the control and coercion methods used by exploiters. Over half (60%, and 58%, respectively) of respondents reported low to no awareness to these survey items.

Attitudes. Table 7 presents survey responses to items measuring attitudes towards CSEC. Respondents were asked questions targeting attitudes towards student risk and vulnerability of CSEC developed through the PPCM. The mean total attitudes score was 46.25 (range= 30-63; SD 6.62).

Respondents were asked about their level of agreement with CSEC as a problem for school age children in the U.S. Over three-fourths of respondents reported that they do not agree that CSEC is a major problem for school aged children in the U.S. (*above average* 14.29%, *very much* 70.54%). Over three-fourths of respondents reported that they do not believe that students who consent to commercial sex are victims of CSEC (*above average* 4.46%, *very much* 91.07%). When asked if CSEC is related to child

abuse, over three-fourths of respondents reported agreement with this item (*not at all* 8.93%, *somewhat* 14.29, *average* 28.57, *above average* 14.29, *very much* 33.93). Over three-fourths of respondents reported that they believe victims of CSEC should be reported to DCF (*above average* 10.71%, *very much* 79.46%). When asked, items targeting respondent attitudes towards female and male victims of CSEC, respondents held similar attitudes towards agreement that both sexes are at risk for CSEC. Most respondents agreed that female students can be at risk for CSEC (*average* 36.61%, *above average* 21.43%, *very much* 20.54%). Similarly, most respondents also agreed that male students can also be at risk for CSEC (*average* 47.32%, *above average* 11.61%, *very much* 16.07%).

Respondents also answered items measuring attitudes towards student vulnerability of CSEC developed in the PPCM. Respondents were asked about their attitudes towards the economic profile of CSEC victims. When asked *how strongly do you believe that victims of CSEC always come from situations of poverty*, most indicated that they do not agree that CSEC can only affect students living in poverty situations (*not at all* 46.43%, *somewhat* 24.11%). When responding to the item *how strongly do you agree that students who frequently run away are emotionally at risk?* over three-fourths of respondents held very positive attitudes towards emotional risk of runaways (*above average* 23.21%, *very much* 65.18%). When responding to the item *how strongly do you agree that students who frequently run away are difficult to work with?* almost all of respondents pointed to the difficulty of working with students who frequently run away (*above average* 47.32%, *very much* 12.5%). Less than half of respondents indicated agreement that students that identify as LGBTQ are more at risk to run away. Less than

half of respondents also indicated agreement that students that identify as LGBTQ were not at risk to run away (*above average* 20.54%, *very much* 10.71%).

Respondent attitudes towards children getting out of CSEC was measured through the survey item *how strongly do you agree that children can get out of trafficking by asking for help?* Respondents disagreed that students can get out of CSEC by asking for help (*not at all* 22.32%, *somewhat* 33.93%). When responding to the survey item *how strongly do you agree that children who are victims of CSEC may still be attending school?* over half of respondents reported that they agree that students attending school can be victims of CSEC (*average* 37.5%, *above average* 28.57%, *very much* 20.54%).

Of respondents who held positive attitudes towards the survey item of exploiters potentially attending school, 34.82% expressed average agreement. Most respondents held positive attitudes (*average* 32.14%, *above average* 33.04%, *very much* 18.75%) towards agreement that CSEC is a major problem affecting youth today. Respondents were asked two survey items measuring attitudes towards students in their school specifically and their risk of CSEC or involvement in CSEC. Of respondents who held negative attitudes towards the survey item of suspecting student involvement in CSEC, approximately two-thirds (64.29%) reported that they do not suspect any of their students are involved in CSEC. However, over half of respondents indicated that they have suspected that their students may be involved in CSEC (*average* 29.46%, *above average* 19.64%, *very much* 10.71%). Likewise, of respondents who held negative attitudes towards the survey item of suspecting a student was a victim of CSEC, most reported *not at all* (64.29%) or *somewhat* (17.86%).

Role Perceptions. Table 8 presents survey responses to items measuring respondent role perceptions regarding prevention of CSEC. Respondents were asked twelve items targeting understanding their perceptions towards incorporating CSEC prevention into their roles. The mean total role perceptions score was 34.34 (range= 27-45; SD 3.83). Of respondents who held positive role perceptions regarding the importance of knowing about CSEC as a school nurse, 56.25% responded *very much*. Respondents were asked *how strongly do you agree that it is appropriate for school nurses to screen students for CSEC?* and just under one-third of respondents (32.14%) responded *above average*. When asked about knowing who to call for help in their role as a school nurse, approximately one-third responded with negative role perceptions (*not at all* 15.18%, *somewhat* 21.43%). Under one-fourth of respondents held average role perceptions towards knowing who to call for help if faced with a CSEC victim (22.32%). Of respondents who had positive role perceptions towards school nurses screening for CSEC, over one-third of respondents felt that school nurses can screen for CSEC (*above average* 28.57%, *very much* 16.96%).

Respondents were asked six survey items measuring role perceptions towards barriers to prevention of CSEC. Questions measuring respondent perceptions to potential barriers included knowledge, time, large student numbers, and funding limitations. Respondents were further asked if there were barriers to preventing CSEC in their role as a school nurse. Of respondents who perceived that there are knowledge barriers for school nurses to prevent CSEC, approximately one-third responded *somewhat* and approximately one-fourth responded *average*, whereas one-third responded *not at all*. Most respondents reported that time is a barrier in their role as a school nurse to prevent.

Approximately three-fourths of respondents indicated that they felt very strongly that school nurses do not have time to screen for CSEC. Approximately three-fourths of respondents felt strongly that large student numbers present a barrier to screen for CSEC (*average* 21.43%, *above average* 43.75%, *very much* 34.82%). Most respondents also reported that funding limitations are a barrier to preventing CSEC in their role as a school nurse (*above average* 34.82% or *very much* 34.82%). When responding to the survey item *how strongly do you agree that there are no limitations for school nurses to identify CSEC?* 35.71% reported *not at all*, 29.46% reported *somewhat*.

Respondent perceptions towards school nurse involvement in preventing CSEC was examined through the survey item *how strongly do you agree that the issue of CSEC should be handled by law enforcement only not school nurses?* No respondents reported disagreement that the problem of CSEC should be handled by law enforcement only, indicating negative role perceptions overall (*average* 25.89%, *above average* 28.57%, *very much* 45.54%).

Bivariate Analysis of Awareness, Attitudes, and Role Perception Scales

Table 9 presents analysis of the correlation between the survey scales measuring the constructs awareness, attitudes and role perceptions in prevention of CSEC. Pearson's *r* correlation coefficient was used to assess the strength of association between scales. Cohen's (1988) conventions to interpret effect size accepted in psychological research was used to interpret the correlation coefficients; a correlation coefficient of .30 is considered a moderate correlation; and a correlation coefficient of .50 or larger is considered a strong correlation. There was a moderate positive correlation between awareness levels and attitude levels reported by respondents ($r = 0.29$, $p = 0.003$).

Likewise, there was a moderate positive correlation between awareness levels and role perception levels reported by respondents ($r = 0.30$, $p = 0.001$). Similarly, there was a moderate positive correlation between attitude levels and role perceptions reported by respondents ($r = 0.38$, $p < 0.001$). In general, respondent awareness, attitudes and role perceptions have a statistically significant linear relationship. The direction of the relationship is positive, meaning awareness, attitudes, and role perceptions tend to increase together. While correlations between the scales were consistently positive and statistically significant, the strength of the correlations were generally moderate. After examining the data further for linearity between the scales by visually inspecting scatterplots, the presence of outliers were not noted. It is possible that survey questions were misread and subsequently not answered as the respondent had intended. Measurement error is also a possibility, including potential participant fatigue in completing the survey or environmental factors, as well as administration errors including possible ambiguity of questions. Repeating the survey in future study with school nurses will be important to compare results and draw further conclusions about correlation between the awareness, attitudes and role perceptions in prevention of CSEC scales.

Exploratory Analysis

Step-wise exploratory multiple linear regression analysis was conducted to examine relationships between levels of awareness, attitudes and role perceptions and respondent age, education level, whether or not they are required to hold the school nurse service credential, type of school setting, geographic location (rural, suburban, urban), community safety, community economic conditions, school diversity, how students arrive to school, presence of a school based health clinic, primary student body (elementary,

middle school, high school, transitions program), whether or not respondents reported working with special education students, and if they reported working with the IEP or 504B teams. A p value of ≤ 0.05 was considered statistically significant.

In the final model, some statistically significant findings were noted between respondent awareness and education level, prior CSEC training, how students arrive to school, student body, and whether respondents report working with special education students (Table 10). Respondents who reported having a baccalaureate degree compared to an associate's degree were more likely to have higher awareness of CSEC ($p = 0.05$). Respondents reporting that they held a post-master's degree compared to an associate's degree were highly likely to have higher awareness of CSEC ($p = 0.02$). Prior training in CSEC was a highly significant predictor of higher awareness of CSEC compared to those who had no prior training ($p < 0.001$). Respondent knowledge of how students arrive to school was a significant predictor of awareness. Those who reported not knowing how students arrive to school compared to those who reported knowing were significantly less aware of CSEC ($p = 0.03$). One significant finding was noted between respondent awareness of CSEC and student body. School nurses who reported currently working with high school students compared to elementary students were significantly less aware of CSEC ($p = 0.003$). Lastly, whether respondents reported working with special education students was a significant predictor of awareness of CSEC. Interestingly, respondents reporting that they do work with special education students were significantly less aware of CSEC as compared to respondents reporting that they do not work with special education students ($p = 0.04$). Respondent age, number of years in school nursing practice, whether they are required to hold a school nurse service

credential, type of school setting, geographic location, community safety, community economics, school diversity, presence of a school based health clinic, and involvement in the IEP/504B Team were not significant predictors of awareness of CSEC in this analysis. The awareness final model was significant ($p < 0.001$, $R^2 = 53.5\%$). The R^2 value indicates that 53.5% of the variation of the dependent variable (awareness level) is statistically explained by variation in the independent variables (education level, prior CSEC training, how students arrive to school, student body, and whether respondents report working with special education students) in the regression analysis.

There were some significant findings noted in the final model between respondent attitudes towards CSEC and prior CSEC training, community safety, school diversity, and whether respondents reported working with special education students (Table 11). Prior training in CSEC was a significant predictor of attitudes towards CSEC. Among respondents who reported prior CSEC training compared to those with no prior CSEC training, significantly more positive attitudes towards students at risk for CSEC were noted ($p = 0.02$). Likewise, school nurses who work in communities that they identify as unsafe compared to safe have more positive attitudes towards students at risk for CSEC ($p = 0.02$). Respondents who reported working in diverse school settings compared to those reporting no diversity held significantly more positive attitudes towards students at risk for CSEC ($p = 0.03$). Consistent with respondent awareness of CSEC, respondents who reported working with special education students were noted to have significantly negative attitudes towards students at risk for CSEC ($p = 0.01$). The attitudes multivariable final model was significant ($p < 0.001$, $R^2 = 26.7\%$). The R^2 value indicates that 26.7% of the variation of the dependent variable (attitudes level) is statistically

explained by variation in the independent variables (prior CSEC training, community safety, school diversity, and whether respondents reported working with special education students) in the regression analysis.

Table 12 presents an exploratory analysis of the relationships between respondent role perceptions towards preventing CSEC and respondent demographics and school, community and student factors identified in the PPCM. Some significant findings were noted between respondent role perceptions towards preventing CSEC and prior CSEC training, student body, and whether respondents reported working with special education students. Consistent with findings noted in the awareness and attitudes scales, prior training in CSEC was a significant predictor of more positive attitudes towards incorporating prevention of CSEC in respondents' role as a school nurse ($p < 0.001$). One significant finding was noted between respondent role perceptions and working with the post-high school transitions program student body compared to working with elementary students. School nurses working with post-high school transitions program students were significantly more likely to have higher attitudes towards incorporating prevention of CSEC in their role as a school nurse ($p = 0.01$). Lastly, whether respondents reported working with special education students was a highly significant predictor of perceptions towards incorporating prevention of CSEC in the school nurse role, where those who reported working with this vulnerable population had lower perceptions towards prevention compared to respondents reporting that they do not work with this student population ($p = 0.001$). The role perceptions multivariable final model was significant ($p < 0.001$, $R^2 = 17.6\%$). The R^2 value indicates that 17.6% of the variation of the dependent variable (role perception level) is statistically explained by variation in the

independent variables (prior CSEC training, student body, and whether respondents reported working with special education students) in the regression analysis.

Open-Ended Survey Question

Eighteen participants provided comments in an open-text field in response to *Do you have anything else to add?* This open-ended survey question was asked to inform development of the second study phase focus group moderator guide. Respondents provided insight into their awareness of student risk for CSEC, role barriers in prevention and comments about the need for education programs for school nurses. Respondents who shared prior exposure to students at risk for CSEC or victims of CSEC expressed working with high risk populations and experiencing a sense of shock when finding out. Some responses included:

> "I have worked in secure treatment facilities for children with major mental illnesses and have known victims of sexual trafficking"
>
> "I have had students who were victims of CSEC- I was shocked when I found out."
>
> "I had a student in my previous district who was brought to the US with a 'relative' as a restevek [domestic servant], but I hadn't heard of that until I researched it after meeting the student."

Respondents who did not express exposure to working with high risk student populations or prior exposure to students at risk for CSEC expressed that they did not necessarily perceive that their students are at risk. Similarly, respondents shared perceptions that elementary students in affluent areas are not necessarily affected by the CSEC problem. Some responses included:

"I work in an elementary school that ends at grade 5. Although I recognize this as a very real and devastating problem, when time for professional development is limited, it may not be my first choice to attend educational opportunities on this topic."

"At the elementary level, in an affluent neighborhood, it has not come up to my knowledge. Wouldn't doubt if it were in the middle and high school though."

Many respondents expressed concern for students in their schools and a desire for education programs, as well as barriers that they face in their roles to screen for student risk for CSEC. Some responses included:

"Our rural school district is adjacent to a major interstate known for drug trafficking. Also, many of our younger students use social media, thus are at risk for cyber predators."

"Additional resources to educate parents are most welcome."

"I am in a small well-run school. I have the ability and time to care about mental health and social issues my students face."

"I believe it is necessary for school nurses to screen for CSEC but funding, staffing in buildings are obstacles."

"It depends on what you mean by screening. If it's a formal meeting with each student, that would be impossible due to limited nursing staff in our district along with more responsibilities and increased caseloads."

"I am now very interested in statistics in my area and would be interested in attending a training program."

"I would like to attend a professional development program on this topic, more knowledge is definitely needed."

Phase Two- Qualitative Phase

One in-depth interview and 3 focus groups with MA school nurse were conducted in order to explain phase one survey results and to enhance understanding of school nurses' attitudes and awareness towards CSEC and their role in prevention through guided dialogue and group reflection. Respondents who elected to participate in a focus group were contacted by email and invited to participate in a focus group scheduled within their geographical area.

A total of 29 school nurses in MA expressed interest in participating in a focus group. Groups were arranged within centralized geographical locations to limit participant travel burden. Locations represented rural, suburban and urban areas. Recruitment and retention for focus group participation was a challenge. Participants were given options for preferred time and location; however, travel, family and work responsibilities remained a barrier for participation and should be carefully considered in future study with this population. A total of four focus groups were planned with 3 to 8 participants scheduled to attend with attrition a major barrier. Twenty-two participants cancelled attendance the week of, or on the day of the scheduled focus groups. Two of the focus groups had to be rescheduled due to short-notice cancellations; one was held and the other completely cancelled due to continued attrition. One participant arrived to a focus group that had been scheduled to occur with two other school nurses, but the two were unable to attend, therefore an in-depth interview was conducted.

Repetitive comments emerged upon completion of three focus groups, with 2 to 3 participants each and one in-depth interview (N= 8). Most focus group participants worked in public school settings (N= 7), and one school nurse who was individually interviewed reported working in a private middle/high school parochial setting for boys. Three school nurse leaders who had a primary role of overseeing the school nurses within their district participated in focus groups; however, these three leaders also had an assigned school where they provided direct school nursing services. These nurse leaders were responsible for alternative high schools serving students through age twenty-two, as well as responsibility for students in elementary schools. Four school nurses had experience within elementary, middle, and high school, which also included special education therapeutic programs.

Focus group and interview data were analyzed using qualitative content analysis in the context of the PPCM. Graneheim and Lundman (2004) describe qualitative content analysis as a form of analysis characterized by identifying differences and similarities between the subject and context of qualitative data coded and categorized into themes. The unit of analysis used was the text of transcripts. The context was the qualitative phase two of the research study aiming to understand the dialectic between the peace-power versus power-over powers. A key aspect of our qualitative content analysis included maintaining an active relationship and ongoing communication between the research team, where the investigator contextualized the manifest content of qualitative data (what the text says) and latent content (what the text means) extensively through critical reading and reflection. Data was coded by themes according to fit within the

PPCM, and categorized into additional sub-themes that emerged from the depth of qualitative data (Graneheim & Lundman, 2004).

The investigator and a second reviewer read transcripts independently, and each transcript was then separated and divided into meaning units. Meaning units were contextualized and condensed into manifest content, a description close to the text, followed by interpretation of the underlying meaning (latent content) in keeping with Graneheim and Lundman's (2004) approach to qualitative content analysis. Themes and sub-themes were identified from the latent content in the context of the PPCM. Credibility and inter-rater reliability were sought by coming together to reflect, discuss, and agree on selected meaning units, interpretation of latent content, coding in the context of the PPCM, and selected sub-themes. Furthermore, agreement was achieved on the selection of representative exemplar quotations from the transcripts to reflect how well the coding and themes covered the data wholly and to enhance transferability and trustworthiness of the findings. Dependability was also sought through analysis of all transcripts together and was evaluated for consistencies. Following this process, six peace-power themes and their corresponding power-over themes were abstracted and coded from condensed meaning units and separated into the categories of awareness, attitudes, and role perceptions. Power-over and peace-power themes were further sorted into four sub-themes. A new conceptual model of *Peace-Power versus Power-Over School Nursing Practice* was developed from the PPCM (see Figure 3).

Peace-Power and Power-Over Powers

In the qualitative phase of the study, a fuller understanding of school nurses' position of the dialectic struggle between the powers was explored, employing the power-

over power and corresponding peace-power themes in the analysis (Table 1) (Chinn, 2013; Chinn & Falk-Rafael, 2015). Six peace-power and power-over themes were identified with four sub-themes extracted, named, and categorized from the identified peace-power and power-over themes: 1) exposure/knowledge, 2) collaboration, 3) role boundaries, and 4) creating respite space. The first sub-theme, 'exposure/knowledge', reflects school nurses' level of prior exposure to student risk factors that, in turn, influences school nurses' awareness, attitudes and perceptions of their role in prevention of CSEC. The second sub-theme, 'collaboration', reflects how school nurses practice and interact with and among other school staff. The third sub-theme, 'role boundaries', reflects both self- and externally-imposed barriers that impede school nurses from practicing to their fullest potential and scope of their professional role within schools. Lastly, the fourth sub-theme, 'creating respite space', reflects school nurses' care of and advocacy for vulnerable students, including being a trusted, stable presence, creating a safe zone for students in need of reprieve and protective spaces, and providing nonjudgmental care. The data will be presented within the six power themes previously defined from the conceptual model.

Power of Consciousness Versus Power of Expediency

Power of consciousness incorporates a consideration for long-range outcomes and ethical behaviors that values and protects life (Chinn, 2013). Decision-making when faced with situations that involved these powers includes confronting that which is destructive to peace and wholeness. On the contrary, power of expediency involves perceptions and decision-making reflective of a lack of consideration for long-range outcomes. Approaches to care with students at risk may be framed by what is readily

seen in the moment with quick solutions, versus care decisions framed by an understanding of the holistic picture of students. Throughout the qualitative data collection participants expressed varied levels of awareness of both the private and public realm regarding student risk factors, revealing insight to how school nurses perceived their role and approached to their delivery of nursing care with students at risk. School nurses' approaches to care either reflected a critically reflexive consciousness or to a 'expedient' care, that is, care that seemed the most practical to manage in the moment. The sub-theme 'exposure/knowledge' was identified in the power of consciousness/power of expediency category.

Exposure/Knowledge. Exposure/knowledge was a prominent sub-theme identified throughout participant comments. Nurses who expressed prior exposure to working with high risk populations of students and knowledge of risks they face described care given that incorporates conscious knowing framing care decisions. A lack of exposure to high risk students was reflected in descriptions of care decisions that did not reflect this consciousness, leading to care provided in-the-moment, or expediently. Whether school nursing care with at risk students was provided consciously versus expediently depended on prior exposure to working with at risk youth as well as prior knowledge of private and public realm risk factors students may face. Nurses who did not express prior exposure or knowledge of working with high risk student populations described care approaches that were expedient, lacking consideration for longer-range outcomes or the holistic picture of students. Participants shared an awareness of public realm risk factors identified in the PPCM facing students. Some examples included poverty issues, homelessness and food insecurity, transiency, exposure to community violence and drug

use, and transportation safety concerns. When asked about risks that students face in their particular schools, a nurse who worked with elementary and middle school students described her setting as very "high risk", with students coming in and out of the school district throughout the school year, many from high risk families as well as facing pervasive poverty struggles: "Very often the kids are coming in from dire circumstances of one kind or another, either homelessness, or they're in a domestic violence shelter, or something like that…" Likewise, another nurse working with elementary and middle school students shared that her perceptions of the cycle of poverty of a non-English speaking, immigrant families in her school: "Many of our families are non-English speakers, and so then they're limited to the service jobs that don't require interaction with the public…often times those jobs are overnight and transportation is not great. If you've got a job in a nearby city, you might have to walk…that interferes with the ability to get a good job." Another participant working in a parochial boy's private school expressed her concern for her students' general safety because they must take public transportation in and out of the city to get to school: "The majority of our kids take public transportation…I always worry about it though, more for our city kids…as they get further into their neighborhoods."

A school nurse administrator also responsible for an alternative high school shared that some students she cares for face homelessness. Several are unaccompanied minors that are staying in places that are unsafe and often go to local emergency rooms (ERs) at night for safe shelter: "Some of them go to the ER because they're afraid to be alone…if they're in a place where they're living alone, or they're living with a roommate who really is not a friend, then they go there because they know it's a place where they're

safe." Another school nurse administrator also working in an economically deprived urban city and responsible for an alternative high school expressed that many of her students face similar extreme poverty issues, similarly highlighting the problem of homelessness: "We had the biggest homeless rate for the last couple of years, so the stability isn't there, because they never know from day to day if they're going to be transferred again…so it's hard…"

When asked to describe the surrounding school community and risks students may face, one participant described how the community demographics have shifted in her city, including a large immigrant and minority population, and she articulated the connection between free school lunch and poverty. This drew similarities to what other participants shared working in high risk, urban communities with a large population of minorities and immigrants and the struggles families face that limit their job and income potentials. Likewise, one participant working in an elementary and middle school setting expressed her anguish and concern that students are hanging out in community areas that are high risk and known for drug use, selling, crime, and violence. When further asked about drug use, a participant with administrative responsibilities for a high school shared similar concerns drawing connections to the surrounding community and its pervasive drug problem, noting that, in high school, students are not only at risk of exposure to drugs within the community, but are at risk of exposure to illicit substances within the school itself. She reflected, "I think it is marijuana. I think there's alcohol use. I think pills are available…to be passed in the hall."

Knowledge of private realm risk factors was also apparent in participant comments. Some examples included high risk families and a lack of parental or adult

stability in students' lives, living in foster care or group home placements, a lack of healthy role models, parental substance abuse, parental mental health issues, parental incarceration, student substance abuse, student mental health issues, student involvement in the juvenile justice system, pervasive exposure to family violence, physical or sexual abuse and neglect, peer social circles, and dating relationships. Across school settings, school nurses described their awareness of vulnerable students as those who frequently visit the school nurse's health office. The nurses commonly referred to these students as 'frequent fliers', noting that this was not perceived negatively.

When asked about familiarity with student family dynamics, one participant who worked at a high school talked about the connection between home instability and student vulnerability: "Certain students might be at risk…she was a vulnerable person…she didn't have a stable home life and she was vulnerable." Likewise, a nurse working in a middle school expressed experience with broken families and student lack of parental/adult stability: "We had a large population being raised by grandparents, aunts, or foster care…and these were the frequent fliers, the ones I was really worried about."

Participants expressed their awareness of a connection between the home life of students and how they present at school, especially related to exposure to violence. An elementary school nurse stated: "Are their priorities to feel safe, and you know…their priority isn't necessarily school…home life really affects what they come in the door with." A school nurse working with elementary students in a therapeutic program shared similar comments about the impact that home life has on how students present at school:

> "So it depends on what home is doing to their child…you know, if they're experiencing things like constant transiency and domestic violence and

uncertainty about life, that is going to be a child who may then have behavioral issues as they cope with all of that stuff…it depends on how those traumatic events are manifesting in the child."

A school nurse working with elementary and middle school students stated: "I have kids who are frequently exposed to violence. Domestic violence, violence on their street, and violence in the video games they're allowed to play, and the stuff they're allowed to watch. Or people in the family being loud and angry and violent or aggressive to each other." Participants also expressed concern that students who lack adult supervision at home, are exposed to community violence and substances, placing them at greater risk. A school nurse working in a middle school connected her experience with students involved in the juvenile justice system and the impact that a lack of supervision is having on the students: "Sometimes it was kids just bored and not having the support or someone at home making them check in at a certain time…mostly property damage or physical fights." Another school nurse administrator also responsible for caring for elementary students similarly shared concerns about the pervasive problem of a lack of supervision at home and in the community, placing students at greater risk for harm: "We have a lot of single parents, a fair number of parents that are in jail, so the mom is working two or three jobs…so these kids are pretty much on their own…and then, yeah, the parents are into drugs." One participant also shared student feedback from an eighth-grade recent student survey highlighting similar concerns regarding lack of supervision among students and risk of exposure to substances: "Kids reported getting into cars with people who had, or knowing people who had gotten in cars, with people who had been drinking." An elementary school nurse shared similar concerns regarding lack of

supervision as a major risk facing her students: “They were discovered over the weekend by a visiting friend…mom had taken off outside the country, and left her second-grader home with the kindergartener by themselves. So they didn’t know how to get themselves to school…until the police found them over the weekend…”

Participants varied in their exposure to students who fit the description of ‘runaways’, and those involved in the juvenile justice system. Participants did not, however, express awareness of the term ‘throwaway kids’; rather, they articulated their lack of awareness through stories they shared with students who may have, indeed, been ‘throwaways’. The majority of participants did not connect the higher risk of LGBTQ students to being a runaway or throwaway. When asked about experience with runaways, a school nurse administrator also working with students in an alternative high school stated: “We truly had the true runaways. We’ve had them. They were the high-risk kids.” Another participant working with students in an alternative high school shared experiences with runaways: “I had a student who ran away and was gone for two weeks…and was discovered in the city or something like that, had gone away with another student who was running away from the police.”

When asked about familiarity with the term ‘throwaway’ kids and experience with throwaways, several participants shared about their experiences with students that were kicked out of their homes, or referred to it as parents giving up on them, but did not express a connection with the term ‘throwaway kid’. Rather, participants referred to these kids as ‘couch surfing’. For example, one participant working with middle school students expressed: “I feel like we had kids that weren’t necessarily kicked out of their homes but their parents gave up on them.” Similarly, another participant working with

elementary and middle school students shared experiences with students whose parents gave up on them: “I have had one parent that said, I don’t want my child. Here, take him…to DCF.”

Several participants described ‘couch surfing’ but did not recognize this as throwaway. A participant working with high school students stated: “I have never experienced a throwaway, but I assume that there are kids in the high school that maybe are doing some couch surfing.” Similarly, a school nurse administrator shared about an experience with a throwaway kid but referred to the situation similarly as ‘couch surfing’: “He just didn’t get along with his stepfather and the mom was just too weak and just kind of gave in and said…yep…just go. He ended up couch surfing.”

Participants were also asked about their experience with students who were engaging in risky sexual behaviors and dating violence. A school nurse administrator also responsible for an alternative high school where she cares for many pregnant teens and teen parents expressed concerns about the vulnerability of her students and their inability to see the risk in unhealthy relationships because of a pattern of unhealthy relationships in their lives, and a lack of healthy role models within the family and outside of the family. She stated, “They’re just so desperate for love. Somebody took advantage of them. And they see it as like, they see it as somebody’s in love with them.” A school nurse caring for boys in a private parochial school shared concerns about pornography and sexting as negatively influencing how they approach relationships. Another participant also commented about problems with relationship and sexual violence among her students in the high school, and she shared: “There was so much

reported that we were able to start a self-defense class in the gym, one of the gym electives that they could have."

When asked to describe who comes to see them in the school health office, participants commonly shared a similar description of students who frequent the school nurse office as 'frequent fliers', and their sense that something more is going on in their lives. Through on-going exposure to these students, participants shared that their awareness of risk increased. Commonly, participants described students who frequent the school nurse office as having vague, somatic complaints. Also, participants described a pervasiveness of mental health issues, particularly anxiety, among students who come to see them and reflect that they know something more is going on in the life of these students. An elementary school nurse stated: "We have a lot of anxious kids in our district, are we missing something for some of these kids? Are we asking the right questions? Are we listening fully? I feel like I'm missing something."

When asked about awareness of human trafficking, the CSEC term itself, and experiences with CSEC, participants varied in their exposure. Overall, participants expressed a disconnection between exposure to students highly at risk and the threat of CSEC, and in some instances that CSEC was what was happening. Prior exposure to students at risk presented as a shared commonality among participants who expressed awareness of student risk, yet none identified having encountered actual experiences of students involved in CSEC. Several participants expressed that they learned about the problem of human trafficking through watching television shows or documentaries, but they did not connect it with being a problem locally or for their students. For example, an elementary school nurses who learned about trafficking by watching a recent

documentary stated: "I was just shocked. I think I was blown away at the severity of the issue. And that it's so hush-hush." Some participants expressed that they had learned about CSEC at professional conferences, yet did not recall what the term meant, or connect it with experiences they expressed having with students. Furthermore, participants had not considered that exploiters could be students at school. For example, one participant working with elementary and middle school students stated: "I think that we don't think about them. We think about the victim. Or at least I think about the victim more than the exploiter." A school nurse working with elementary and middle school students expressed awareness that harm may come to a trafficked victim if the school nurse is not careful about how to help them get out of the situation: "I think that they probably, you know, there's some harm that could come to them if you're not careful about how you help them get extricated from the situation." One participant shared a conversation she had with a student who reported regularly engaging in exchanging sex for food or shelter, but did not make the connection that the student was being trafficked. Rather, the participant perceived that the student was not taking care of herself:

> "I worry about the kids who are not taking good care of themselves…they may be engaging in sexual favors in return for food or shelter. There are a couple of young women at this school that I have concerns about, that that's what they're doing. They have a history of getting their needs met by engaging in sexual favors."

School nurses may approach care considering the longer-term outcomes of student health and wellness. However, school nurses may also approach care

expediently, with approaches that seek solutions in-the-moment. Attitudes towards students at risk for CSEC or victims of CSEC differed based on prior exposure to working with vulnerable students or exposure to or knowledge of the CSEC problem.

Participants exposed to working with high risk students expressed an attitude conscious of student vulnerability. Two examples of participant comments that reflect the power of consciousness include:

> "I would say the students that would be vulnerable to trafficking would be students that aren't with their family members. I would be more concerned about somebody who doesn't have a permanent loving person in their life who's really looking out for them."
>
> "The purpose of the alternative high school, it's not for bad kids. It's for kids who just cannot conform to the traditional classroom setting…so maybe they feel they just want to get up and go take a walk."

Participants that expressed limited exposure to students vulnerable to CSEC shared attitudes about students that resulted in the provision of expedient, or in-the-moment care, adopting judgments about them that others had made reflecting power of expediency. One school nurse working with a student who returned from prison expressed frustration with how many times the student came to see her that day: "He was a frequent flier at the nurse's office, and so again…has already been down there three times today. I have a headache, I have a stomachache, can I rest? And this kid…he's a pathological liar…and the poor mom is like…I don't know. She's at her wit's end."

Participants also shared decision-making strategies in prevention of CSEC that school nurses can use. Exposure to working with high risk populations repeatedly was

discussed among participants who shared stories of providing care reflecting power of consciousness. One participant working with a highly vulnerable population facing truancy, homelessness and food insecurity mentioned the importance of asking pointed questions to assess for risk:

> "A lot of times we lose track of these kids…but whenever they do resurface, I think it's important to check in with them and find out if they're safe or not. I ask them…are you safe? Are you safe at home? Are you practicing safe sex? And in fact, if they show up again...it'll be more on my radar to ask them specifically…about CSEC."

Participants also expressed uncertainty about how to approach decision-making and care for a student they suspected was involved in CSEC or at risk for CSEC which may lead to expedient care. Several expressed the need for training and education for school nurses, particularly how to navigate conversations and assessment of students, as well as what to look for. When asked if participants ever thought about trafficking or had experience with a student, one participant mentioned: "I've thought about it [trafficking], but not a particular student. Just…I mean, sort of more of a general concern. And in terms of what do I need to watch for? And what do I do if I have a concern?" Another participant similarly expressed her hesitancy in knowing how to navigate what to do if caring for a victim of CSEC: "I guess I would…I mean…I would engage the administrators at school, or the adjustment counselors. But I think eventually what I would do is call DCF….but I'm not sure that's right…"

When asked what would be helpful to school nurses in supporting their role in prevention of CSEC, several participants expressed the need for a screening tool, which

may help them navigate assessing student risk of CSEC. Some examples of what participants shared include: "A simple screening tool…small questionnaire could be beneficial." A participant likewise welcomed a screening tool, yet cautioned that the tool must be sustainable and effective: "I think the problem with a lot of these screening tools that we have, whether it's screening for suicide, screening for abuse or neglect…trafficking. We have all these great tools to screen, but then what? That's really important…"

Power of Whole Versus Power of Division

Power of the whole reflects nurturing helping networks and solidarity, where individuals are valued as integral to the functioning of the whole (Chinn, 2013). By contrast, power of division occurs within hierarchal contexts where power is centralized to a select few resulting in knowledge hoarding (Chinn, 2013). Participants repeatedly expressed a divide between themselves and colleagues, creating a boundary in which school nurses practice within the larger school organization. Participants also shared similar comments that knowledge regarding students belongs to a select few members of the school team, within a hierarchal organizational structure and culture. Sub-themes identified in the category of power of division/power of the whole included 'collaboration', and 'exposure/knowledge'.

Collaboration. Collaboration was a common theme that came up from all participants. Collaboration could either be positive or negative, stemming from a division externally-imposed by the school team as well as a self-imposed division created by school nurses themselves. Participants were asked if they are made aware of student academic achievement including an awareness of those students who receive special

education services through a 504B or IEP plan given that students with disabilities are at greater risk of CSEC (Grace et al., 2012). Participants expressed a clear division externally-imposed between student information that they have access to compared to other school staff (teachers, guidance counselors) which influenced their awareness of this area of student risk. Participants discussed a lack of access to key assessment information, which was perceived as lacking access to the holistic picture of students in order to provide comprehensive school nursing care. This was largely influenced by how the school nurse fits into the school community and culture of day-to-day operations.

Several participants also shared that they are not typically given information about student academic achievement. When asked if and how they do become aware of academic achievement, all eight participants mentioned that their awareness began with the experience of caring for a student who frequented the school nurse office with vague, somatic complaints, and dealing with concurrent truancy or tardiness issues. Another way participants expressed becoming aware of academic concerns was through finding out from the student when the student shared what was going on with their classes or by directly asking a teacher about this information in an attempt to complete the puzzle. Additionally, nurses reported that sometimes a teacher or guidance counselor might have mentioned poor academic performance to the school nurse. Examples of participant comments that reflect this power of division include:

> "I didn't have all the pieces of the puzzle [when caring for students]."
>
> "Is it that they're chronically absent and tardy because they're struggling academically? And therefore school avoidant? Or are they struggling academically because they're not here enough to learn? Which is the cause?"

> "Some [guidance counselors or teachers] say 'you don't need to know that information'….if I ask if something is going on with the student's grades…it's like…actually, yeah…we do need to know that information…"

Furthermore, the majority of participants expressed that they are only given access to medical disability diagnoses and included in 504B health accommodation plans, but are not given information about IEP plans for learning disabilities and are only part of the planning if there is a perceived medical component involved. Some examples shared by participants that further reflect the power of division include:

> "We have a computer system where we can see who is on a 504 or IEP…we don't know specific accommodations or what they are, necessarily. Quite frankly, in my school, I don't always know about the student's education plan or what their exact issues are."

> "If the nurse is invited [to an IEP meeting], then they usually discuss the medical portion in the beginning so they can leave…but they definitely go to the 504s."

> "We're not involved in the IEP because they have so many specialists that are helping with the learning plan. With the 504B, I'm always invited to the meetings…the 504 is the medical plan, there might be medical accommodations."

Exposure/Knowledge. Participants expressed a disconnect between their perception of learning disabilities and medical disabilities, demonstrating a potential lack of knowledge that the two are intertwined and all affect student health and wellbeing. Participants further shared that they may infer what IEP services students are receiving by what they observe but they are not given the information or diagnoses. For instance, an elementary school nurse expressed that she can tell who receives services by her

intentional observation of students that she cares for: "I usually have a pretty good sense of kids that are struggling, either in general or with a particular issue, whether it's a struggle with reading, for instance…I can just look in the classroom and see who is having a hard time…" Likewise, another elementary school nurse shared the following: "We may have a sense who seeks services…like who goes to reading group, or who spends time with OT or PT, who has an IEP…not that they're doing well academically, but that they need support academically."

Those participants who had more knowledge of the academic achievement of students, including special education services received, also had prior exposure to working with students in specialized programs. Several participants recognized and expressed a difference regarding how school nurses perceive these students versus how teachers and guidance counselors may perceive them. Students were often labeled as 'behavioral' by teachers and guidance, yet school nurses shared a common understanding that there was more going on in the child's life underlying the behavior. A school nurse who cared for elementary students in a therapeutic program shared an exemplar that reflects the power of the whole:

> "They all carry a diagnosis of some type of psychosocial emotional basis for it…so for them, sitting in a mainstream classroom is difficult for them, because they really need to focus more on their social emotional needs first, before they can even be in a space where they would have access to learning."

Another statement shared by a school nurse administrator who also cared for elementary students further reflected the power of the whole: "Kids who aren't able to maintain

regular classroom, usually behavior is what's flagged…but often, you know…there's underlying issues behind the behavior…"

When asked about the population of students with whom participants worked, several school nurses expressed that students in behavioral therapeutic programs were challenging to work with. The school nurses had shared previously that they do not have access to special education information and students who are not in mainstream classrooms are being given special education services. Participant comments reflected the power of division between the school nurse and other school staff in terms of who has access to this information, and the attitudes expressed that this is a difficult population may likely be due to a lack of exposure or knowledge about the holistic view of students. An exemplar from an elementary school nurse working with a behavioral therapeutic program included: "At my particular school, we house the behavioral therapeutic support program…so that's a very difficult population within our school that we're caring for…" Participants' statements also reflected the power of division between those who have access to information about student risk factors and/or CSEC, thus influencing their attitudes about risk perceptions. Those who have access to information include inter sectorial and cross-sectorial colleagues, including other school staff and outside agencies, such as DCF. Access to information about CSEC impacts how school nurses perceive risk. For instance, school nurses may perceive that their community is safe from CSEC and that CSEC is a problem solely affecting urban cities, however CSEC may affect all communities, regardless of economic conditions. An elementary school nurse shared her perceptions about risk in an affluent community and an attitude that her students are not at risk because they live in a safe community, and CSEC is a problem for urban areas:

"The community was safe…completely. Near where the high school is located there is a city I wouldn't want to walk around at night…but in our town, it was a safe space to be…no violence in general." A participant working with elementary and middle school students similarly shared an attitude that her student population is not at risk for CSEC because they live in an affluent community with involved parents: "I don't necessarily ruminate about the kids a lot…it's a population where it's fairly well-to-do. Parents involved in the school…"

Participants' discussion also conveyed an attitude that students were not at risk even when school nurses or other school leaders knew the student was engaging in exchanging sex for food or shelter. This attitude appeared to have been influenced by a lack of exposure to CSEC or knowledge about CSEC and potentially reflective of a division in the sense that school nurses are representing a discipline lacking access to information that other disciplines have access to, or invited to be an integral part of the conversation about CSEC. One school nurse administrator caring for students in an alternative high school shared: "I guess I would get law enforcement involved if I felt like a student was in a situation where they were being harmed…and so, for their protection. But in terms of…I'm not sure that I would engage law enforcement if somebody said…you know, I slept with so and so…so that I could get a sub." Likewise, four participants expressed attitudes that older students may be able to consent to sell sex in exchange for payment. However, all eight participants agreed that younger students, especially elementary age, are too young to consent. This attitude that older students may consent to sell sex for payment also seemed to stem from a lack of exposure to CSEC and how it occurs, reflecting a divide where school nurses are not given this information. A

school nurse working with an alternative high school program serving students through age twenty-two stated: "To me, trafficking is more like imprisonment. You're enslaved. And at least my way of thinking is…prostitution is more free will. That you may be paying the John, but you can quit the job whenever you want."

Power of Intuition Versus Power of Causality

Power of intuition encompasses sensing actions on a perception of the totality of human experience (Chinn, 2013). Power of causality relies on a set of standards or procedures without regard to consequences carried over into the future (Chinn, 2013). Participants expressed power of intuition, manifesting in awareness of risk factors students face that may be invisible. Through their expression of care, school nurses described reflecting on past experiences and the context of students' lives in informing practice. School nurses' approaches may also reflect power of causality. Chinn and Kramer (2015) describe the influence of hegemonic views that are hidden as influencing expressions of nursing care. School nurses may express care for students at risk that seek to treat the outward manifestation, without taking in the invisible context of students' lives, resulting in care provide that accepts 'the way things are'. Sub-themes identified within this category include 'exposure/knowledge' and 'creating respite space'. Exposure to working with vulnerable high-risk students manifested itself in comments that either reflected power of intuition or power of causality. Participants also repeatedly shared that the school nurses' health office is a place of reprieve for students. Participants unanimously expressed their drive and desire to create warm, welcoming respite spaces for students to come to.

Exposure/Knowledge. School nurses may sense which actions to take based on perceptions of the whole child presenting to the school health office. In contrast, school nurses may approach decision-making and care approaches without regard to future consequences. Participants who were exposed to vulnerable students expressed an awareness of the long-term wellbeing of students when making decisions about care approaches. A school nurse working with elementary and middle school students reflected upon the resiliency of students who must deal with difficult situations:

> "Some kids who are less resilient or just need more support academically…it's harder. They are the frequent fliers…and frequently absent and tardy. And maybe not allowed to come and see the school nurse or go to the bathroom…and then [they're considered] 'behavioral'…it's like they're being denied their human rights."

One participant also shared her perspective about students living in foster placements or group homes reflecting power of intuition: "In general, the kids were not happy in those placements. They would almost rather be at home with their bad situation than in those placements." Another elementary school nurse shared about approaches with students in a specialized therapeutic program, where all struggled with complex mental health and behavioral needs. Her comments reflected empathy and a reflective knowing about this high-risk population, in tune to their holistic needs. Her comments also reflected power of intuition: "There are days where they get a lot of academic work done, and then there are days where it's mostly just…OK, let's have circle time, or let's talk about it online…and we'll do small group work. Let's work through what's bugging you right now." A school nurse working with elementary students discussed an

experience with a student who used sexually explicit language that alerted her to something more going on:

> "It was the beginning of fifth-grade year…and I remember flagging as…hmm…that's not vocabulary I would have expected her to have. She was asking the meaning of a phrase 'pop my cherry'…so that was where I was like…OK…there's something there that she heard that she shouldn't have been hearing…if she were in a safe place…DCF was involved, there was an ongoing investigation."

Participants also shared insight into their decision-making with students they care for. Many shared their intentionality to make care decisions in context of the whole student and to provide holistic care, reflecting power of intuition. Participants also shared decision-making that reflected solutions limited by few options, without integrating all factors influencing student health, reflecting power of causality.

Creating Respite Space. When asked about how they would approach caring for students, one participant shared her intentionality around decision-making as she carefully approached assessing a student for risk. A student was frequently coming to the school health office complaining that he was exhausted. The school nurse was concerned the student was exposed to violence at home. Her comments reflected power of integration: "I usually say, so why do you think you're tired? Why do you think you couldn't sleep last night?" Similarly, a participant working with elementary students reflected power of integration as she carefully decided how she would attempt to gather information from a student she suspected was at risk: "Do you share a room with

someone? Is it noisy where you are living? They will tell you, especially if you don't put any judgment on it."

One participant shared her intentionality in maintaining a safe space for students who come to see her. She shared about push-back that she may receive from teachers who are frustrated that specific children are always wanting to get out of class to come see the nurse. When asked by a teacher to call the parent, the school nurse maintained student trust in her decision-making in responding to the teacher, reflecting power of integration:

> "And I said no, we're not going to call the parent…because then the parent will tell her she can't come to the nurses' office. And that's not going to get us where we need to go. There's something going on for her that she needs to see me each day…the question isn't, how do we not let her come, but how do we do it at a time that's going to be less disruptive to her learning."

Another participant working as a school nurse administrator shared how a nurse approached caring for a student experiencing a crisis and her intentionality about how she navigated her assessment decision-making:

> "She just came down crying, and so the nurse was able to say, you know…obviously, you're upset about something…do you want to talk about it? And she did divulge it [rape]. Sometimes though, they don't. So I think they'll come back three or four or five times, until finally they spit out what's going on"

Power of Trust Versus Power of Fear

Power of trust is built upon fostering genuine human relationships, with a commitment to honesty, respect and consistency (Chinn, 2013). In contrast, power of

fear involves approaching situations with imagined future disaster, where fear controls action and behavior (Chinn, 2013). School nurses may provide care that is consistent, always seeking to build trusting relationships with students. They may also approach difficult situations with hesitancy and unwillingness to engage in full care interactions with students at risk for fear of what they may learn demonstrating the power of fear. Participants expressed attitudes about students who frequent the school nurse office that reflected that something more was going on with students, despite practicing without crucial assessment data. A Sub-theme identified within this category includes 'creating respite space'. The dichotomy between consciously striving to foster trust with high-risk students versus allowing fear to drive care actions and decision-making was reflected within participant comments.

Creating Respite Space. Throughout the focus groups, the perceived need to create nonjudgmental, trusting relationships with students through the process of creating safe respite space was identified as an important subtheme. Examples of comments that reflect the power of trust included:

> "I feel like whether it's an underlying issue around anxiety, there's something that they are needing in the connection in the nurse's office to make it through the day…sometimes it can take the better part of a year to figure out what's going on."

Similarly, another participant shared her understanding that students who are struggling connect the school nurse and health office as a safety net. "That's all the kid needs…that extra assurance that the nurse is there for them if needed." One participant shared about experiences with throwaway kids who were presenting with difficult behaviors at school.

The school nurse expressed an attitude reflective of the power of trust in her assertion that the student needed to be able to access the school nurse office, a consistently safe space at school where others were not speaking of the issues that troubled this student: "He needs a safe place to be…where nobody's talking about that."

A participant also shared about a situation where she was caring for highly vulnerable students. A student ran away for several weeks and was found in another city. When asked how the school nurse approached the student when the student presented back at school, the participant expressed a sense of fear to inquire of the student for fear of what she might learn. Her comments reflect power of fear: "I didn't ask where she was or what she was doing for those two weeks she was missing…I didn't want to know…"

Power of Nurturing Versus Power of Use

Power of nurturing encompasses a view that life is to be cherished and respected, deserving of respect and protection (Chinn, 2013). Power of use encourages exploitation of people and resources, with a view that this acceptance is normal and acceptable (Chinn, 2013). Within this category, the sub-themes 'exposure/knowledge' and 'creating respite space' were identified. Prior exposure and knowledge of the complex integrated factors affecting vulnerable students were reflected in participant comments who either worked with high risk populations or had previous work experience with high risk communities and students. Participants also repeatedly shared stories of protecting their students and providing respectful, nurturing care through creation of welcoming, nonjudgmental respite spaces within the school nurse health office. School nurse administrators repeatedly shared how they not only are protective of the students in the

district, but also their team of school nurses. However, participants expressed a general acceptance of their diminished role within schools, knowing they are undervalued and under-resourced.

Exposure/Knowledge. An example of a comment made by a school nurse administrator that highlights nurturing for students and her school nursing staff includes: "And then you worry about…not only the kids, but the nurses…like how they handled a situation. You kind of replay that situation in your head and try to figure out if there maybe had been a better way to handle it, or did we forget something?" Participants also articulated that they can identify the students most vulnerable and intentionally work with these students to empower them. A participant working as a school nurse administrator shared: "I think that we could probably come up with a handful of students in any given grade that we would say…yeah, that one is the one that I worry about what's going to happen when they get to middle school. And thinking about how we can empower that child…" A participant working in a private parochial school for boys shared her insight into knowing her students need access to a neutral, trusted adult, an adult that is not in a disciplinary role. Her comments reflect power of nurturing:

> "Kids just need someone to care about them, you know. The just need someone they can trust and someone who cares…that's sometimes…that's what we do, you know. He wasn't a perfect kid. No kids are perfect, but they just need to be cared about and a little bit of stability. As much as parents try, sometimes things just get in their way…"

Similarly, a participant highlighted the nonjudgmental, neutral role school nurses have in the lives of students. Particularly, school nurses are not in a position to discipline

students: “The nurses are not involved in discipline. They’re not involved in discipline at all…so they see that their grades aren’t going to be affected if they tell the nurse something. They’re not going to get Saturday school if they tell the nurse something…”

Creating Respite Space. Another participant shared her experience working with students that she knew were exchanging sex for food or shelter. When asked how she would approach the situation, she stated: “What I say to them is…I’m concerned about you. I care about you. I want to make sure that you have the things that you need…and let’s look at other ways that you might deal with this situation if it comes up again…” Another school nurse administrator also caring for students in an alternative high school, many facing homelessness and food insecurity, shared how she will intentionally protect her students in the present, but also taking into account the realities of the student’s highly vulnerable situation. She emphasized teaching the students self-care by providing them a guided, nurturing approach:

> “Sometimes I’ll keep a student in the health office barfing all day, saying, you don’t really need to go to the hospital. You need to get some rest. You need to get hydrated. And then I’m going to teach you how to do this…so that next time this happens, you won’t go to the ER…”

One participant expressed knowing the importance of the role of school nurses, as well as her frustration that school nurses are often not part of the team or given full access to student information. Her comments reflect power of use: “It becomes a question of…I think as health people in the school, we need to sort of claim that as part of health [our role].” A participant also shared the inner conflict of how she felt knowing

a student was sexually assaulted by a family member and having a to notify her mother and DCF. Her comments reflected power of nurturing:

> "She had to come to the nurse to tell the nurse. But didn't feel comfortable telling her mother…you know? So that's an issue too, because now that puts the nurse in a predicament…because now she's got to let the mom know that the child just divulged this information to her, and that she has to report it…"

When discussing the general role of school nurses, one participant working with a vulnerable population of elementary and middle school students shared:

> "There are things that have to happen, depending on where you are in the year…checking immunizations at the beginning, or doing hearing and vision and growth screenings, all of those state-mandated annual things. We are also giving medications throughout the day…caring for kids with diabetes…that takes a lot of planning and coordination with parents and hospital care-givers."

Another participant also shared about managing medically complex children, highlighting the complexity of the power of responsibility of the school nurses' role: "We all have some medically complex children. I have a lot of seizure disorders that need to be managed. I have a student with a genetic cardiac disorder…"

Participants also commonly shared that their role often involves more than hands-on care where students seek out the school nurse beyond the school day and school year. "In many respects, it's not so much like doing the hands-on care, but rather being a resource so that they can then be able to care for themselves beyond the school day and the school year."

Power of Creativity Versus Power of Rules

Power of creativity involves taking into account pre-set rules, policies and procedures, however, values actions and solutions that are created from ingenuity and imagination fit to each unique situation (Chinn, 2013). Power of rules relies solely on following pre-set policies, procedures and rules without regard to context (Chinn, 2013). Within this category, the sub-themes 'creating respite space' and 'exposure/knowledge' were identified. Participants commonly shared situations where they creatively approached caring for students, at times bending the rules or what was expected of the school nurse to do based on a hierarchal culture of the school, and divisiveness among school nurses and colleagues. Participants also expressed working in a hierarchal culture where the expectation was to follow the rules, without a key voice. Prior exposure to working with high risk student populations reflected in creative approaches to complex student situations through comments shared.

Creating Respite Space. A school nurse working with middle school students shared how she will creatively create respite space for students who are overwhelmed with their academics, willing to face conflict with the teacher. Her comments reflect power of creativity:

> "A lot of students would come in, and I would say…what are you missing right now? What's happening right now…to see if they would open up. And sometimes I would let them stay, and they would miss an example the teacher was giving…and a teacher would come down on me. Which was fine. But maybe they just weren't prepared. Maybe they were up late, because parents were

fighting…so I feel like I sort of bridge that gap between the student and the teachers…"

Participants also shared how they creatively approached helping students through empowerment and self-care strategies reflecting power of creativity:

"I'll ask what's your strategy? Ok, so you have an assessment today…and you're telling me you have an anxious belly. What are you going to do? What are your strategies? What's your plan? It's normalizing the normal discomfort…helping them to identify resources for the things that aren't normal…"

A participant shared how she navigated through conflict with a teacher who was frustrated that a child was always coming to see the school nurse. The participant shared how she creatively worked with the child to make sure that she has access to the school nurse, yet also incorporated strategies to help the student feel more comfortable in the classroom:

"I asked the teacher and the instructional assistant about when she is asking to come down? What's happening in the room? Can we set something up in the room to meet some of her needs? This kid has chronically dry hands. The back of her hands get really bad in the winter. We can set up a little moisturizer station for her. The thing that bothered me in the conversation, as I was reading the teacher…I was thinking, oh, she doesn't like this…and I said, you know…I'm still figuring out what's happening to this student…"

Exposure/Knowledge. Another commonality among participants is the need to creatively approach prevention efforts around CSEC. Participants expressed acknowledgment of the developmental needs of students, particularly adolescents, and to

be able to cast a broader net of who they can reach through creative education and prevention efforts. Several participants shared the need to provide students with anonymous literature to educate them about trafficking and healthy versus unhealthy relationships. One participant stated: "I think that one of the things that is important is to have literature available, pamphlets in the bathroom that people can look at in private…or put it in their pocket…" Participants working with younger grades also expressed creative planning and the importance of the school nurses' role in educating students about CSEC. One participant stated: "I think it's important to be clear about teaching kids to trust their instinct in terms of what feels safe and what doesn't feel safe…best step further would also be in terms of who in your life would you talk to if something didn't feel right."

CHAPTER V

DISCUSSION AND CONCLUSION

Mixed Methods Findings

Qualitative findings provided greater insight into why respondents reported the way they did in the survey. Findings from this study also support other published studies that explored HCP awareness and attitudes towards CSEC. Major findings of this study indicate that school nurses in MA have varied awareness of student private and public realm risk factors identified in the PPCM. School nurses are generally aware of factors that increase risk of student vulnerability, but were not able to draw connections to student vulnerability specifically to CSEC. A similar finding was noted with child protective service providers where they reported general awareness of risks youth face, however less awareness of CSEC specifically and the complexities that surround it (McMahon-Howard & Reimers, 2013). Furthermore, child protective service providers also reported inconsistencies regarding their knowledge of how CSEC occurs and how youth become entangled in it, increasing the likelihood that providers believe that youth may not be victims in these situations (McMahon-Howard & Reimers, 2013).

School nurses in this study generally were aware of the many public and private realms that increase risk for students (i.e.; high risk family dynamics, history of child abuse and substance misuse, social peer relationships, vulnerability of minorities, those in the

juvenile justice system, foster care system and homeless or runaway, mental health issues, student attendance and truancy, surrounding community economic conditions and safety, and school funding limitations). However, the nurses were unaware of the academic performance or disability diagnoses of students on an IEP plan, vulnerability of students identifying as LGBTQ, and in particular, 'throwaways'. Additionally, the nurses were generally unaware of the problem of human trafficking, CSEC, and how CSEC occurs. Major findings related to awareness, attitudes, and role perceptions in prevention of CSEC among MA school nurses in this study include prior exposure to working with vulnerable students, prior education and training in CSEC, uncertainty in identifying and labeling CSEC, and lack of professional collaboration with colleagues in schools.

Exposure to Vulnerable Students

One of the major findings from the qualitative analysis related to awareness, attitudes and role perceptions in prevention of CSEC included prior exposure to working with high risk, vulnerable student populations. Participants working with vulnerable populations reported knowledge of students who were homeless, runaways, involved the juvenile justice system, struggling with significant mental illness, high-risk families, and living in high-risk communities. Nurses working with highly vulnerable students reported some knowledge of human trafficking and shared attitudes toward the students that were nurturing, employing peace-power practice to view these students in context of their situation. Participants who were also exposed to diverse school and community settings shared an understanding of the increased risk and vulnerability of their students. In fact, participants shared that their role as school nurses often provided more understanding attitudes towards students as compared to other school staff, particularly teachers.

Cole and Sprang (2015) explored victim service providers' awareness of trafficking in rural, suburban and urban areas. Their findings were supportive of differences in awareness of the trafficking problem among service providers depending on their geographical location; rural providers reported lower awareness compared to those working in suburban and urban areas (Cole & Sprang, 2015). Regardless of geographic location there were no differences in trafficking awareness noted among the nurses. However, findings revealed that MA school nurses who work with populations of students in high-risk communities reported higher levels of awareness of student risk. Questions about what defines rural, suburban and urban areas were not asked directly in the study phase one, therefore, respondents may answer differently should definitions of survey options be given in a future study with school nurses. Furthermore, comments participants made in the second study phase supported Cole and Sprang's (2015) finding that participants were aware that children face higher risk of vulnerabilities in more urbanized areas. Study findings in the second phase also supported increased experiences with and exposure to highly vulnerable students in more urbanized areas, similar to findings Cole and Sprang (2015) reported with service providers.

Prior Education and Training in CSEC

Qualitative findings supported the statistically significant correlation between prior CSEC training and awareness, attitudes, and role perceptions towards students at risk for CSEC. Participants discussed varied ways of hearing about CSEC, for example some watched documentaries while others attended workshops. Yet, participants still did not seem to draw connections between actual situations of student risk and vulnerability and the relationship of those risks and the occurrence of CSEC, indicating a great need

for ongoing training and education of school nurses. Participants commonly shared that preventing CSEC was important for school nurses. In fact, participants expressed that the school nurse is in an ideal position to assess for student risk of CSEC and intervene because they are the only staff member in schools that are not involved with imposing discipline or grading students. Participants unanimously reported that school nurses provide an open door to a safe, nonjudgmental space that many students use as respite space. School nurses intentionally work with students to build lasting, trusting relationships, providing care that extends beyond the school day and into their family and community lives. Furthermore, participants reported interactions with students for vague somatic complaints, yet the nurse knew something was going on in the student's life causing inner turmoil and anguish. The nurses attributed the turmoil and anguish secondary to academic, relationship, family, or community struggles.

Prior training in CSEC as well as prior exposure to working with high-risk student populations and communities were both connected to increased awareness of CSEC. Cole and Sprang (2015) and Beck et al. (2015) reported similar findings. Medical providers and social workers who had prior training on CSEC and exposure to working with high risk populations were more likely to identify a child as a victim compared to those without training (Beck et al., 2015).

Uncertainty in Identifying and Labeling CSEC

Respondents were unaware of what constitutes CSEC, which was similar to studies with other HCP's (Beck et al., 2015; Cole & Sprang, 2014; Edinburgh, Richtman, Marboe, & Saewyc, 2012; Ferguson et al., 2009; Grace et al., 2014; Isaac et al., 2011; McMahon-Howard & Reimers, 2013; Titchen et al., 2015; Wong, Hong, Leung, Yin, &

Steward, 2011). The nurses in this study agreed that CSEC is the same as child abuse; however, they did not make the connection of survival sex for food or other basic needs as a form of CSEC. School nurses in this study lacked an understanding of CSEC and were they not able to label CSEC although some nurses shared stories of situations with students that were likely CSEC victims. This was a similar finding to a study with child protective service personnel where McMahon-Howard and Reimers (2013) found that child protective service personnel shared attitudes that youth involved in what was perceived as prostitution were not considered victims but rather had played a part in their situation. Law enforcement officers also perceive youth as engaging in willful prostitution and not victims of trafficking (Cole & Sprang, 2015). Beck et al. (2015) found that many HCP's do not understand trafficking, nor are they able to accurately identify and label sex trafficking. They reported that HCPs were confused as how to identify CSEC, especially when the person stated they had consented. McMahon-Howard and Reimers (2013) also noted that respondents in their study did not identify youth consenting to selling sex for basic needs the same as trafficking. School nurses in this study agreed that trafficking is the same as child abuse, however, similar to McMahon-Howard and Reimers' (2013) findings, reported that they did not agree that consent to sell sex is necessarily the same as trafficking, despite a student being a minor. Additionally, Beck et al. (2015) shared similar findings regarding beliefs about child abuse among HCP's. When asked how HCP's would classify a child whose mother commercially sells her daughter to have sex with men so that she can pay the rent, most participants agreed that this constitutes child abuse, yet similar to study findings here, did not connect this scenario with the definition of human trafficking (Beck et al., 2015).

Low awareness, confusion and only having access to part of a student's academic record likely increases the risk of missed opportunities to identify, intervene, and prevent CSEC.

Lack of Professional Collaboration with Colleagues in School

Another primary finding in this study included a divide between school nurses and colleagues, where the nurses reported that colleagues focus on the student's acting out behaviors and labeled the students' issues as 'behavioral', whereas school nurses wanted to understand the underlying risk influencing how students present outwardly at school. This understanding was frequently expressed in attitudes towards students that were nonjudgmental and care that reflected the peace-powers of nurturing, consciousness and trust. This is especially true for nurses who had experience with vulnerable youth and had previous training in CSEC. The nurses commonly expressed viewing their role as a bridge between students and teachers, where nurses will act to protect and advocate on behalf of student's needs to colleagues. The nurses described resulting conflict with colleagues when advocating for student needs in an area that colleagues perceived as not within the purview of the school nurse, such as student academic struggles. The nurses felt that their role is poorly understood by colleagues. This lack of understanding of school nurses potential contributes to a lack of professional collaboration with colleagues. The nurses expressed a sense of powerlessness and resorted to passive acceptance of a diminished role within schools, partly due to their overwhelming workload and working in an organizational culture that suppresses the voice of the school nurse.

Qualitative findings also included insight into how school nurses interact with colleagues, and how they further fit into the larger school community. Many participants described strained relationships with guidance counselors and teachers, in particular.

Participants commonly shared that some guidance counselors can be a resource of information, but collaboration does not always occur. They described a clear division between school nurses and teachers about perceptions of students, with the school nurse is an advocate and protector, whereas the nurses see the teacher viewing his or her role purely to provide education to students. This was a perspective from the nurses and the teachers view should be investigated in a future study.

The nurses shared their understanding that a student comes to school as a whole child, and cannot leave part of themselves at the classroom door, especially given youth cannot be expected to process what might be happening in their life and put on a façade that all is well. Participants repeatedly commented that a students' presentation at school reflects the constellation of and interaction between all aspects of what is happening in their lives. Some of the comments from the nurses suggested that they do not believe that teachers have the same perspective, so it would be important to obtain the teachers' views in a future study.

Qualitative findings also added greater insight and explained results from the survey questions, especially in regard to students with special needs. One perplexing finding was that nurses who reported working with this population were significantly less aware of the private and public realm risk factors of these students and they families. Participants in the qualitative study phase explained that they only work with students on 504B plans (i.e.; diabetes, seizure disorder), whereas they are not involved in IEP plans (i.e.; autism, ADHD), nor are they given access to this information or diagnoses, even though they may be responsible for administering medication in either situation.

Although the school nurses realize that medical and learning disabilities as under the umbrella of health and wellness, there were times that they did not understand the connection between academic performance, disabilities and the connection with students who frequent the school health office. The nurses felt that if they knew about the IEP diagnoses and planning they would have much to offer. They did repeatedly expressed passive acceptance and a reluctance to put themselves out there, in part due to perceived time constraints considering the number of students they are responsible for. The nurses frequently commented that they are only given a list indicating if a student is on an IEP but no other information beyond that. The nurses expressed frustration that they are not allowed to have access to this information, however did not quite make the connection that their role should be central in planning for these students as a health expert in the schools. The nurses demonstrated their attempt to find out some information by intentionally observing students and making inferences that they must be receiving services (i.e.; watching a student walk down the hall with an Occupational Therapist, or observing a student receiving reading services). The nurses also discussed trying to put the puzzle pieces together by looking in a classroom door and seeing the students that frequent the school health office struggling with their schoolwork.

These findings are significant in that there is a clear need to provide education and training that is inclusive of not only addressing the vulnerabilities of learning-disabled children, but also incorporating the role of the school nurse as an integral team partner and leader. Future research should include an interdisciplinary approach to assess the views of the whole team in regard to what role the school nurse could contribute. It is clear from what the nurses stated that they also need clarification on their role. The

qualitative findings also indicate that survey questions targeting awareness of students with disabilities (including learning disabilities) need to be carefully worded, to differentiate between the IEP and the 504B. The nurses repeatedly drew from both their current roles as well as their prior roles, with many nurses working at different educational levels over the course of their careers. This may explain why elementary school nurses in this study were significantly more aware of student risk and vulnerability as compared to high school nurses, for they may have worked in high schools in the past.

Implications

Although MA school nurses are aware of personal, familial and community vulnerabilities students face they lacked a full holistic picture of students being unable to express connections between human trafficking and CSEC. CSEC was acknowledged as a devastating problem, however the nurses perceived it as a problem outside of their local communities and schools.

Peace-Power Versus Power-Over Practice

School nurses in the U.S. are in an ideal position to effectively screen, intervene, and prevent CSEC. According to Schaffer, Anderson and Rising (2016), school nurses are equipped with public health knowledge and skills to provide comprehensive nursing services to school populations. Furthermore, Schaffer et al. (2016) describe the role of school nurses to include screening, referral and follow-up, case management, and health teaching as some of the most frequently performed health interventions. Likewise, NASN (2016) notes that specialty standards of school nursing practice are subsumed under the standards of clinical practice applied to all nurses, namely assessment, diagnosis, outcome identification, planning, implementation and evaluation. NASN

notes the expectation of professional attributes highlighted by the American Nurses' Association (ANA) to include quality of care, performance appraisal, education, collegiality, ethics, collaboration, research, and resource utilization. School nursing is also described as a specialty branch of professional nursing, specifically school nurses: 1) seek to prevent or identify health or health-related problems, and 2) intervene to modify or remediate these problems (NASN, 2016). School nursing is further described as a community-based role with the school community as the center of focus and recipient of nursing services (NASN, 2016). School nurses are in a pivotal role to address population health concerns of school children/youth and their surrounding communities. Similar to public and community health nurses, school nurses direct actions towards high-risk individuals and groups emphasizing health promotion, disease prevention, and wellness (NASN, 2016). School nurses also provide family-centered care, understanding the impact the family may have on student health and wellness.

Students at risk for CSEC or victims of CSEC are a vulnerable population of students that school nurses can comprehensively provide care to, including screening, identifying, intervening and acting to promote protection and emancipation from CSEC. School nurses are well suited for this role because of the amount of time they spend with students, their nonjudgmental approach, their position as a neutral adult in schools, and the scope of their role and clinical expertise equipping them to be central leaders of health and wellness in schools and in surrounding communities. Grace et al. (2012) emphasizes the importance of the school nurse in prevention of CSEC, as CSEC is most likely to be prevented through student disclosure to a trusted adult. School nurses can provide safe spaces for students, build trust, critically reflect, followed by critical action

that is consistent with emancipatory knowing/doing care resulting in praxis; the integrated expression of emancipatory knowing (Chinn & Kramer, 2015).

School nurses have many responsibilities within their role. Incorporating prevention of CSEC into the role of school nurses should be carefully considered in terms of developing approaches that are sustainable and effective. Findings from this study indicate that school nurses in MA do not have full access to student health information, presenting limitations to practicing effectively and comprehensively. The culture of the school setting, along with select decision-makers, present large gaps in what school nurses know about student risk, especially the vulnerability of students receiving special education services. In 2013, NASN adopted a position statement, *Section 504 and Individuals with Disabilities Education Improvement Act – The Role of the School Nurse*, in order to bring clarity in regards to the role of school nurses in caring for students on 504B plans or IEP plans. NASN maintains that school nurses are essential members of the teams participating in the identification, evaluation and planning of students who may be eligible for or receive special education services (NASN, 2013). Furthermore, NASN asserts school nurses are the link between the medical and educational communities and act as a primary health resource to the school team. School nurses are also key members of multidisciplinary teams, using their expertise to comprehensively identify students who have health, socio-emotional or developmental issues putting them at greater risk for learning issues (NASN, 2013). School nurses are the health experts in schools who can contribute in robust, meaningful ways in both health and educational plans.

Despite the strong position of NASN, the professional organization of the specialty of school nursing, findings from this study do not reflect that school nurses are

practicing to the full scope of their role, nor are they equal members of the full school team. This study was theory-guided by the PPCM and our results reflect that often school nurses practice in a team environment that conducts itself with power-over powers instead of peace-powers. An organizational power-over culture impacts awareness of student vulnerability to CSEC, attitudes towards students at risk for CSEC, and overall role perceptions in prevention. Figure 3 presents a new conceptual model of *Peace-Power versus Power-Over Practice*.

Power of Division emerged as a prominent theme, in that school nurses practice in school settings divided from their colleagues, namely guidance counselors and teachers. A division exists where power is centralized to certain school staff, and does not include school nurses. This phenomenon was apparent in the divide between who has access to full student information and who does not. Those who do have the access are gatekeepers of that access. Findings also included examples of school teams functioning as the whole, reflective of *Power of the Whole*. Examples included school nurses brought into the fold of the whole school team, practicing in solidarity with colleagues and respected for what is brought to the decision-making table.

Power of Use was one of the most prominent findings. School nurses often are not valued as an equal member of the full school team, unless there is a perceived 'medical' issue. School nurses are also not understood by colleagues, nor are they aware of what school nurses really do. However, school nurses passively accept a diminished conceptualization of their role as well as practicing to a much lesser extent than their abilities. This may be due, in part, to time constraints given the many responsibilities that a school nurse manages day-to-day, with limited nursing staff and limited resources; most

often, one school nurse is the only nurse practicing in a building on a given day. A high case load also likely contribute to school nurses accepting a diminished role. Conflict with colleagues, reflective in relationships and collaboration, also present a strain on school nurses, who culturally have a limited voice in the school setting. Often, school nurses share very different perceptions and attitudes towards students at risk than teachers especially. *Power of Nurturing* manifests in school nurses advocating for and protecting students, with a knowing that is reflective of the dynamic education and training of school nurses as holistic health experts. In contrast, teachers, guidance counselors and other school personnel can have negative perceptions about students that do not encompass a whole-child view. These polar perspectives create conflict, as the school nurse will advocate for and protect patients, despite facing conflict amongst colleagues.

School nurses may also reflect *Power of Causality* in care approaches with high-risk students. School nurses may approach care and make treatment decisions without conducting a full, comprehensive assessment. In many instances, our findings indicate that exposure to students at risk and knowledge of potential risks influence how school nurses approach care, and make assessment and treatment decisions. It was clear throughout our findings that exposure to working with students at risk resulted in school nursing practice reflective of *Power of Consciousness*. Care approaches incorporated prior knowledge about risks, including knowledge of and exposure to the public and private realm of students.

Furthermore, school nursing practice may reflect *Power of Expediency*. School nurses may resort to care decisions that are most expedient, with the easiest solutions. Prior exposure to students at risk was a consideration. Furthermore, school nurses can

self-impose role boundaries, limiting the effectiveness of care provided to students. For instance, school nurses are willing to create a nonjudgmental respite space for students, yet impose a boundary in how far they will take assessment of student risk. This can be a particular issue when faced with assessing a student for social-emotional issues, or are in crisis. School nurses may not want to ask the critical questions as part of assessing students for risk, and more often pass the student off to the guidance counselor. This may be due to a lack of confidence on how to approach assessing a student in crisis. This may also be due to a lack of training in caring for CSEC victims, what to say and how to say it, as well as what to do next. However, school nurses may reflect *Power of Intuition*, attuned to the totality of the student's life. School nurses will create a safe space for students to escape to, as well as approach students with a knowing that there is something more going on in their life. Furthermore, school nurses will intentionally ensure students are welcomed into the school health office, cognizant that they need to be able to access the school nurse.

Power of Rules can be reflected in providing school nursing care to patients without taking in the full context, resorting to care that conforms to rules and the overall school culture. Power in this culture is only in the hands of a few, namely the school administrators, guidance counselors and classroom teachers. School nurses are largely powerless, where this powerlessness carries over to care interactions and decision-making with patients presenting to the school health office. However, *Power of Creativity* can be reflected when school nurses are empowered, making care decisions in context, knowing there is always a better way to achieve student wellness. In this context, school nurses reflect willingness to non-conformity, to bend the rules and come

up with intuitive, creative solutions to meet the student's needs, while thinking about helping students to access their educational needs as well.

Lastly, *Power of Fear* can be reflected in care interactions with students who are in crisis or are highly vulnerable. School nurses may intentionally avoid fully assessing a student, or asking questions for fear of what they might find out. This fear may be due to a lack of confidence in providing care to students in crisis, or are highly vulnerable. Fear to ask critical assessment questions may also be due, in part, to perceptions about how much time it will take with the student should the school nurse open that door. School nurses lack adequate education and training of the CSEC problem, as well as what to do if they suspect a student is a victim, and reflect uncertainty in how to navigate the situation. In contrast, *Power of Trust* is a prominent highlight of holistic care school nurses provide to students at risk. School nurses are seen as a trusted adult in the schools, free from ties to discipline or academic grades. School nurses are neutral, create warm and inviting school health offices, as well as provide care that is nonjudgmental. Most importantly, school nurses are consistent in their relationships with students, many which come from histories and experiences in and out of school where adults in their lives are inconsistent. School nurses work intentionally to build trusting relationships with students, creating a respite space that students feel safe in, and safe to share even the most difficult things happening in their lives.

Research, Policy and Practice

Given what the study findings revealed, education and training addressing the problem of CSEC and the integration of the role school nurses can play in prevention and intervention is greatly needed. Respondents to the open-ended survey question, as well

as participants in the second study phase repeatedly commented that school nurses should take an active role in prevention of CSEC. Similarly, respondents discussed a need for education and training programs to be effective in their role. Respondents also expressed that a screening tool would be beneficial to use in identifying CSEC, yet cautioned that any screening tool should be effective and sustainable.

Based on the findings from this study, development of an education intervention targeting school nurses should not be implemented without taking into context the group, or how school nurses function within the greater school community. Recommendations include developing training and education interventions that are implemented using multidisciplinary, community-based participatory approaches. Guidance counselors, classroom teachers, special education administrators and school leaders should be jointly targeted with school nurses, as findings from our study indicate the importance of targeting the whole group in order to promote group cohesiveness in addressing CSEC. Through multidisciplinary interventions, the scope and practice of school nurses can be illuminated to colleagues, fostering understanding of what school nurses do and what they offer school teams facilitating power of the whole. Power of the whole will be crucial in preventing CSEC among at risk youth attending schools. Goals of future education interventions should focus on creating sustainable, effective change.

Recommended next steps include revising the *Assessment of School Nurse Awareness and Attitudes Toward CSEC Survey* based on the findings gleaned from this study. Specifically, a question should be added to inquire about prior school nursing experience as well as current student population and setting. Furthermore, questions targeting involvement with the special education process should be revised to

differentiate between involvement in the IEP versus the 504B based on what we learned in this study. The survey should be sent to a larger national sample of school nurses through the National Association of School Nurses (NASN) membership pool. Qualitative study using focus groups with a larger sample of school nurses in MA is also recommended given the final sample in the second study phase was small and attrition was a barrier to retention. Despite the small sample, repetition and common themes emerged. Determining the presence of continued repetition and common themes among a larger sample of MA school nurses can confirm data saturation and build on the findings of this study.

Efforts should also focus on school and broader local and national policy in terms of advocating for more resources to aid school nurses in their roles to successfully assess, intervene and prevent CSEC. Limited staffing and workload present a barrier for school nurses to practice to their full potential. In 2015, NASN adopted a position statement titled *School Nurse Workload: Staffing for Safe Care*. Within this document, NASN highlights that daily access to a registered nurse can improve student health, safety, abilities to learn, and meet the comprehensive health and safety needs of students, families, and school communities. In order to accomplish the full breadth of the school nurse role and its impact on student populations and beyond, school nurse workloads should be reviewed at least annually, using student and community health data to inform staffing practices (NASN, 2015). Currently, staffing practices are planned using outdated guidelines, and have not been revised to reflect the dynamic changing role of school nurses, nor the changing complex health needs of students or communities. Furthermore, staffing guidelines have not been updated to reflect the inclusion of students with medical

and learning disabilities with the enactment of Section 504 of the ADA (2000) and the Individuals with Disabilities Education Improvement Act (IDEA) (2004). Staffing recommendations have not been updated since the early 1970's, when these and similar laws were enacted to protect student rights to attend public school, including students with significant health needs (NASN, 2015). Significantly outdated staffing guidelines from the 1970's are misguiding staffing practices in schools as well as misguiding major public health initiatives, and are mentioned in Healthy People 2020 (USDHHS, 2014), as well as by the APA (2008). This approach is impacting the ability of school nurses to practice to the full scope of their practice, and significantly limiting their ability to provide comprehensive care to students and school communities.

Staffing constraints present a major barrier to school nurses and their ability to successfully prevent CSEC, presenting a need for policy action for more resources to support school nurses. Furthermore, given that individual states regulate nursing practice, collaboration with state policy-makers and stakeholders will be crucial in framing compelling arguments for improving practice conditions for school nurses. NASN recommends that school nursing services must allow for every student to have direct access to a school nurse, and that all students have the opportunity to achieve health and safety, as well as access to learning (NASN, 2015). Furthermore, school nursing services cannot be determined without consideration of the population of students, including incorporation of the social determinants of health and student needs when making decisions about staffing and school nurse workloads (NASN, 2015). In order to build sustainable programs that target multidisciplinary approaches in prevention of CSEC, simultaneous policy action to support the school nursing role is critical.

Limitations

Despite the depth of information gleaned in this mixed methods study, there are some limitations to consider. Firstly, the sample was a small convenience sample of MSNO members and survey response rate was low. The MSNO membership pool is not necessarily inclusive of all school nurses in MA. Secondly, most of the study sample consisted of public school nurses, leaving out the perspective of charter, and private school nurses. The sample consisted of only female school nurses, and lacked the perspectives of male school nurses. Furthermore, this study was cross-sectional; therefore inferences about causality cannot be made.

Study recruitment challenges and attrition were also limitations, presenting a concern that the sample may be non-representative. Recruitment for the quantitative phase was through email with an electronic survey link, a recruitment strategy known for low response and recruitment challenges. Similarly, recruitment of focus group participants was also by email, which presented major challenges with attracting participants as well as study attrition. Originally, four focus groups were confirmed across MA, with six-to-eight participants each. The final sample of study phase two participants included three focus groups with two-to-three participants each, and one in-depth interview given the second focus group participant was lost to attrition. Participation in this study as well as attrition may have been due to the time of year that the study was conducted. The first phase was conducted throughout the month of October. This is a busy time for school nurses, as they are likely still adjusting to returning to the start of a new school year and conducting state-mandated screenings, such as immunization, vision and hearing, and height and weight screenings.

Furthermore, during the same time period, the MSNO was collecting data from members through a survey study and similarly recruiting through electronic emails. Likewise, NASN was also conducting a survey of members during this timeframe. Participants may have been overburdened with too many recruitment solicitation emails at the same time. Focus groups were also scheduled and held during the month of December, which also is a busy time for school nurses as schools are preparing to close for their winter holiday break and finish up the semester.

Nonresponse bias and voluntary response bias may present limitations. Those who self-selected to respond to the survey may have strong opinions about CSEC, or prior knowledge of the topic. Individuals who did not elect to respond to the survey may differ in meaningful ways compared to those who responded.

The data is also self-reported, presenting potential limitations. There is the possible presence of social desirability bias given the sensitive nature of the survey questions measuring awareness, attitudes and role perceptions of a highly vulnerable population. Respondents may not have answered questions truly reflective of their awareness and attitudes towards students at risk of CSEC, or accurate perceptions about their role in prevention. What participants shared may not accurately reflect their actual practices with students at risk.

The qualitative phase of the study shed light into why respondents answered some questions the way they did in the first quantitative phase, illuminating limitations of the survey. Firstly, respondents were asked to share their current school setting, yet did not include a question about prior experience. During the qualitative phase, participants drew from all of their past experiences with different school populations as well as their current

setting in sharing perspectives. Also, questions were not separated addressing involvement in the IEP versus the 504B special education planning and processes. Hence, there was conflicting data between the quantitative survey findings and qualitative findings. This was due to the survey only including questions that addressed IEP's and 504B's together, instead of separate entities.

Despite identified limitations of this study, several strengths were identified. To mitigate social desirability bias as a potential limitation, the survey was delivered confidentially, which may have lessened social desirability bias. Also, survey questions and the focus group interview guide were designed to present questions in a concrete manner, without judgment attached. In designing the survey, demographics questions were presented first in order to minimize missing data, followed by Likert scale questions measuring their awareness, attitudes and role perceptions in prevention of CSEC. The length of the survey and time to complete it were also factors that were carefully considered to minimize participant burden, missing data and incomplete surveys. The survey also included a final open-ended question asking participants if they had anything further to add. Comments analyzed were insightful in further understanding quantitative and qualitative findings. Furthermore, even though a highly sensitive topic was presented for discussion during focus groups and the in-depth interview, participants shared openly, appeared comfortable with speaking to one another, and to the investigator. Participants were also assured that what they shared is confidential, and the investigator would be presenting findings as group data, without any identifying information.

Conclusion

CSEC is a real and devastating population health problem that affects thousands of school-aged children and youth across the U.S. School nurses are in an ideal position to identify, prevent, protect, and raise awareness of students who are at risk or victims of CSEC. Findings support the need for future education interventions targeting school nurses in developing their role to effectively screen, intervene and prevent CSEC. Additionally, findings support the need for multidisciplinary approaches and to illuminate the role of school nurses in the greater school community, particularly among school colleagues. Advocacy at the local and national policy levels for additional resources to support the school nurse role is critical in moving forward with efforts to develop the role of school nurses in effectively preventing CSEC.

APPENDIX A: ASSESSMENT OF SCHOOL NURSE AWARENESS AND ATTITUDES TOWARD CSEC

Introduction to the Survey: This survey will help us understand awareness and perceptions among school nurses regarding students at risk. Please read each question carefully and select one option that most appropriately represents your opinion.

Definitions of terms:

CSEC = Commercial Sexual Exploitation of Children

Exploiters = Perpetrators who either sell or buy commercial sex

Sex trafficking = Holding a person or group of people against their will and forcing them to sell sex commercially

Runaway kids = Leave home by choice

Throwaway kids = Told to leave home

Demographics

Please read and respond to the questions by selecting one option

1. Are you a Registered Nurse currently practicing in a school setting? CSEC 1

    1. **No**
    2. **Yes**

2. How long have you practiced as a School Nurse (in years)? _____ CSEC 2

3. What is your highest level of education? CSEC 3

    1. **Associates**
    2. **Baccalaureate**
    3. **Masters**
    4. **Post-Masters**

4. Are you required to hold the School Nurse Service Credential to practice as a School Nurse by your employer? CSEC 4

    1. **No**

2. **Yes**

5. Are you male or female? CSEC 5

1. **Male**

2. **Female**

6. What is your current age (in years)?: _____ CSEC 6

7. What type of school setting do you work in? CSEC 7

1. **Public District**
2. **Public Charter**
3. **Private**
4. **Special Education**
5. **Transitions Program**
6. **Alternative Program**

8. Is your school located in a rural, suburban, or urban area (select one)? CSEC 8

1. **Rural**
2. **Suburban**
3. **Urban**

9. How would you describe the surrounding community safety of your school setting? (Select one option) CSEC 9

1. **Crime is not a problem**
2. **Crime is somewhat of a problem**
3. **Crime is a problem**

10. How would you describe the economic conditions of your local school community? (Select one option) CSEC 10

1. **Jobs are not a problem**
2. **Joblessness is somewhat of a problem**
3. **Joblessness is a problem**

11. Describe your school setting (select one that best applies): CSEC 11

1. **Not Ethnically Diverse**
2. **Some Diversity**
3. **Ethnically Diverse**

12. How do most students arrive at your school? CSEC 12

1. **Walk**

2. **School Bus**
3. **Public Transportation**
4. **Car**
5. **Unsure**

13. Does your school have a school-based health clinic? CSEC 13

1. **No**
2. **Yes**

14. What educational level of school children do you primarily work with? CSEC 14

1. **Elementary School**
2. **Middle School**
3. **High School**
4. **Transitions Program**

15. How many schools do you provide nursing care to in your role as a school nurse? CSEC 15

_____

16. How many students are you responsible for in your role as a school nurse? CSEC 16

_____

17. Do you work with special education students? CSEC 17

1. **No**
2. **Yes**
3. **Unsure**

18. Do you work with the Individualized Education Team (IEP) or 504B Team? CSEC 18

1. **No**
2. **Yes**

Survey Instructions: Please read and respond to the questions by selecting the number that most appropriately represents your opinion

1 = *not at all* 2 = *somewhat* 3 = *average* 4 = *above average* 5 = *very much*

19. How familiar are you with the academic achievement levels of students under your care?

1 2 3 4 5 CSEC 19

20. How familiar are you with student absences and tardiness?

1 2 3 4 5 CSEC 20

21. How familiar are you with the social peer relationships of students?

1 2 3 4 5 CSEC 21

22. How familiar are you with the family relationships of students?

1 2 3 4 5 CSEC 22

23. How familiar are you with the social-emotional status of students?

1 2 3 4 5 CSEC 23

24. How familiar are you with mental health diagnoses of students?

1 2 3 4 5 CSEC 24

25. How familiar are you with the dating relationships of students?

1 2 3 4 5 CSEC 25

26. How familiar are you with students who are in foster care and/or Department of Children and Family (DCF) custody?

1 2 3 4 5 CSEC 26

27. How aware are you of student involvement in the Juvenile Justice System?

1 2 3 4 5 CSEC 27

28. How familiar are you with disability (medical and/or learning) diagnoses of students?

1 2 3 4 5 CSEC 28

29. How familiar are you with the problem of human trafficking?

1 2 3 4 5 CSEC 29

30. How familiar are you with the term Commercial Sexual Exploitation of Children (CSEC)?

1 2 3 4 5 CSEC 30

31. How aware are you with the multiple forms of CSEC?

1 2 3 4 5 CSEC 31

32. How aware are you with the scope of the CSEC problem—nationally and locally?

1 2 3 4 5 CSEC 32

33. How familiar are you with control and coercion methods used by exploiters?

1 2 3 4 5 CSEC 33

34. How strongly do you agree that children can get out of trafficking by asking for help?

1 2 3 4 5 CSEC 34

35. How strongly do you agree that children who are victims of CSEC may still be attending school?

1 2 3 4 5 CSEC 35

36. How strongly do you agree that exploiters can be students at school?

1 2 3 4 5 CSEC 36

37. How strongly do you agree that sex trafficking is **NOT** really a problem for school age children in the U.S.?

1 2 3 4 5 CSEC 37

38. How strongly do you believe that students who consent to commercial sex are **NOT** victims of trafficking?

1 2 3 4 5 CSEC 38

39. How strongly do you agree that child sexual abuse is related to child sex trafficking?

1 2 3 4 5 CSEC 39

40. How strongly do you believe that victims of CSEC should be reported to the Department of Children and Families (DCF)?

1 2 3 4 5 CSEC 40

41. How strongly do you agree that victims of CSEC are females?

1 2 3 4 5 CSEC 41

42. How strongly do you agree that victims of CSEC are males?

1 2 3 4 5 CSEC 42

43. How strongly do you agree that CSEC victims always come from situations of poverty?

1 2 3 4 5 CSEC 43

44. How strongly do you agree that students who frequently runaway are emotionally at risk?

1 2 3 4 5 CSEC 44

45. How strongly do you agree that students who frequently runaway are difficult to work with?

1 2 3 4 5 CSEC 45

46. How familiar are you with the term "throwaway" kids?

1 2 3 4 5 CSEC 46

47. How strongly do you agree that runaways are more likely to identify as LGBTQ?

1 2 3 4 5 CSEC 47

48. How strongly do you agree that CSEC is a major problem facing youth today?

1 2 3 4 5 CSEC 48

49. How strongly do you agree with the following statement:

"It is important for me to know about CSEC for my role as a School Nurse"

1 2 3 4 5 CSEC 49

50. How strongly do you agree that it is appropriate for school nurses to screen students for CSEC?

1 2 3 4 5 CSEC 50

51. How strongly do you agree with the following statement:

"I would not be surprised if children in my school were involved in CSEC"

1 2 3 4 5 CSEC 51

52. How strongly do you agree with the following statement:

"I know who to call if I encounter a potential CSEC victim"

1 2 3 4 5 CSEC 52

53. How strongly do you agree with the following statement:

"I have suspected that a student was a victim of CSEC"

1 2 3 4 5 CSEC 53

54. How strongly do you agree with the following statement:

"School nurses can screen for student risk for sexual exploitation"

1 2 3 4 5 CSEC 54

55. How strongly do you agree that nurses do not have time to screen students for CSEC?

1 2 3 4 5 CSEC 55

56. How strongly do you agree that knowledge of CSEC is a barrier for school nurses to identify CSEC?

1 2 3 4 5 CSEC 56

57. How strongly do you agree that time is a barrier for school nurses to identify CSEC?

1 2 3 4 5 CSEC 57

58. How strongly do you agree that large student numbers are a barrier for school nurses to identify CSEC?

1 2 3 4 5 CSEC 58

59. How strongly do you agree that funding limitations are a barrier for school nurses to identify CSEC?

1 2 3 4 5 CSEC 59

60. How strongly to you agree that there are no limitations for school nurses to

identify CSEC?

1 2 3 4 5 CSEC 60

61. How strongly do you agree that the issue of CSEC should be handled by law enforcement only not school nurses?

1 2 3 4 5 CSEC 61

62. How strongly do you agree with the following statement:

"If educational opportunities were available to me to learn how to prevent CSEC in my role as a School Nurse I would attend"

1 2 3 4 5 CSEC 62

63. Have you attended any training program on CSEC? CSEC 63

1. **No**
2. **Yes**

64. Do you think that children who you see as a school nurse could be involved in CSEC? CSEC 64

1. **No**
2. **Yes**

65. Have you ever identified a child (children) who are involved in CSEC? CSEC 65

1. **No**
2. **Yes**

66. Is there anything you would like to add? _____ CSEC 66

Thank you for taking the time to participate in this survey. If you elected to participate in the Apple iPad drawing and your name is selected, we will contact you further.

APPENDIX B: FOCUS GROUP MODERATOR GUIDE

School Nurses' Awareness and Attitudes Towards Student Risk

Phase 2: Focus Group Moderator's Guide

Have a planned introductory statement that is the same in all focus groups, to give the participants a notion of what you'll be discussing and why they've been brought together for the focus group.

1. Tell me about the students that you care for.
    - Elementary, Middle, High School, Special Education
    - As a school nurse, how would you say you spend the majority of your time?
    - Do you ever take work home with you?
2. From your perspective, what are the major risks your students face?
    - Family
    - Peer/Social relationships
    - Dating violence – sexual violence
    - Sexual risk behaviors-
    - Example Probes:
        - Talk to us about a time when you cared for a student who was engaging in sexually risky behavior.
        - How did you care for that student?
            - How involved did you feel you should get?
        - How did the student respond?
        - How did you feel after that encounter with the student?

- Drugs
- Academics
    - Talk to us about how you typically become aware of student grades/academic performance.
- Learning/Medical Disabilities
    - How do you typically become aware of learning or medical diagnoses of students?
    - Let's talk about your role in the IEP/504B team – first, do you have a role? Can you tell us a bit about your involvement?
- School attendance/truancy
- Community – violence, poverty, economic conditions

3. Tell me about a time that you cared for a student with family problems.
    - What kinds of family problems?
    - Family involvement
    - Family violence- history of abuse
    - How did you care for this student?
    - What kinds of effects do you see these family issues having on your students?
    - Have you personally encountered any students in DCF custody or foster care?
4. Have you personally encountered any students who were 'runaways'?
    - Runaways?

- Have you heard of the term “throw-away”? (If not, define it for the group)
- What happens with those kids?

5. Have you personally encountered any students involved in the juvenile justice system?

6. As a school nurse, what do you think about risk of trafficking to students in your own area? (If respondents do not know what this means, define it for the group)
    - There is another term called Commercial Sexual Exploitation of Children, or CSEC; talk to me about your familiarity with this issue; when did you first hear of it? In what context?
    - Tell me about your thoughts about trafficking versus child abuse
    - Tell me about your thoughts about trafficking versus consent to sexual activity for payment; are they different or similar?
7. Can you think of a time that you may have cared for a student who was at risk for trafficking or exploitation? If so, tell us about that experience.
    - Do you think school nurses have a role to play in this area of prevention?
    - How so?
    - Do you see this as part of your role, personally, in your day to day work as a school nurse?

REFERENCES

Adams, P. M., & Shineldecker, S. C. (2014). Unaccompanied youth school nurses caring for adolescent minors living without a parent or guardian. *NASN School Nurse*, 90-95. doi: 10.1177/1942602X13501202

Ahn, R., Alpert, E. J., Purcell, G., Konstantopoulos, W. M., McGahan, A., Cafferty, E.,…& Burke, T. F. (2013). Human trafficking review of educational resources for health professionals. *American Journal of Preventive Medicine, 44*, 283-289. doi: 10.1016/j.amepre.2012.10.025

American Academy of Pediatrics. (2008). *Role of the School Nurse in Providing School Health Services*. Retrieved from http://www.aappolicy.aappublications.org/cgi/reprint/pediatrics;121/5/1052.pdf

Beck, M. E., Lineer, M. M., Melzer-Lange, M., Simpson, P., Nugent, M., & Rabbitt, A. (2015). Medical providers' understanding of sex trafficking and their experience with at-risk patients. *Pediatrics, 135*, e895-e902. doi: 10.1542/peds.2014-2814

Bleazby, J. (2009). Overcoming relativism and absolutism: dewey's ideals for truth and meaning in philosophy for children. *Educational Philosophy and Theory, 43*(5), 453-466. doi: 10.1111/j.1469-5812.2009.00567.x

Castleman, J. B., Novak, M. A., & Sposetti, V. J. (2005). Training school nurses: Screening and brief intervention for tobacco use. *Substance Abuse, 26*, 35-39. doi: 10.1300/J465v26n03_08

Child Advocacy Center of Suffolk County (2012). *Support to End Exploitation Now (SEEN)*. Retrieved from http://www.suffolkcac.org/programs/seen/

Chinn, P. L., & Falk-Rafael, A. (2015). Peace and power: A theory of emancipatory group process. *Journal of Nursing Scholarship, 47,* 62-69. doi: 10.1111/jnu.12101

Chinn, P. L. (2013). *Peace & Power: New directions for building community* (8th ed.). Burlington, MA: Jones and Bartlett Learning.

Cook, D. A., & Beckman, T. J. (2006). Current concepts in validity and reliability for psychometric instruments: Theory and application. *The American Journal of Medicine, 119,* e7-e16. doi: 10.1016/j.amjmed.2005.10.036

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Earlbaum Associates.

Cole, J., & Sprang, G. (2015). Sex trafficking of minors in metropolitan, micropolitan, and rural communities. *Child Abuse & Neglect, 40,* 113-123. doi: 10.1016/j.chiabu.2014.07.015

Cole, J., Sprang, G., Lee, R., & Cohen, J. (2014). The trauma of commercial sexual exploitation of youth: a comparison of CSE victims to sexual abuse victims in a clinical sample. *Journal of Interpersonal Violence,* published online before print 0886260514555133, 1-25. doi: 10.1177/088626051455133

Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks: Sage Publications, Inc.

Cowell, J. M. (2014). Commercial sexual exploitation and sex trafficking of minors as child abuse. *The Journal of School Nursing, 30,* 87-88. doi: 10.1177/1059840514524732

Diaz, A., Clayton, E. W., & Simon, P. (2014). Confronting commercial sexual exploitation and sex trafficking of minors. *JAMA Pediatrics, 169,* 791-792. doi: 10.1001/jamapediatrics.2014.1002

Edinburgh, L., Huemann, E., Richtman, K., Marboe, A. M., & Saewyc, E. (2012). The safe harbors youth intervention project: Inter-sectorial collaboration to address sexual exploitation in Minnesota. *Nursing Reports, 2,* 18-24.

Edinburgh, L., Saewyc, E., Thao, T., & Levitt, C. (2006). Sexual exploitation of very young Hmong girls. *Journal of Adolescent Health, 39,* 111-118.

Education Commission to the States. (2015). *Number of Instructional Days/Hours in the School Year*. Retrieved from http://www.ecs.org

Estes, R., & Weiner, N. (2001). The commercial sexual exploitation of children in the U.S., Canada, and Mexico. Philadelphia: University of Pennsylvania Press.

Fawcett, J., & DeSanto-Madeya, S. (2013). *Contemporary nursing knowledge: Analysis and evaluation of nursing models and theories* (3rd ed.). Philadelphia: F. A. Davis.

Ferguson, K. M., Soydan, H., Lee, S., Yamanaka, Freer, A. S., & Xie, B. (2009). Evaluation of the CSEC community intervention project (CCIP) in five U.S.. cities. *Evaluation Review, 33,* 568-597. doi: 10.1177/0193841X09346132

Flaherty, M. P. (2010). *Narrating the past to vision the future: Constructing civil society with women in Ukraine* (PhD dissertation). University of Manitoba, Winnepeg, Manitoba. Retrieved from: http://mspace.lib.umanitoba.ca/jspui/handle/1993/4466

Freeman, S. A., Rosenbluth, B., & Cotton, L. (2013). Teen dating abuse recognition and interventions. *NASN School Nurse, 28,* 79-82. doi: 10.1177/1942602X12469410

Gonzalez, E. (2013). The nexus between human trafficking and terrorism / organized crime: Combating human trafficking by creating a cooperative law enforcement system. *Student Scholarship,* 227, 1-29.

Grace, A. M., Lippert, S., Collins, K., Pineda, N., Tolani, A.,…& Horwitz, S. M. (2014). Educating health care professionals on human trafficking. *Pediatric Emergency Care, 30,* 856-861.

Grace, L. G., Starck, M., Potenza, J., Kenney, P. A., & Sheetz, A. H. (2012). Commercial sexual exploitation of children and the school nurse. *The Journal of School Nursing, 28,* 410-417. doi: 10.1177/1059840512448402

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24,* 105-112. doi: 10.1016/j.nedt.2003.10.001

Greenbaum, V. J. (2014). Commercial sexual exploitation and sex trafficking of children in the United States. *Current Problems in Pediatric and Adolescent Health Care, 14,* 245-269. doi: 10.1016/j.cppeds.2014.07.001

Greenbaum, V. J., & Crawford-Jakubiak, J. E. (2015). Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics, 135,* 566-574. doi: 10.1542/peds.2014-4138

Hootman, J., Houck, G. M., & King, M. C. (2002). A program to educate school nurses about mental health interventions. *The Journal of School Nursing, 18,* 191-195.

Hoskins, S. A. (2005). Nurses and national socialism- a moral dilemma: one historical example of a route to euthanasia. *Nursing Ethics, 12*(1), 79-91. doi: 10.1191/0969733005ne759oa

Individuals with Disability Improvement Act (2004), 20 U.S.C. 1400 et seq.

Institute of Medicine, National Research Council. (2013). C*onfronting commercial sexual exploitation and sex trafficking of minors in the United States*. Washington, D. C.: National Academies Press

Isaac, R., Solak, J., & Giardino, A. P. (2011). Health care providers' training needs related to human trafficking: Maximizing the opportunity to effectively screen and intervene. *Journal of Applied Research on Children: Informing Policy for Children at Risk, 2 (8), 1-28.*

Jenkins, E. K., Johnson, J. L., Bungay, V., Kothari, A., & Saewyc, E. M. (2015). Divided and disconnected- An examination of youths' experiences with emotional distress in the context of their everyday lives. *Health Place, 35*, 105-112. doi: 10.1016/j.healthplace.2015.08.006

Kruger, A., Harper, E., Harris, Pl, Sanders, D., Levin, K., & Meyers, J. (2013). Sexualized and dangerous relationships: Listening to the voices of low-income African American girls placed at risk for sexual exploitation. *Western Journal of Emergency Medicine, 14*, 370-376. doi: 10.5811/westjem.2013.2.16195

Leung, K., Travena, L., & Waters, D. (2012). Development of an appraisal tool to evaluate strength of an instrument or outcome measure. *Nurse Researcher, 20,* 13-19.

Leung, K., Travena, L., & Waters, D. (2014). Systematic review of instruments for measuring nurses' knowledge, skills and attitudes for evidence-based practice. *Journal of Advanced Nursing, 70*, 2181-2195. doi: 10.1111/jan/12454

Mackey, S. (2005). Phenomenological nursing research: Methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies*, 42, 179-186. doi: 10.1016/j.ijnurstu.2004.06.011

Mangena, A. S., & Maughan, E. (2015). The 2015 school nurse survey developing and providing leadership to advance school nursing practice. *NASN School Nurse, 30* (6), 329-335. doi: 10.1177/1942602X15608183

Massachusetts Interagency Human Trafficking Policy Task Force. (2013). *Findings and Recommendations*. Retrieved from http://www.mass.gov/ago/docs/ihttf/ihttf-findings.pdf

Massachusetts School Nurse Organization. (2016). *About MSNO*. Retrieved from http://www.msno.org

Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review, 62*, 279-299.

McMahon-Howard, J., & Reimers, B. (2013). An evaluation of a child welfare training program on the commercial sexual exploitation of children (CSEC). *Evaluation and Program Planning, 40*, 1-9. doi: 10.1016/j.evalprogplan.2013.04.002

Morrison-Sandberg, L. F., Kubik, M. Y., & Johnson, K. E. (2011). Obesity prevention practices of elementary school nurses in Minnesota: Findings from interviews with licensed school nurses. *Journal of School Nursing, 27*, 13-21. doi: 10.1177/10.59840510386380

Munhall, P. L. (2007). *Nursing research a qualitative perspective* (4th ed.). Sudbury: Jones and Bartlett Publishers

National Association of School Nurses. (2011). *Role of the School Nurse*. Retrieved from http://www.nasn.org

National Association of School Nurses. (2016). *Annual Report*. Retrieved from http://www.nasn.org

National Association of School Nurses. (2015). *The Role of the 21st Century School Nurse*. Retrieved from https://www.nasn.org

National Association of School Nurses. (2013). *Section 504 and Individuals with Disabilities Education Improvement Act- The Role of the School Nurse*. Retrieved from http://www.nasn.org

National Association of School Nurses. (2015). *School Nurse Workload: Staffing for Safe Care*. Retrieved from http://www.nasn.org

National Center for Missing and Exploited Children. (2014). *Child Sexual Exploitation*. Retrieved from http://www.missingkids.com

Office of the Attorney General (2013). *Massachusetts Interagency Human Trafficking Policy Task Force*. Retrieved from http://www.mass.gov/ago/docs/ihttf/ihttf-findings.pdf

Pierce, A. S. (2012). American Indian adolescent girls: Vulnerability to sex trafficking, intervention strategies. *American Indian and Alaska Native Mental Health Research, 19,* 37-56. doi: 10.5820/aian.1901.2012.37

Plano Clark, V. L., & Creswell, J. W. (2008). *The mixed methods reader*. Thousand Oaks: Sage Publications, Inc.

Poland, B., Frohlich, K., Haines, R. J., Mykhalovskiy, E., Rock, M., & Sparks, R. (2006). The social context of smoking: the next frontier in tobacco control? *Tobacco Control, 15*, 59-63. doi: 10.1136/tc.2004.009886

Polit, D. F., & Beck, C. T. (2008). *Nursing research generating and assessing evidence for nursing practice* (8th ed.). Philadelphia: Lippincott Williams & Wilkins

Rehabilitation Act of 1973, 29 U.S.C. § 504.

Rosner, B. (2010). *Fundamentals of Biostatistics* (7th ed.). Boston: Brooks/Cole, Cengage Learning.

Saewyc, E. M., Solsvig, W., & Edinburgh, L. (2007). The Hmong youth task force: Evaluation of a coalition to address the sexual exploitation of young runaways. *Public Health Nursing, 25*, 69-76. doi: 10.1111/j.1525-1446.2008.00681.x

Sandelowski, M. (2000). Focus on research methods whatever happened to qualitative description? *Research in Nursing & Health, 23*, 334-340.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health, 33*, 77-84. doi: 10.1002/nur.20362

Schaffer, M. A., Anderson, L. J. W., & Rising, S. (2016). Public health interventions for school nursing practice. *Journal of School Nursing, 32* (3), 195-208. doi: 10.1177/1059840515605361

Schutt, R. K. (2012). *Investigating the social world the process and practice of research* (7th ed.). Thousand Oaks: Sage Publications, Inc.

Snelling, P. C. (2003). Consequences count: against absolutism at the end of life. *Journal of Advanced Nursing, 46*(4), 350-357.

Speroni, K. G., Earley, C., & Atherton, M. (2007). Evaluating the effectiveness of the kids living fit program: A comparative study. *The Journal of School Nursing, 23*, 329-336.

Todres, J., & Clayton, E. W. (2014). Responding to the sexual exploitation of minors. *New England Journal of Medicine, 370,* 1282-1283. doi: 10.1056/NEJMp1314927

Titchen, K. E., Harrison, S. L., DeLeon, J., & Atkinson, H. G. (2015). Human sex trafficking education in healthcare: Evidence for a novel free online curriculum. Paper presented at the 2015 Eastern SPR Annual Meeting. Report retrieved from http://www.aps-spr.org

United States, Department of Education. (2009). *Protecting students with disabilities*. Retrieved from: https://www2.ed.gov/about/offices/list/ocr/504faq.html

United Nations, Office on Drugs and Crime. (2000). *A protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the united nations convention against transnational organized crime*. Retrieved from: http://www.unodc.org

United States Congress, Library of Congress. (2000). *Trafficking Victims Protection Act* (H.R. 4703). Retrieved from http://www.congress.gov

United States Department of Health and Human Services. (2009). *Human Trafficking Into and Within the United States: A Review of the Literature*. Retrieved from http://www.aspe.hhs.gov/hsp/07/HumanTrafficking/LitRev/

United States Department of Health and Human Services (2014). *Healthy People 2020, Educational Based Programs*. Retrieved from http://www.healthypeople.gov

United States Department of Labor Division of Federal Employees' Compensation Act. (1995). Retrieved from http://www.dol.gov

United States Department of Justice. (2010). *The National Strategy for Child Exploitation Prevention and Interdiction, a Report to Congress*. Retrieved from http://www.justice.gov

United States Department of Justice Office of Justice Programs, National Institute of Justice. (2007). *Commercial Sexual Exploitation of Children: What Do We Know and What Do We Do About It?* Retrieved from http://www.ncjrs.gov

United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (2004). *Prostitution of Juveniles: Patterns from NIBRS.* Retrieved from http://www.ncjrs.gov

United States Federal Bureau of Investigation. (2015). *FBI Announces Results of Nationwide Human Trafficking Operation.* Retrieved from http://www.fbi.gov

Viechtbauer, W., Smits, L., Kotz, D., Bude, L., Spigt, M., Serroyen, J., Crutzen, R. (2015). A simple formula for the calculation of sample size in pilot studies. *Journal of Clinical Epidemiology*, *68*, 1375-1379. doi: 10.1016/j.jclinepi.2015.04.014

Wong, J. C., Hong, J., Leung, P., Yin, P., & Stewart, D. E. (2011). Human trafficking: An evaluation of Canadian medical students' awareness and attitudes. *Education for Health*, *24* (1), 1-10.

Table 1. *Peace-Powers Versus Power-Over Powers*

Identified Power-Over Powers	Identified Peace-Powers
Power of Division: A culture of centralized power and knowledge belonging to a select few.	*Power of the Whole*: Fostered through a culture of decentralized solidarity.
Power of Use: Encouraging exploitation of people and resources.	*Power of Nurturing*: Promotes and values respect and protection for all.
Power of Causality: Relies on a quick-fix approach without regard to potential future consequences or context.	*Power of Intuition*: Fosters perceptions of human experience wholly instead of in part.
Power of Expediency: Making choices based on what is easy and readily available.	*Power of Consciousness*: Consideration of longer-range outcomes and ethics that protect life, forming a framework for acting to confront injustice.
Power of Rules: Calls for action and prescription of punishment based solely on policies and laws.	*Power of Creativity*: Values action taking into consideration the full context of the individual.
Power of Fear: Fosters action taken to prevent and control the behavior of others.	*Power of Trust*: Fosters striving for genuine human relationships coupled with consistent action.

*(Chinn, 2013; Chinn & Falk-Rafael, 2015)

Table 2. *School Nurse Demographics*

Variable	Sample (N) %	Range	Mean (SD)
Current RN School Nursing Practice No Yes	N=112 N= 2 (1.79%) N= 110 (98.21%)		
School Nurse Years	N=112	0.5-29	12.92 (7.21)
Education Level Associates Baccalaureate Masters Post-Masters	N= 112 N=4 (3.57%) N=50 (44.64%) N=49 (43.75%) N=9 (8.04%)		
School Nurse Credential Requirement No Yes	N= 112 N=63 (56.25%) N=49 (43.75%)		
Sex Male Female	N= 112 N= 0 (0%) N= 112 (100%)		
Age (Years)	N=111 (99.11%)	24-68	53 (9.68)

Table 3. *School Setting Characteristics*

Variable	Sample (N) %	Range	Mean (SD)
Student Population	N=107 (95.54%)		
Elementary School	N=64 (57.14%)		
Middle School	N=13 (11.61%)		
High School	N=29 (25.89%)		
Post-High School	N=1 (0.89%)		
School Setting	N=112		
Public	N=95 (84.82%)		
Public Charter	N=6 (5.36%)		
Private	N=7 (6.25%)		
Special Education	N=4 (3.57%)		
Daily Care Responsibility	N= 108 (100%*)	50-4000	585.806 (544.421)
School Location	N= 111 (99.11%)		
Rural	N=13 (11.61%)		
Suburban	N=69 (61.61%)		
Urban	N=29 (25.89%)		
School Based Health Clinic	N= 112		
No	N= 92 (82.14%)		
Yes	N= 20 (17.86%)		

**Daily Care Responsibility* variable: four respondents who indicated "0" were recoded to missing as all indicated in survey comments that they are current school nurse administrators.

Table 4. *School Community and Student Risk Factors*

Variable	Sample (N) %	Percent
Community Crime Levels	N=112 (100%)	
Crime is not a problem	N=50	44.64%
Crime is somewhat a problem	N=41	36.61%
Crime is a problem	N=21	18.75%
Economic Conditions	N=112	
Joblessness is not a problem	N=44	39.29%
Joblessness is somewhat a problem	N=45	40.18%
Joblessness is a problem	N=23	20.54%
Diversity	N= 112 (100%)	
No diversity	N= 16	14.29%
Some diversity	N=54	48.21%
Diverse	N=42	37.50%
School Location	N= 111 (99.11%)	
Rural	N=13	11.61%
Suburban	N=69	61.61%
Urban	N=29	25.89%
Student Arrival to School	N= 112 (100%)	
Walk	N= 13	11.61%
School Bus	N= 71	63.39%
Public Transportation	N=6	5.36%
Car	N=16	14.29%
Unsure	N=6	5.36%
Learning and/or Medical Disabilities Diagnoses Knowledge	N=112 (100%)	
No	N= 7	6.25%
Yes	N= 105	93.75%
IEP/504B Team Involvement	N= 112 (100%)	
No	N= 12	10.71%
Yes	N= 100	89.29%

Table 5. *Reliability of Awareness, Attitudes and Role Perception Scales*

Construct	Number of Items	M (SD)	Cronbach's α
Awareness	15	46.05 (9.07)	$\alpha = 0.87$
Attitudes	16	46.25 (6.62)	$\alpha = 0.74$
Role Perceptions	12	34.34 (3.83)	$\alpha = 0.70$

Table 6. *Student Vulnerability Awareness*

Awareness Items	Sample (N) %	Percent
How familiar are you with student achievement levels?	N=111 (99.11%)	
Not at all	N=5	4.46%
Somewhat	N=25	22.32%
Average	N=48	42.86%
Above Average	N=27	24.11%
Very Much	N=6	5.36%
How familiar are you with student absences/tardiness?	N=112 (100%)	
Not at all	N= 0	0%
Somewhat	N=13	11.61%
Average	N=23	20.54%
Above Average	N=31	27.68%
Very Much	N=45	40.18%
How familiar are you with social peer relationships?	N= 112 (100%)	
Not at all	N= 4	3.57%
Somewhat	N=24	21.43%
Average	N=47	41.96%
Above Average	N=31	27.68%
Very Much	N=6	5.36%
How familiar are you with family relationships?	N= 112 (100%)	
Not at all	N=2	1.79%
Somewhat	N=23	20.54%
Average	N=48	42.86%
Above Average	N=31	27.68%
Very Much	N=8	7.14%
How familiar are you with student social-emotional status?	N= 112 (100%)	
Not at all	N= 0	0%
Somewhat	N= 18	16.07%
Average	N= 26	23.21%
Above Average	N=54	48.21%
Very Much	N=14	12.50%
How familiar are you with student mental health diagnoses?	N=112 (100%)	
Not at all	N= 1	0.89%
Somewhat	N= 7	6.25%
Average	N= 20	17.86%
Above Average	N=65	58.04%
Very Much	N=19	16.96%

How familiar are you with dating relationships?	N= 110 (98.21%)	
Not at all	N= 34	30.36%
Somewhat	N= 29	25.89%
Average	N=40	35.71%
Above Average	N=7	6.25%
Very Much	N= 0	0%
How familiar are you of DCF custody / Foster Care?	N= 112 (100%)	
Not at all	N= 4	3.57%
Somewhat	N=16	14.29%
Average	N= 32	28.57%
Above Average	N= 31	27.68%
Very Much	N= 29	25.89%
How familiar are you with disability diagnoses?	N= 112 (100%)	
Not at all	N= 0	0%
Somewhat	N= 8	7.14%
Average	N= 18	16.07%
Above Average	N= 54	48.21%
Very Much	N= 32	28.57%
How familiar are you with human trafficking?	N= 111 (99.11%)	
Not at all	N= 15	13.39%
Somewhat	N= 35	31.25%
Average	N= 41	36.61%
Above Average	N= 17	15.18%
Very Much	N= 4	3.57%
How familiar are you with the CSEC term?	N= 112 (100%)	
Not at all	N= 19	16.96%
Somewhat	N= 29	25.89%
Average	N= 43	38.39%
Above Average	N= 15	13.39%
Very Much	N= 6	5.36%
How aware are you with the multiple forms of CSEC?	N= 110 (98.21%)	
Not at all	N= 28	25.00%
Somewhat	N= 39	34.82%
Average	N= 25	22.32%
Above Average	N= 13	11.61%
Very Much	N= 5	4.46%

How aware are you with the scope of CSEC?	N= 111 (99.11%)	
Not at all	N= 20	17.86%
Somewhat	N= 44	39.29%
Average	N= 29	25.89%
Above Average	N= 14	12.50%
Very Much	N= 4	3.57%
How familiar are you with the term "throwaway kids"?	N= 112 (100%)	
Not at all	N= 13	11.61%
Somewhat	N= 32	28.57%
Average	N= 34	30.36%
Above Average	N= 20	17.86%
Very Much	N= 13	11.61%
How familiar are you with exploiter methods?	N= 112 (100%)	
Not at all	N= 19	16.96%
Somewhat	N= 30	26.79%
Average	N= 36	32.14%
Above Average	N= 19	16.96%
Very Much	N= 8	7.14%

Table 7. *Attitudes Towards CSEC*

Attitudes Items	Sample (N) %	Percent
How strongly do you agree that sex trafficking is not really a problem for school age children in the U.S.?	N=112 (100%)	
Not at all	N=0	0%
Somewhat	N=1	0.89%
Average	N=16	14.29%
Above Average	N=16	14.29%
Very Much	N=79	70.54%
How strongly do you believe that students who consent to commercial sex are not victims of trafficking?	N=112 (100%)	
Not at all	N= 0	0%
Somewhat	N=1	0.89%
Average	N=4	3.57%
Above Average	N=5	4.46%
Very Much	N=102	91.07%
How strongly do you agree that child sexual abuse is related to child sex trafficking?	N= 112 (100%)	
Not at all	N= 10	8.93%
Somewhat	N=16	14.29%
Average	N=32	28.57%
Above Average	N=16	14.29%
Very Much	N=38	33.93%
How strongly do you believe that victims of CSEC should be reported to DCF?	N= 112 (100%)	
Not at all	N=5	4.46%
Somewhat	N=2	1.79%
Average	N=4	3.57%
Above Average	N=12	10.71%
Very Much	N=89	79.46%
How strongly do you agree that victims of CSEC are females?	N= 112 (100%)	
Not at all	N= 11	9.82%
Somewhat	N= 13	11.61%
Average	N= 41	36.61%
Above Average	N=24	21.43%
Very Much	N=23	20.54%

How strongly do you agree that victims of CSEC are males?	N=112 (100%)	
Not at all	N= 9	8.04%
Somewhat	N= 19	16.96%
Average	N= 53	47.32%
Above Average	N=13	11.61%
Very Much	N=18	16.07%
How strongly do you agree that CSEC victims always come from situations of poverty?	N= 110 (98%)	
Not at all	N= 52	46.43%
Somewhat	N= 27	24.11%
Average	N=23	20.54%
Above Average	N=7	6.25%
Very Much	N= 3	2.68%
How strongly do you agree that students who frequently run away are emotionally at risk?	N= 112 (100%)	
Not at all	N= 2	1.79%
Somewhat	N=0	0%
Average	N= 11	9.82%
Above Average	N= 26	23.21%
Very Much	N= 73	65.18%
How strongly do you agree that students who frequently run away are difficult to work with?	N= 112 (100%)	
Not at all	N= 1	0.89%
Somewhat	N= 0	0%
Average	N= 44	39.29%
Above Average	N= 53	47.32%
Very Much	N= 14	12.5%
How strongly do you agree that runaways are more likely to identify as LGBTQ?	N= 111 (99.11%)	
Not at all	N= 12	10.71%
Somewhat	N= 25	22.32%
Average	N= 40	35.71%
Above Average	N= 23	20.54%
Very Much	N= 12	10.71%
How strongly do you agree that children can get out of trafficking by asking for help?	N= 112 (100%)	
Not at all	N= 25	22.32%
Somewhat	N= 38	33.93%
Average	N= 32	28.57%
Above Average	N= 16	14.29%
Very Much	N= 1	0.89%

How strongly do you agree that children who are victims of CSEC may still be attending school?	N= 112 (100%)	
Not at all	N= 1	0.89%
Somewhat	N= 14	12.5%
Average	N= 42	37.5%
Above Average	N= 32	28.57%
Very Much	N= 23	20.54%
How strongly do you agree that exploiters can be students at school?	N= 112 (100%)	
Not at all	N= 2	1.79%
Somewhat	N= 21	18.75%
Average	N= 39	34.82%
Above Average	N= 30	26.79%
Very Much	N= 20	17.86%
How strongly do you agree that CSEC is a major problem facing youth today?	N= 112 (100%)	
Not at all	N= 1	0.89%
Somewhat	N= 17	15.18%
Average	N= 36	32.14%
Above Average	N= 37	33.04%
Very Much	N= 21	18.75%
How strongly do you agree with the following statement "I would not be surprised if children in my school were involved in CSEC"	N= 112 (100%)	
Not at all	N= 11	9.82%
Somewhat	N= 34	30.36%
Average	N= 33	29.46%
Above Average	N= 22	19.64%
Very Much	N= 12	10.71%
How strongly do you agree with the following statement "I have suspected that a student was a victim of CSEC"	N= 112 (100%	
Not at all	N= 72	64.29%
Somewhat	N= 20	17.86%
Average	N= 11	9.82%
Above Average	N= 6	5.35%
Very Much	N= 3	2.68%

Table 8. *Role Perceptions*

Role Perception Items	Sample (N) %	Percent
How strongly do you agree with the following statement: "It is important for me to know about CSEC for my role as a school nurse"	N=112 (100%)	
	N=0	0%
Not at all	N=2	1.79%
Somewhat	N=16	14.29%
Average	N=31	27.68%
Above Average	N=63	56.25%
Very Much		
How strongly do you agree that it is appropriate for school nurses to screen students for CSEC?	N=112 (100%)	
Not at all	N= 1	0.89%
Somewhat	N=9	8.04%
Average	N=38	33.93%
Above Average	N=36	32.14%
Very Much	N=28	25.0%
How strongly do you agree with the following statement: "I know who to call if I encounter a potential CSEC victim"	N= 112 (100%)	
Not at all	N= 17	15.18%
Somewhat	N=24	21.43%
Average	N=25	22.32%
Above Average	N=24	21.43%
Very Much	N=22	19.64%
How strongly do you agree with the following statement: "School nurses can screen for student risk for sexual exploitation"	N= 112 (100%)	
Not at all	N= 2	1.79%
Somewhat	N= 21	18.75%
Average	N= 38	33.93%
Above Average	N=32	28.57%
Very Much	N=19	16.96%
How strongly do you agree that school nurses do not have time to screen students for CSEC?	N=112 (100%)	
Not at all	N= 0	0%
Somewhat	N= 0	0%
Average	N= 31	27.68%
Above Average	N= 46	41.07%
Very Much	N= 35	31.25%

How strongly do you agree that knowledge of CSEC is a barrier for school nurses to identify CSEC?	N= 112 (100%)	
Not at all	N= 39	34.82%
Somewhat	N= 40	35.71%
Average	N= 33	29.46%
Above Average	N= 0	0%
Very Much	N= 0	0%
How strongly do you agree that time is a barrier for school nurses to identify CSEC?	N= 112 (100%)	
Not at all	N= 0	0%
Somewhat	N= 0	0%
Average	N= 26	23.21%
Above Average	N= 42	37.5%
Very Much	N= 44	39.29%
How strongly do you agree that large student numbers are a barrier for school nurses to identify CSEC?	N= 112 (100%)	
Not at all	N= 0	0%
Somewhat	N= 0	0%
Average	N= 24	21.43%
Above Average	N= 49	43.75%
Very Much	N= 39	34.82%
How strongly do you agree that funding limitations are a barrier for school nurses to identify CSEC?	N= 112 (100%)	
Not at all	N= 1	0.89%
Somewhat	N= 0	0%
Average	N= 33	29.46%
Above Average	N= 39	34.82%
Very Much	N= 39	34.82%
How strongly do you agree that there are no limitations for school nurses to identify CSEC?	N= 112 (100%)	
Not at all	N= 40	35.71%
Somewhat	N= 33	29.46%
Average	N= 26	23.21%
Above Average	N= 8	7.14%
Very Much	N= 5	4.47%
How strongly do you agree that the issue of CSEC should be handled by law enforcement only not school nurses?	N= 112 (100%)	
Not at all	N= 0	0%
Somewhat	N= 0	0%
Average	N= 29	25.89%
Above Average	N= 32	28.57%
Very Much	N= 51	45.54%

How strongly do you agree with the following statement: "If educational opportunities were available to me to learn how to prevent CSEC in my role as a school nurse I would attend"	N= 112 (100%)	
Not at all	N= 1	0.89%
Somewhat	N= 6	5.36%
Average	N= 24	21.43%
Above Average	N= 32	28.57%
Very Much	N= 49	43.75%

Table 9. *Correlation Between Awareness, Attitudes, and Role Perception Scales*

Construct			
	Awareness	Attitudes	Role Perceptions
Awareness		$r = 0.29$ $p = 0.003$*	$r = 0.30$ $p = 0.001$*
Attitudes			$r = 0.38$ $p < 0.001$*
Role Perceptions			

Table 10. *Exploratory Analysis of Awareness Items*

Variables	Final Model 95% CI P value
Education	
Baccalaureate vs. AND	(-0.05, 18.22) + 0.05*
Masters vs. AND	(-1.22, 17.16) 0.08
Post-Masters vs. AND	(1.57, 22.49) + 0.02*
Prior CSEC training	
Yes vs. No	(3.47, 10.88) + <0.001*
Student arrival to school	
School bus vs. walk	(-1.00, 8.91) 0.12
Public transportation vs. walk	(-2.26, 13.86) 0.12
Car vs. walk	(-1.96, 10.55) 0.18
Unsure vs. walk	(-16.07, -0.68) – 0.03*
Student Body	
Middle school vs. Elementary	(-6.14, 3.58) 0.60
High school vs. Elementary	(-9.59, -1.98) – 0.003*
Transitions vs. Elementary	(-13.92, 16.46) 0.87
Special Education Students	
Yes vs. No	(-16.87, -3.32) – 0.004*
Model Significance	$p < 0.001$* Adj $R^2 = 53.5\%$

Table 11. *Exploratory Analysis of Attitudes Items*

Variables	Final Model 95% CI P value
Prior CSEC training Yes vs. No	 (0.47, 5.53) p= 0.02*
Community Safety Somewhat safe vs. safe Not safe vs. safe	 (-2.51, 2.89) 0.89 (0.53, 9.12) 0.02*
School diversity Some diversity vs. no diversity Diverse vs. no diversity	 (-6.36, 0.39) 0.08 (-7.99, -0.33) 0.03*
Special Education Students Yes vs. No	 (-11.10, -1.51) 0.01*
Model Significance	$p < 0.001$* Adj $R^2 = 26.7\%$

Table 12. *Exploratory Analysis of Role Perception Items*

Variables	Sensitivity Analysis 95% CI P value
Prior CSEC training Yes vs. No	 (0.82, 4.20) p< 0.001*
Student Body Middle school vs. Elementary High school vs. Elementary Transitions vs. Elementary	 (-2.52, 1.62) 0.67 (-2.79, 0.39) 0.14 (1.74, 15.45) 0.01*
Special Education Students Yes vs. No	 (-7.69, -2.06) 0.001*
Model Significance	p < 0.001* Adj R^2 = 17.6%

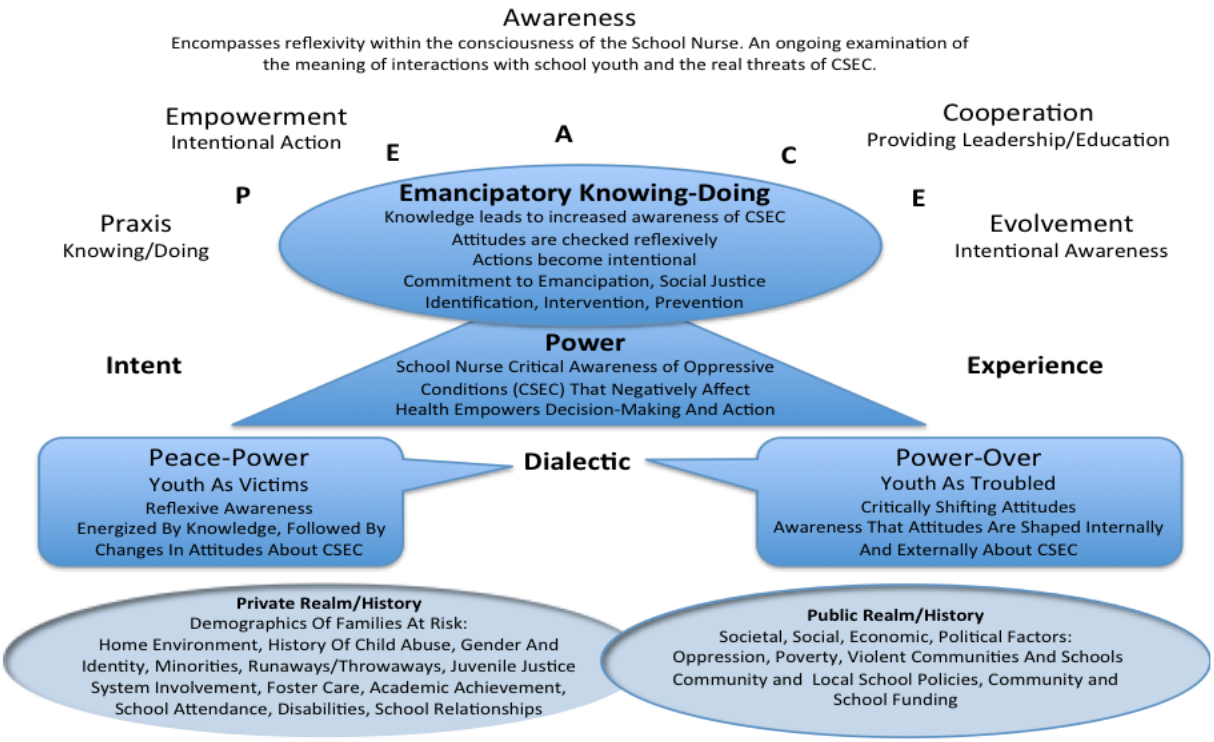
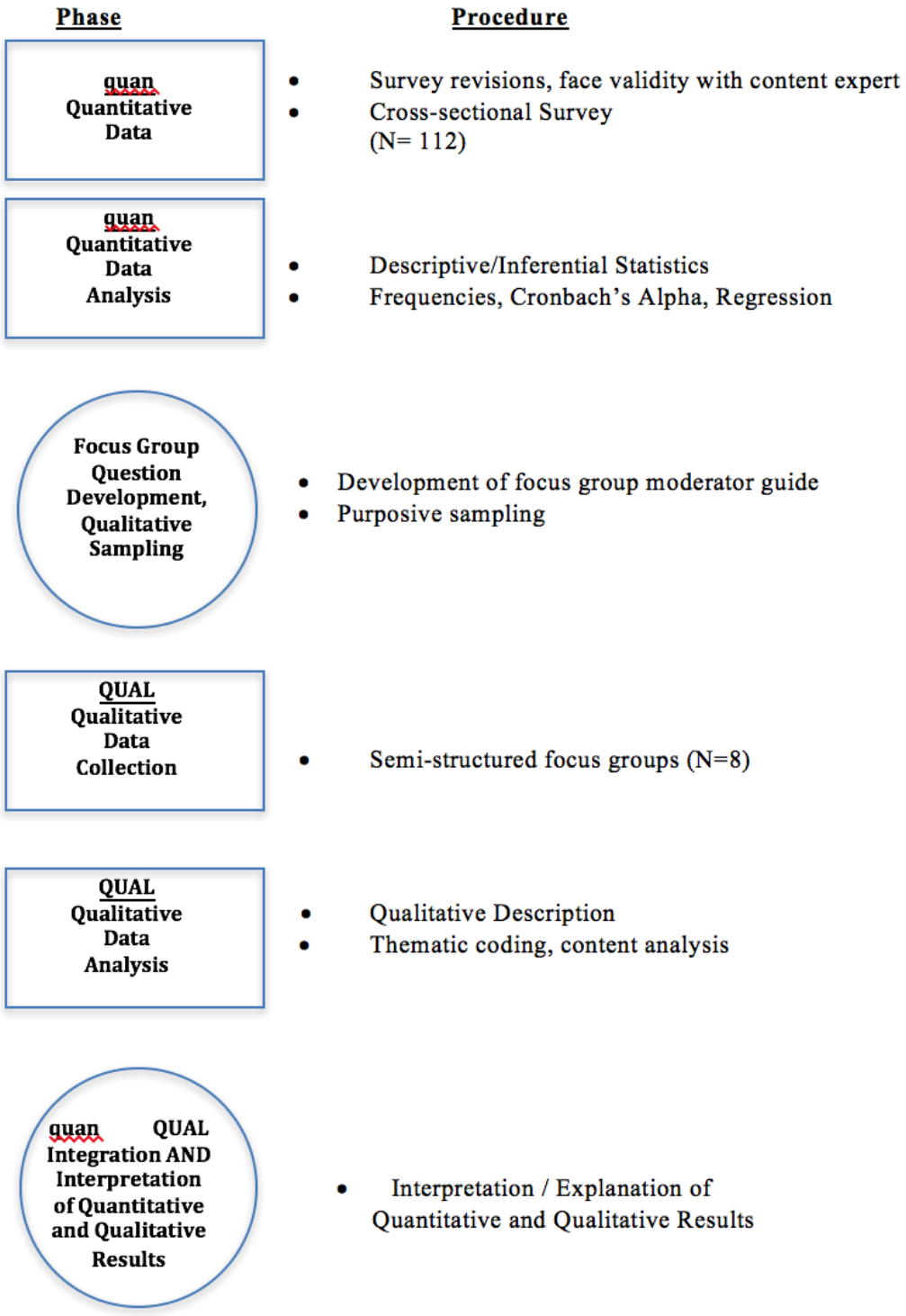


Figure 1. Developed From the Chinn & Falk-Rafael (2015) Peace and Power Conceptual Model

Figure 2: Mixed Methods Sequential Explanatory Study Visual Diagram



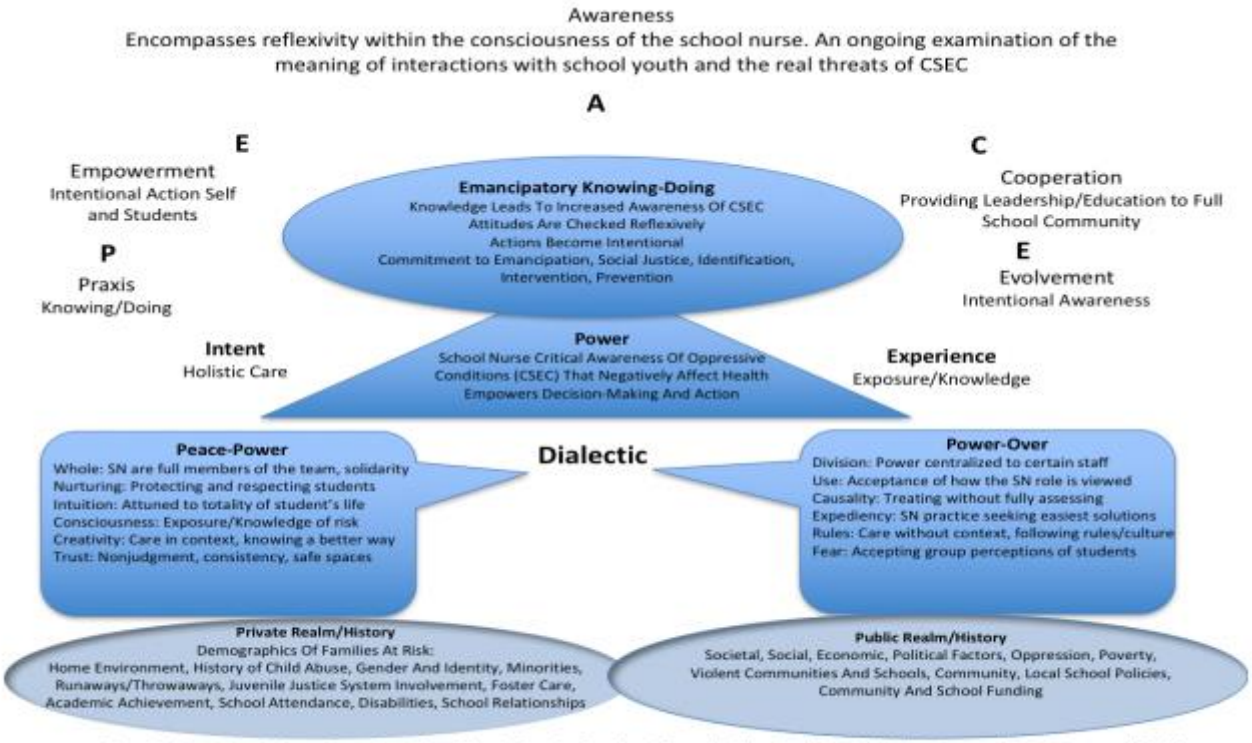


Figure 3: Peace-Power Versus Power-Over School Nursing Practice Developed From the Chinn & Falk-Rafael (2015) Peace and Power Conceptual Model