IDENTIFICATION AND REPORTING OF DOMESTIC MINOR SEX TRAFFICKING:

THE ROLE OF HEALTHCARE WORKERS

by

LAURA TRACEY COLMAN

(Under the Direction of Pamela Orpinas)

ABSTRACT

Victims of domestic minor sex trafficking experience a myriad of health problems, giving healthcare providers an important opportunity to identify these children. Despite the significant role of physicians, midlevel providers, nurses, and social workers, little is known about factors influencing healthcare providers' likelihood of identifying and reporting possible victims. The purpose of this study was to examine the individual (knowledge, perceived barriers, self-efficacy) and environmental (healthcare environment) factors impacting a healthcare provider's intention to identify and report domestic minor sex trafficking victims within a clinical setting.

This exploratory, mixed-methods study was divided into two phases. In both phases, participants were healthcare providers working in the United States. In Phase 1, participants (n=21) completed an in-depth interview exploring their views and experiences in relation to sex trafficking of American children. In Phase 2, participants (n=59) completed an electronic survey examining knowledge, perceived barriers, self-efficacy, views of the healthcare environment, and behavioral intention. Results from the analysis in Phase 1 informed the development of the survey in Phase 2.

Interview respondents reported a lack of awareness and minimal education on sex trafficking as the primary factors impacting their perceived ability to assist victims. Environmental factors constraining their capacity to identify victims were time limitations, lack of multidisciplinary teams, and unclear policies to identify and report victims. Phase 1 participants described the need for more education among healthcare providers in order to increase victim identification. Results of the Phase 2 surveys supported the results from Phase 1. Participants in Phase 2 reported low self-efficacy in their ability to identify and assist victims of sex trafficking. Knowledge and views of the healthcare environment predicted participants' intention to identify and report possible sex trafficking victims. Participants with higher knowledge of domestic minor sex trafficking and greater self-efficacy had the greatest intention to report possible victims. Based on these results, interventions targeting healthcare professionals should incorporate more education on trafficking victims and their clinical characteristics. As a part of these interventions, improving policies and organizational environment for healthcare providers are essential to increase identification and reporting

INDEX WORDS: sex trafficking, domestic minor sex trafficking, healthcare, violence prevention, mixed-methods

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DEDICATION

This study is dedicated to my dad. You were the inspiration for this research. I could not have done this without your help. Thank you for always believing in me, putting my needs before your own, and for always supporting me in everything I do.

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ABBREVIATIONS

Topic and Research

CI	Confidence Interval
DMST	Domestic Minor Sex Trafficking
IPV	Intimate Partner Violence
SD	Standard Deviation

Healthcare

BSN	Bachelor of Science in Nursing
CPS	Child Protective Services
DO	Doctor of Osteopathic Medicine
LPN	Licensed Practice Nurse
MD	Doctor of Medicine
NP	Nurse Practitioner
PA	Physician’s Assistant
RN	Registered Nurse

CHAPTER 1

INTRODUCTION

Enacted by congress in 2000, the Trafficking Victims Protection Act was the first comprehensive federal law protecting victims of human trafficking in the United States. An important aspect of this act is the specific mention of sex trafficking involving minors in the United States, known as domestic minor sex trafficking (DMST). According to Shared Hope International (2012), DMST is the commercial sexual exploitation of anyone under the age of 18 in the United States. Forcing children to engage in a commercial sex act is a form of human trafficking according to U.S. law (Kotrla, 2010). Unlike the definition of human trafficking of adults in the United States, force, fraud, or coercion is not required for it to be considered trafficking when the commercial sex act involves a person under the age of 18 years (Clawson & Dutch, 2008). The age of a minor disaffirms his or her ability to make a free and educated choice about entering the commercial sex industry (Adelson, 2008).

Although involvement of American children in sex trafficking has been more openly discussed recently and there has been an increase in awareness in the past decade, DMST has been a serious public health problem for many years. According to Andrew Oosterbaan (2008), the chief of the Child Exploitation and Obscenity section of the Criminal Division of the Department of Justice, a big concern with DMST is the boundless amount of possible victims in America. Identifying victims is exceptionally difficult due to the hidden nature and secrecy of the crime. Even with clear definitions, trafficking victims are difficult to find and identify (Clawson & Dutch, 2008).

Victims of DMST are at greater risk for experiencing a range of acute and chronic health problems, demonstrating the important and rare opportunity healthcare providers have to identify this population (Miller, Decker, Silverman, & Raj, 2007). Healthcare professionals are more likely than the general population to encounter victims (Patel, Ahn, & Burke, 2010). Physicians and nurses specializing in primary care, emergency medicine, pediatrics, and gynecology may be the most likely to encounter victims (Patel et al., 2010). Currently, healthcare settings are not equipped for investigating potential trafficking cases (Miller et al., 2007). Healthcare professionals receive little training on characteristics and needs of victims (Miller et al., 2007). Despite the importance of healthcare workers, little is known about the specific factors influencing healthcare providers' likelihood of identifying and reporting possible victims. Given the lack of information currently available, there is a critical need to identify and better understand the factors that influence a healthcare provider's intention to identify trafficking victims, and to develop effective strategies to help these professionals gain the skills they need to assist victims.

1.1 Present Study

The overall purpose of this study was to examine the factors influencing healthcare providers' behavioral intention to identify and report DMST victims. The central hypothesis was that a lack of comprehensive knowledge of DMST and an unsupportive external work environment contribute to a low self-efficacy and low behavioral intention among healthcare providers for victim identification and reporting suspected cases. The objectives of this study were:

Objective 1: Identify personal and environmental factors that increase or decrease a provider's self-efficacy to identify and appropriately assist victims of DMST.

Objective 2: Identify the factors that increase or decrease a provider's intention to identify and report victims of DMST at varying levels of certainty that a patient is a victim.

Objective 3: Explore the influence of demographic and professional characteristics—age, gender, years of experience, occupation, work setting, and healthcare specialty—on proposed constructs.

Preliminary data do not exist on this topic, emphasizing the need to conduct a needs assessment on DMST in the context of healthcare settings and healthcare workers. The information generated from this research will help fill several major gaps in the literature and plan interventions that address the needs of healthcare providers working with this population. The deficiency of a well-established, peer-reviewed evidence base is one of the greatest challenges in addressing sex trafficking of American minors and creating change (Institute of Medicine, 2013). The current study provides rigorous research on factors affecting identification of victims, the knowledge and awareness of healthcare professionals, and participants' experiences in healthcare settings. In the absence of research and evidence-based interventions, victims of DMST will continue to go unidentified and unable to receive the help that they need.

CHAPTER 2

LITERATURE REVIEW

This chapter covers topics relevant to the study of domestic minor sex trafficking (DMST) and the role of healthcare providers in the United States. This chapter is composed of three sections. The first section provides an overview of the victims of DMST. The second section discusses the role of healthcare providers and the experiences drawn from the literature on healthcare providers work with victims of trafficking, victims of child abuse, and victims of intimate partner violence. The third section explains the theoretical basis for this study.

2.1. Victims of Domestic Minor Sex Trafficking

This section provides an overview of the risk factors for DMST victimization, health problems associated with DMST victimization, and services available to victims of DMST.

Risk Factors for Victimization and Entry into DMST

Youth in the United States are most at risk for DMST victimization due to the traffickers' beliefs that it is easier to recruit children within the United States because the need to cross another country's border is eliminated (Kotrla, 2010). There is no conclusive research attempting to explain why some minors who are considered high risk for victimization are sexually exploited while others are not (Reid, 2011). However, there are individual, familial, and community factors that increase a child's chances for sexual victimization.

Personal demographics that increase a child's risk include gender, age, race, socioeconomic status, a history of criminal behavior, and a history of abuse. While both boys and girls are vulnerable to sexual exploitation, girls comprise the majority of sexually exploited

children (Coy, 2009; Smith, Healy Vardaman, & Snow, 2009). More girls are arrested for prostitution (Holger-Ambrose, Langmade, Edinburgh, & Saewyc, 2013). Girls are also the primary population for residential homes targeting children who have had involvement in the commercial sex industry (Twill, Green, & Traylor, 2010).

The age of exploitation varies, with some believing the average age is 13 years old (Holger-Ambrose et al., 2013). For those arrested for prostitution, the average age is 15 years old (Twill et al., 2010). Sexually exploited girls involved in the commercial sex industry are typically between the ages of 12 and 16 years old (Twill et al., 2010)

Every young female in the United States is vulnerable to becoming a victim of DMST, but risk varies by race. Friedman (2005) found that African American girls were more likely to be sexually exploited in their own communities, while victims who were runaways, from the Midwest, and trafficked along the main U.S. trafficking routes were more likely to be Caucasian. That being said, the overwhelming majority of DMST victims who are clients at non-profit organizations and victim service organizations are racial and ethnic minorities (Ring, 2010; Twill et al., 2010).

Poverty is one of the most important factors increasing risk for DMST victimization (Logan, Walker, & Hunt, 2009). Victims typically come from low socioeconomic families, with more than 80% of girls in the commercial sex industry living in poverty at the time of their exploitation (Christenson, 2012; Twill et al., 2010). According to Fong and Cardoso (2010), youth involved in DMST are considered especially vulnerable due to a variety of personal factors including homelessness or involvement in the foster care system. In most cases, preceding victims' exploitation is running away, becoming homeless, and a history of being involved in child protective services (Holger-Ambrose et al., 2013). Perpetrators also target drug-users, poor

students, and children with a history of criminal behavior (Logan et al., 2009; Williamson & Prior, 2009).

The most significant predictor of a child becoming a victim of DMST is a history of maltreatment at home (Mitchell, Jones, Finkelhor, & Wolak, 2010). The majority of sexually exploited youth have a history of abuse (Christenson, 2012). A history of sexual abuse is a risk factor for girls to become further victimized in the commercial sex industry (Flowers, 2011). Since a substantial number of runaway youth escape from home due to sexual victimization (Belknap, 2007), it is not a coincidence that the association is so strong among child abuse victims, child runaways, and sexual exploitation. Sexually abused girls are more likely to run away, engage in criminal behavior, get arrested, and go to jail than girls who do not have a history of sexual victimization (McCormack, Janus, & Burgess, 1986).

Beyond personal risk factors, many community and societal risk factors contribute to DMST. Cities with high rates of poverty, homelessness, low literacy and drug use increase DMST vulnerability (McClain & Garrity, 2011). According to Williamson and Prior (2009), cities at high risk are those with easy access to highway systems, which facilitates transporting victims easily to cities with the greatest demand.

Health Problems Associated with Domestic Minor Sex Trafficking Victimization

Risks and health conditions that victims experience throughout their time in the commercial sex trade are unique to this population. Research on the health needs of trafficking victims is very limited compared to research on their experiences as trafficking victims (Oram, Stockl, Busza, Howard, & Zimmerman, 2012). Even more limited is research on the specific health problems associated with DMST. The available evidence highlights that sex trafficking victims suffer from violence and an assortment of severe health problems (Oram et al., 2012).

Research discussed in this section found that prior abuse, mental health problems, drug use, certain physical conditions, and sexually transmitted diseases were common among girls and women in the commercial sex industry, all of which are important clinical indicators for identifying a victim of DMST.

High levels of current and previous physical and sexual abuse is common among sexually exploited girls and women (Oram et al., 2012). When examining victims' experiences with violence, researchers found that 59% had a history of violence prior to being trafficked, 76% suffered from harsh restraints on personal freedom, and 95% experienced violence while being trafficked (Zimmerman & Borland, 2009). Among street-level sex workers, the majority experienced abuse in their childhood, with 70% reporting a history of childhood sexual abuse (Jeal & Salisbury, 2004). After they had entered the commercial sex industry, 73% of these women experienced additional violence including rape and physical assault (Jeal & Salisbury, 2004).

Prostituted women experiencing illegal forms of violence are limited in their options regarding what they can do to receive necessary help. They are committing a crime because the act of prostitution is illegal, but they are also victims of crime including rape, physical assaults, and homicide (Author, 2008). Prostituted females have a history of being frequent targets of perpetrators such as serial rapists and murderers (Flowers & Flowers, 2004). Dukes, Pettingel, McMorris, and Borowsky (2010) explain that a pathway is created from early victimization leading to criminal offending because of damage in psychological development. Having a history of child sexual abuse may indirectly increase someone's likelihood of entering prostitution (Flowers, 2010).

Individuals in the commercial sex industry suffer from a range of mental health problems (Oram et al., 2012). When examining the mental health symptoms of victims who recently left a trafficking situation, some researchers found these girls and women were in at least the 95th percentile for depression, anxiety, and hostility when compared to the general non-patient population in the United States (Zimmerman & Borland, 2009). Many of these people also experienced depression and post-traumatic stress disorder due to their experiences being sexually exploited (Oram et al., 2012).

Physical health problems are also common among sexually exploited girls and women. Common physical health symptoms experienced by victims are headaches, stomach pain, and loss of memory (Oram et al., 2012). When examining the physical symptoms of commercial sex workers, researchers found that more than half of these victims have headaches, back pain, memory loss, and stomach pain (Zimmerman & Borland, 2009).

Pelvic pain, gynecological infections, and sexually transmitted diseases (STDs) are rampant among girls and women engaging in commercial sex (Zimmerman & Borland, 2009). Screening for a sexually transmitted infection is rare in this population, with less than 50% receiving screening annually, and 20% never getting screened for any STDs (Zimmerman & Borland, 2009). Sixty-one percent had been treated for a STD at some point (Jeal & Salisbury, 2004). More than 60% of street-level commercial sex workers have been treated for at least one STD throughout their time in the commercial sex industry (Jeal & Salisbury, 2004).

Among their various health issues, sexually exploited girls and women in the commercial sex industry are largely affected by drug and alcohol use and abuse (Oram et al., 2012). Almost all commercial sex workers are currently addicted or have had a previous addiction to drugs and alcohol (Jeal & Salisbury, 2004). Of those who have had a previous or current problem with

addiction, 95% have struggled with alcohol and 60% are current or former intravenous drug users (Jeal & Salisbury, 2004). Heroin was the most common drug of choice in this study, used by 83% of the women. Eighty one percent of these women also used crack-cocaine (Jeal & Salisbury, 2004).

While several researchers have examined different health consequences associated with the commercial sex industry and DMST victimization, there is still slight ambiguity regarding health outcomes for these girls and women. Many of the previously described studies had small samples. Additionally, most of the samples were not from the United States or included juveniles. While more research is needed to understand the health effects of being in the commercial sex industry and sex trafficking, these described studies paint the start of a clinical picture for signs and symptoms of DMST that can assist healthcare providers in identifying victims.

Services Available to Victims of Domestic Minor Sex Trafficking

Two studies describing services for victims of DMST have been published. Holger-Ambrose et al. (2013) researched effective street-outreach strategies to work with this population. The authors interviewed sexually exploited minors to learn what they wanted from outreach workers and what services they needed. The participants first identified what kinds of interaction styles were important to them when interacting with outreach workers. The girls explained that they wanted the workers to treat them with respect, be brief in their interaction, lack judgment, provide resources, and show care. Next, the participants identified what type of supplies or services they would like outreach workers to provide to them. The primary need was access to condoms. Important to this study, more than half of this sample stated that they would like outreach workers to provide information on service providers.

Saewyc and Edinburgh (2010) evaluated the effects of the Runaway Intervention Program, a program in Minnesota designed for girls ages 12-15 years, who have run away from home and have experienced sexual exploitation or sexual assault. The authors designed this study to inspect how well this intervention repaired relationships, improved self-esteem, and reduced emotional distress among this target population. The sample consisted of 68 girls who were all patients enrolled in the program in 2006-2007 and received services for at least 6 months. The comparison group consisted of 12,775 ninth-grade girls in a 2004 statewide survey from the metropolitan area around Minneapolis and St. Paul. The researchers found that at entry into the program, the girls in the Runaway Intervention Program were comparable to girls in the general population who were sexually abused, having more risk behaviors and less protective factors than non-abused girls in the general population. After 6 to 12 months in the program, significant improvements were observed on measures of positive development, trauma responses, and risk behaviors, with the girls in the program more closely resembling responses of the non-abused girls in the general population.

The lack of research in this area demonstrates that more information is needed on secondary prevention programming available to young girls in the commercial sex industry. What these two studies highlight are possible needs and treatment plans for this vulnerable population. Ambrose et al. (2013) discussed possible communication strategies providers can implement when working with this population. Saewyc and Edinburgh (2010) discovered positive effects of implementing a targeted treatment plan for DMST victims. However, whether it is because of a lack of programming or a lack of peer-reviewed research, much is still unknown regarding evidence-based interventions for DMST victims.

2.2. Healthcare Professionals

Healthcare Professionals and Domestic Minor Sex Trafficking Victims

Although victims of DMST remain hidden from the general population, Baldwin, Eisenman, Sayles, Ryan, and Chuang (2011) noted that many victims have received medical care while still in a trafficking situation. In the only study collecting primary data on physicians' understanding, awareness, and experience with DMST victims, Reinhard, Whitacare, Hervey, and Berg (2012) investigated the knowledge, awareness, and training of physicians in Kansas regarding DMST. The descriptive, cross-sectional study employed a 20-question survey sent via email to physicians in the specialties of family medicine, pediatrics, obstetrics and gynecology, and emergency medicine who were registered with the Kansas Board of Healing Arts. Of the 69 respondents, 86% indicated that DMST was a problem in the United States, 80% said that DMST was a problem in Kansas, 61% said that they encountered possible signs of DMST in patients, 12% felt confident in their ability to identify a victim, and 11% had previously screened a patient for DMST. While 81% indicated it was important to educate young female patients on DMST, only 64% reported that patients should be educated during annual physicals by the physician. Regarding training, 67% reported that, if available, they would participate in training specific to DMST. Additional findings were lack of awareness of signs that a patient is a victim of DMST, lack of broad knowledge of the topic, inability to identify health hazards, and lack of awareness of the National Human Trafficking Resource Center. The authors concluded that DMST is a concern in Kansas, but physicians have not received training for victim identification.

No articles collecting primary data on nurses' roles were found, but one described the importance of nurses' roles in helping these girls. McClain and Garrity (2011) provided general information on victims of DMST, clinical implications, and the nurses' role. The authors

discussed the health problems seen in victims, screening questions that could be used, available resources for victims, and strategies for nurses to help. The specialties addressed in this article were nurses working in the emergency department, school nurses, women's health nurses, and nurse practitioners; the authors noted that these nurses should be aware of a variety of warning signs that is specific to their specialty. In terms of screening questions, the authors stated that screening should begin with general health questions, followed by questions that address safety, violence, involvement in commercial sex, and being forced into sex work.

Previous research suggests that low self-efficacy among healthcare providers could be at least partially attributed to a lack of education and training on how to identify, assist, and report victims of DMST. Five-percent of healthcare providers reported being uncomfortable treating victims of DMST, and only 8% felt confident to treat victims without receiving any training on how to work with this population (Chisolm-Straker, Richardson, & Cossio, 2012). Low self-efficacy influenced by a lack of training is problematic since few healthcare providers receive training on how to assist this specific population of girls (Reinhard et al., 2012). Further, of the available educational interventions, few have been evaluated (Ahn et al., 2013). To describe the existing educational options for healthcare professionals on human trafficking, Ahn et al. (2013) searched the peer-reviewed and gray literature. Of the available educational resources, none had been appropriately evaluated. The authors also noted that the majority of the resources were in the gray literature as opposed to peer-reviewed publications, highlighting their low accessibility. No studies assessed the outcomes of medical interventions. Lastly, the authors concluded that the resources that are currently available offer very little information or support regarding the role of health professionals in prevention of human trafficking.

Finding research in this area was difficult. The majority of the literature in this field is either published as *think pieces* or developed based on field experience. In addition to the lack of studies collecting original data, there is still a lack of clarity regarding recommendations for domestic victims versus international victims, little information on establishing relationships with the potential victims, confusion on the recommended immediate response to victims upon identification, and lack of knowledge of what communities should be doing in terms of services available for aftercare (Macy & Graham, 2012).

Since there is little information available on domestic minor sex trafficking, understanding the similarities between intimate partner violence (IPV) victims and sex trafficking victims, as well as child abuse victims and sex trafficking victims, could help healthcare providers better understand DMST victims and how to assist them. Perpetrators of IPV, child abuse, and trafficking use their relationship with the victim to their advantage (Countryman-Roswurm, 2012; Kotrla, 2010; Williamson & Cluse Tolar, 2002). IPV batterers and DMST traffickers use dominance and manipulation to control a victim (Christenson, 2012; Estes & Weiner, 2002). Perpetrators often threaten victims of these forms of violence into remaining silent and not disclosing the abuse the victim has experienced. (Kennedy, Klein, Bristowe, Cooper, & Yuille, 2007; Stark & Hodgson, 2003).

There is frequently overlap between involvement in the commercial sex industry and having a history of victimization, including IPV and child abuse (Christenson, 2012; Mitchell, Jones, Finkelhor, & Wolak, 2009). A pathway may be created between early victimization from child abuse to involvement in IPV or DMST (Dukes et al., 2010; Lalor & McElvaney, 2010). Additionally, many girls in DMST are often victims of IPV at the hands of their pimps or johns

(Faugier & Sargent, 1997). Having a history of child sexual abuse may indirectly increase someone's likelihood of entering the commercial sex trafficking industry (Flowers, 2010).

Women and girls comprise the majority of victims of IPV and victims of sex trafficking (Coy, 2009; na, 2012). Victims of IPV, child abuse, and DMST are often targeted due to their vulnerabilities and risk factors for victimization (Albanese, 2007; Smith et al., 2009). Many often blame themselves for their abuse or do not self-identify as victims (Clawson & Dutch, 2008).

Several signs and clinical indicators of DMST are specific to this form of victimization including the potential victim being accompanied by person with whom there is an ambiguous relationship, inconstancies in their stories, a lack of identification, a lack of a home address, and frequent relocation (Thomas, n.d.). However, victims of child abuse, IPV, and sex trafficking often have similar physical descriptions of clinical signs and symptoms of abuse, and similar emotional damage and trauma (CDC, 2009; Farley, 2003). Victims often experience mental health issues including depression and anxiety, as well as clear signs of physical and sexual abuse (Krug, Mercy, Dahlberg, & Zwi, 2002). Victims of DMST, child sexual abuse, and IPV sexual abuse also experience reproductive health issues including sexually transmitted infections, vaginal and rectal trauma, unintended pregnancies, and urinary tract infections (Campbell et al., 2002; Sabella, 2011).

Due to these overlapping similarities between victimization, the possible link between experiencing more than one of these forms of victimization, signs of victimization, and the lack of information available on DMST in clinical settings, understanding victims and treatment of victims of IPV and child abuse could shed light on victims of DMST for healthcare providers. This link is discussed in the next two sections.

Healthcare Professionals and Victims of Intimate Partner Violence

Given the limited amount of research with healthcare providers and victims of trafficking, it is important to examine the literature of healthcare professionals' responses to other vulnerable patients who were victims of IPV. Similar to DMST, when healthcare providers understand the characteristics associated with a certain type of victimization, their ability to appropriately assist those patients increases.

Addressing IPV with every female patient in healthcare settings is an effective way of helping all victims, including those who are not receiving medical care for IPV-related injuries. Using data from the New York City Department of Health and Mental Hygiene's Injury Surveillance System between 2000-2007, researchers found that of the 5514 assault-related female visits to the emergency department, 28% were caused by IPV (Yao, Stayton, & Davidson, 2013). Among abused women surveyed in the Midwest, 50% reported physical abuse, 70% reported emotional abuse, and 26% reported sexual abuse (Kramer, Lorenzon, & Mueller, 2004). When differentiating IPV from non-IPV assaults, the distinguishing factors were injuries occurring at home, injuries to the head, and sexual violence (Yao et al., 2013).

Women do not always report that their injuries are related to IPV. Among women visiting emergency departments, 70% stated that they had at least one health problem, but only 26% reported that they needed healthcare due to their abuse (Kramer et al., 2004). It is important for healthcare providers to inquire about a patient's history with IPV since many do not disclose this information voluntarily. Women agree with this sentiment, with 83% reporting that they believe it is a good idea for healthcare professionals to inquire about abuse as a part of regular screenings (Kramer et al., 2004). Additionally, 58% said that they would disclose their abuse to a healthcare

professional, with the majority of those women, 57%, saying they would do so if asked directly (Kramer et al., 2004).

The problem for many healthcare professionals is that they do not have a hospital or practice protocol regarding IPV screening, and they lack the necessary training to adequately address IPV with their patients. Boursnell and Prosser (2010) found that 52% of nurses indicated they have limited knowledge on current policies and procedures related to IPV. Additionally, 52% were unaware of their responsibilities regarding IPV cases, 47% did not feel confident in their ability to identify and respond to possible IPV indicators, and 53% did not feel proficient in addressing IPV in the emergency department.

Similarly, school nurses did not feel prepared to handle adolescent dating violence (Khubchandani, Telljohann, Price, Dake, & Hendershot, 2013). Among school nurses, 87% reported that their schools had no protocol for responding to a victim or incident of adolescent dating violence. Additionally, 88% reported that their schools had not provided training to assist adolescent dating violence victims within the past two years (Khubchandani et al., 2013). Providing training and having adequate protocols reduces problems associated with assisting victims. For example, nurses who came from schools with a protocol addressing adolescent dating violence reported fewer barriers to helping victims (Khubchandani et al., 2013), demonstrating the need for more protocols to be in place.

Healthcare Professionals and Victims of Child Abuse

In addition to studying IPV literature, examining the research on child abuse and the role of the healthcare professional could also provide insight on how healthcare providers interact and assist other vulnerable populations experiencing violence.

Physicians, particularly those working in pediatrics and the emergency department are very likely to encounter victims of child abuse throughout their career (Flaherty et al., 2006). Among pediatricians, 45% reported that they treated a child for an injury caused by child abuse in the prior year. Only 11% said that they had never seen a patient who they suspected was a victim of child abuse throughout their career, while 89% said that they had seen at least one injury that they suspected was caused by abuse in their entire career (Flaherty et al., 2006). With the high number of patients they see who are possible victims of child abuse, certain policies should be in place to assist in responding to the child. These include having a child-friendly environment, building rapport with the patient, being an engaged listener with the child, believing unconditionally what the child is disclosing, and being mindful of the potential for false disclosures (Finn, 2011).

Healthcare providers report feeling comfortable in their ability to identify victims of child abuse, with 61% reporting a strong self-efficacy (Flaherty et al., 2006). Even with a high self-efficacy, levels of knowledge vary within the topic. When surveyed about their knowledge, 88% correctly answered where to report child abuse, 90% knew how to report, and 72% accurately responded how soon they needed to report (Fraser, Mathews, Walsh, Chen, & Dunne, 2010). Additionally, 32% of the healthcare providers were unaware that they were legally protected from being sued if they reported a case of child abuse, and 81% did not know that they were legally required to report all suspected cases of abuse, regardless if they believe the harm to the child is insignificant or nonexistent (Fraser et al., 2010).

The lack of knowledge could be related to training. Among pediatricians, 81% reported that they had received some training in the past five years, while 22% reported that they do not feel adequately trained to identify victims of child abuse (Flaherty et al., 2006). Regarding

training for nurses, 58% have participated in formal training, while 71% had viewed a video to raise awareness on child abuse legislation (Fraser et al., 2010). When answering questions about the vignettes, nurses who had training in reporting child abuse were more likely to report possible cases of neglect in the examples (Fraser et al., 2010). The barriers to helping victims could exist due to community issues, with 49% of healthcare providers feeling that there were not adequate services in their communities in place to assist victims of child abuse (Flaherty et al., 2006).

The recommended guidelines for evaluations of child sexual abuse includes a medical evaluation, collection of a medical history, specific timing of the examination, appropriate documentation of injuries, appropriate examination techniques, testing for sexually transmitted infections, accurate interpretation of physical and laboratory findings, and specific recommendations for healthcare providers depending on their specialty and training (Adams et al., 2007). Since many victims of DMST are also victims of child abuse, understanding how medical professionals examine and diagnose cases of suspected child abuse could shed light on strategies useful to diagnosing cases of DMST. Identifying the problems healthcare providers have with diagnosing child abuse could also highlight the problems they will face when working with suspected trafficking victims.

2.3. Theoretical Background

The literature examining factors influencing or impeding a healthcare professional's likelihood of correctly identifying and reporting victims of DMST is limited. Two established and supported theories have been applied to similar areas of study and can guide researchers in examining this topic. The conceptual model designed for this study incorporates knowledge, perceived barriers, self-efficacy, and the healthcare environment (environmental facilitators and

environmental constraints). The conceptual model for this study is founded on Social Cognitive Theory and the Integrated Change Model, which hypothesize a pathway from distal psychosocial variables to professional practices via self-efficacy (Bandura, 1982; Zhu, Norman, & While, 2013). Since DMST research is scare, the conceptual model is also founded on research studies in similar areas of research, including child abuse and intimate partner violence, as well as the use of health behavior theory with healthcare providers. This section provides an overview of these theories, as well as a description of the conceptual model. Figure 2.1 displays the theoretical model that guides this study.

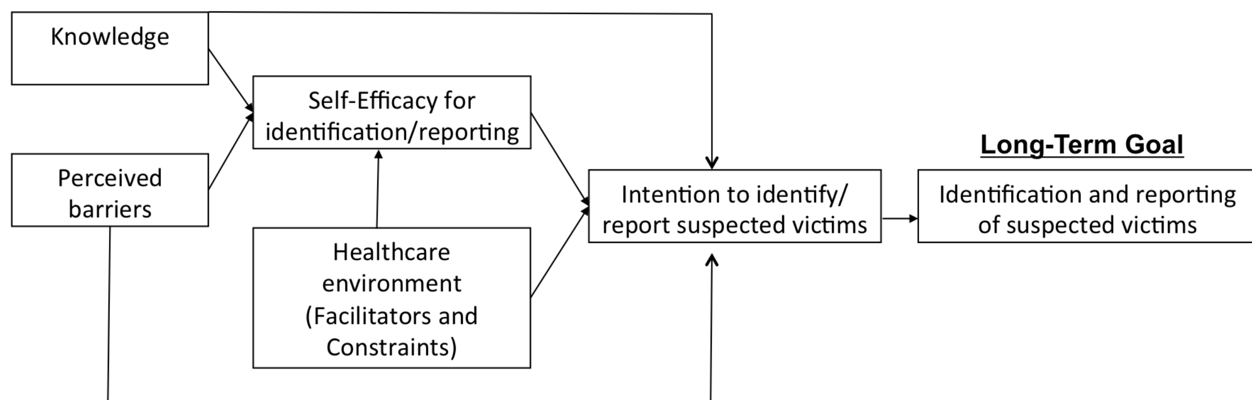

Figure 2.1. Conceptual Model

Social Cognitive Theory. Social Cognitive Theory emphasizes that individual and social change are a result of the interaction between people, behaviors, and environment (Bandura, 1977; McAlister, Perry, & Parcel, 2008). An important contribution of social cognitive theory is self-efficacy. Self-efficacy is an individual's confidence in his or her ability to perform a certain behavior (Bandura, 1977). As stipulated by this theory, self-efficacy beliefs are important determinants in motivation and behavior action (Bandura, 1989).

Another important contribution of social cognitive theory is the influence of the external environment on individual behavior. The theory highlights that individuals are not entirely independent agents, meaning environmental determinants are influencing all decision-making

(Bandura, 1989). While the environment plays an important role in influencing health behavior decisions, individuals also influence their environment, a concept called reciprocal determinism (Bandura, 1989). According to social cognitive theory, for any health behavior, researchers must examine how health behavior, cognitive features of the individual, other personal factors such as knowledge, and the external environment all come together and function as interacting determinants (Bandura, 1989).

Social cognitive theory is important when studying healthcare professionals' behaviors in clinical settings. Clinical practice decisions are largely influenced by professional decisions, highlighting the need to understand the interconnections of the individuals and their professional environments (Godin, Belanger-Gravel, Eccles, & Grimshaw, 2008). The current study examines the roles of self-efficacy and the external healthcare environment on intention to identify and report victims of DMST. This study also tests the factors that influence self-efficacy in regards to DMST identification and reporting.

Integrated Change Model. For a behavior change to occur, the Integrated Change Model describes that a person has to have behavioral intention, knowledge and skill to perform the behavior (Montano & Kasprzyk, 2008). Derived from the Attitude-Social Influence-Self-Efficacy Model (de Vries, Dijkstra, & Kuhlman, 1988), the integrated change model has been used to study many public health problems including healthcare providers' approaches to detecting substance abuse among their patients (Ketterer et al., 2014) and reporting behavior of child abuse among teachers and physicians (Godin et al., 2008; Schols, de Ruiter, & Ory, 2013).

The integrated change model was used to propose categories of variables that drive behavior of healthcare professionals in clinical settings (Legare et al., 2014). According to this model, the intention to perform a behavior is heavily influenced by the belief about a person's

ability to perform the behavior, his or her beliefs about consequences, his or her feelings of personal obligation regarding behavior adoption, social influences, and the role of identity (Legare et al., 2014). The primary hypothesis of this behavior change model is that intentions are more likely to be turned into actions the more abilities and skills an individual has (Schols et al., 2013). Using the concepts from this model, the present study examines the role of knowledge, personal perceived barriers, and self-efficacy on the behavioral intention of reporting and identifying victims of DMST.

1. Knowledge

While knowledge by itself will not lead to behavior change, knowledge is a precondition for change (Bandura, 2004). Motivation to perform a certain behavior is largely influenced by a person's level of knowledge (de Vries, Mesters, Van de Streeg, & Honing, 2005). In their study investigating the factors associated with detecting and reporting cases of child abuse, Schols et al. (2013) found that lacking specific knowledge decreased teachers' and physicians' likelihood of identifying a child abuse victim. A deficient amount of knowledge was found among physicians when examining why most physicians seeing children and adolescents do not screen for intimate partner violence (Borowsky & Ireland, 2002). Researchers in Israel investigated why detection rates of domestic violence were so low since healthcare providers have a rare opportunity to identify and report victims (Shefet et al., 2007). Along with other factors, these researchers concluded that to increase detection rates, there needed to be an increase in knowledge among healthcare providers regarding identification and reporting of domestic violence victims.

Similar to other forms of violence, healthcare providers also lack knowledge on domestic minor sex trafficking. In a study conducted among healthcare providers in Kansas, Reinhard et

al. (2012) concluded that participants did not have the necessary knowledge regarding DMST. Reinhard et al. (2012) concluded that even when there was a case of suspected human trafficking, proper victim identification and reporting rarely occurred. These findings represent the notion put forth in the integrated change model that behavior is influenced by knowledge (de Vries & Mudde, 1998).

2. Perceived Personal Barriers

Perceived barriers are the beliefs about the material and psychological costs of performing the behavior (Hochbaum, 1958). Personal barriers could negatively influence a person's intention of performing a certain behavior, decreasing the likelihood that the desired behavior will be performed (Schols et al., 2013). Perceived barriers are based on individual perception of doing a behavior, and play a significant role in decision-making and taking action among healthcare providers in clinical settings.

When surveying Kansas physicians on their knowledge and attitudes regarding DMST victims, Reinhard et al. (2012) found that after a lack of knowledge, the perceived barrier to reporting a possible victim was the perception that the victim did not need help, followed by a perceived lack of time to assist the victim appropriately. Khubchandani et al. (2013) examined the factors that inhibit school nurses' from identifying and reporting suspected cases of adolescent dating violence, specifically perceived barriers. The primary perceived barrier that they determined had a negative influence on victim identification was also lack of time. Regarding child abuse, teachers also reported several perceived barriers influencing their identification of victims (Schols et al., 2013). In this study, researchers found that perceived barriers included feelings of guilt, fear of parents' reaction to report, the parents' control, and the fear of false positives.

3. Self-Efficacy

Beyond behavioral capability, success in performing a behavior also requires personal confidence in one's ability to perform a behavior (Bandura, 1988). A person's self-efficacy is the outcome of a variety of individual experiences and personal factors, including achieving behavioral capability, others' vicarious experiences, self-judgment, comparison to others, and individual strength and ability (Bandura, 1989). As stipulated by social cognitive theory, self-efficacy beliefs are important determinates in motivation, intention, and behavior action (Bandura, 1989). Bandura (1989) expounded that nothing has greater influence on individual behavior than the individual's confidence in his or her ability to perform a behavior correctly and effectively. The greater the self-efficacy a person has, the more effort that person will put into the behavior in question (Bandura, 1988). As Bandura (1998) explained, "Efficacy beliefs is a major basis of action. Unless people believe they can produce desired efforts by their actions, they have little incentive to act…(p. 625)."

Self-efficacy is regularly identified as a predictor of clinical performance among healthcare providers (Zhu et al., 2013). Ehrenberg et al. (2014) found that low self-efficacy was one of the primary factors reducing the probability of investigating whether or not a patient is a victim of intimate partner violence. In their study determining a healthcare provider's readiness to screen for intimate partner violence, John, Lawoko, Svanstrom, and Mohammed (2010) concluded that higher self-efficacy was linked to an increase in screening, as well as an increase in referrals for patients to access services specifically for victims of violence. For healthcare providers to have the intention to screen for victimization among their patients, they need to be dedicated to do so, have the necessary knowledge, and most importantly, have the confidence in their ability to identify and help victims (Chapin, Coleman, & Varner, 2011).

Beliefs about one's self-efficacy operates as one of the strongest determinants of decision making and behavior (Bandura, 1998). Individuals with high self-efficacy are able to focus their efforts on understanding and perfecting tasks, while those with low self-efficacy avoid tasks they deem to be more complicated or difficult (Bandura, 1988). A method to increase self-efficacy is through mastery experiences, meaning successfully performing a behavior or task (Wood & Bandura, 1989); therefore, if providers are never screening for or identifying victims of DMST, their self-efficacy will never increase. If healthcare providers have low self-efficacy regarding assisting DMST victims, they will have significant challenges in ever learning how to identify victims.

4. Healthcare Environment (Facilitators and Constraints)

Healthcare facilitators and constraints are part of the healthcare environment that will influence decisions to identify and report DMST victims. The external environment is considered a determinant of health behavior given the great influence it exerts on individuals and factors that affect decision-making (Bandura, 1988). As highlighted by social cognitive theory, individual factors like self-efficacy operate in accordance with perceived environmental facilitators and constraints (Bandura, 1998). These environmental influences greatly impact self-efficacy and the decision to do a behavior. Even in environments that do not hinder or promote the identification of victims, healthcare workers may perceive barriers in their day-to-day routines or in their perception of victims to identify them.

Social cognitive theory explains that no amount of learning, knowledge, skill-building, or goal setting will lead to a behavior change without an appropriate and helpful external environment (Bandura, 2002). According to Bandura (1998), an effective approach to influencing behavior through the environment is by generating components of the environment

that make behaviors easier to perform, something he called facilitation. Environmental, system-level facilitators can improve identification and reporting behaviors among healthcare providers by making professional decisions and behaviors easier to accomplish.

Facilitators play an important role in increasing intention to report suspected victims (Ambuel et al., 2013). An example of an environmental facilitator is placing abuse-screening tools directly in all charts to prompt the healthcare provider to screen for abuse among all patients (Wiist & McFarlane, 1999). Another approach is including a reminder in medical records prompting providers to screen for intimate partner violence among female patients (Hamberger, Guse, Patel, & Griffin, 2010). Both make screening for abuse easier to perform because the necessary tools and reminders are easily available and streamlined for all providers.

In social cognitive theory, facilitation and external facilitators are empowering for the target audience, positively encouraging them to perform a specific behavior (McAlister et al., 2008). Ambuel, Phelan, Hamberger, and Wolff (2009) identified five key environmental facilitators for identifying and reporting victims of violence:

1. Create partnerships between healthcare organizations and community-based organizations to increase collaboration and provide care to victims.
2. Hire victim advocates as a part of a multidisciplinary team who can be on-site to assist the organization's and provider's response to victims.
3. Provide more training for healthcare providers focusing on knowledge, attitudes, and skills for victim identification and prevention.
4. Implement policies, procedures, and continuous quality improvement.
5. Make an organizational investment in improving response to victims and have an ongoing commitment to improve care.

Providing tools, resources, and training to individuals can increase the performance of positive behaviors (Sherman, 2006). In line with social cognitive theory, increasing facilitators such as these in the healthcare environment can reduce external barriers to identifying and reporting victims of violence.

While an increase in external facilitators can positively influence the performance of individual behavior, negative environmental factors can have the opposite effect on behavior (McAlister et al., 2008). If an environment does not encourage the performance of a behavior by, for example, lacking the necessary tools, resources, and support, a behavior change is unlikely to occur (Bandura, 2002). Also referred to as system-level barriers (Ambuel et al., 2013), environmental constraints are the barriers that exist within the work or social environment that inhibit healthcare providers from appropriately identifying and reporting victims of violence. Reinhard et al. (2012) discovered that while the majority of their participants would like to receive training on DMST identification and reporting, very few have been provided the training they need to increase their intention to report. Other researchers have found the same environmental constraint when studying healthcare providers and victims of other forms of violence (Khubchandani et al., 2013; Minksky-Kelly, Hamberger, Pape, & Wolff, 2005).

Minksky-Kelly et al. (2005) explored the factors that lead to failure in identifying victims of violence in clinical practice, determining the importance of environmental constraints to identifying and reporting victims of intimate partner violence. The authors found that scheduling leading to time constraints played a significant role in victim reporting. Also affecting reporting practices were uncertainty regarding the referral process and the confusion over the values of their organization, specifically the competition between family-centered care and individual

patient confidentiality. The authors concluded that these barriers were system-level barriers, signifying that reporting behaviors are not just determined by intrapersonal factors.

A primary focus of social cognitive theory is individuals' capabilities to create and be a part of environments that assist them in reaching goals and performing behavior (McAlister et al., 2008). Changes need to occur at the organizational level for environmental constraints to be removed, increasing the intention to identify and report victims among healthcare providers (Ambuel et al., 2013; Minksky-Kelly et al., 2005).

5. Intention to identify and report victims of DMST

In addition to determining the influences on healthcare providers' level of self-efficacy in regards to DMST victims, this study examines the role of these theoretical constructs on behavioral intention. The integrated behavioral model assumes that the most important determinant in performing a behavior is the intention to perform that behavior (Montano & Kasprzyk, 2008). For intention to increase, a person needs to have the knowledge and skill to perform the behavior in question (Jaccard, Dodge, & Dittus, 2002). Additionally, intention to perform a behavior is largely influenced by the environmental facilitators and constraints existing for that person (Bandura, 2002). For behavioral intention to increase, there needs to be few or no environmental constraints negatively impacting a person's ability to easily perform a behavior (Triandis, 1980). Lastly, according to social cognitive theory and the integrated behavioral model, a person's self-efficacy has the largest influence on his or her intention to perform a certain behavior (Bandura, 1989; Montano & Kasprzyk, 2008). The present study examines the influence that theoretical constructs from social cognitive theory and the integrated behavioral model have on a healthcare provider's intention to identify and report a victim of DMST in a clinical setting.

CHAPTER 3

METHODS

The purpose of this study was to examine the individual (knowledge, perceived barriers, self-efficacy) and environmental (healthcare environment) factors that impact a healthcare provider's intention to identify and report domestic minor sex trafficking victims (DMST) within a clinical setting. Publications from researchers, government agencies, and advocates provide minimal guidance to help healthcare providers understand, recognize and be part of the solution to eliminate this crime. A community needs assessment was needed to evaluate the knowledge and skills of healthcare providers to reply to DMST victims appropriately and provide necessary care for a victim. A long-term goal of this research is to generate practical, theory-driven and feasible information for educating healthcare providers to be part of the solution.

This study used a mixed-methods design. I conducted this study in two consecutive phases. Phase 1 (qualitative) consisted of semi-structured interviews. To the best of my knowledge, no measurement instrument currently exists for this health topic; therefore, the data collected in Phase 1 informed the creation of a quantitative survey used in second phase of the study. Phase 2 (quantitative) consisted of surveys of healthcare providers.

This chapter describes the methodology of this study and is divided into three sections. The first section explains goals, objectives, and hypotheses for the study. The second section describes Phase 1 of the study. The third section describes Phase 2 of the study.

3.1 Goals, Objectives and Hypothesis

The goal of this study was to evaluate the factors influencing healthcare providers' behavioral intention for identification and reporting of DMST victims. The long-term goal in this research is to increase identification and reporting of suspected victims. This study could inform interventions to improve the knowledge and self-efficacy of healthcare providers, and ultimately increase the number of DMST victims who are identified and receive necessary services. Preliminary data do not exist on this topic, emphasizing the need for this study. The objective of the study was to examine healthcare providers' knowledge (general DMST knowledge and knowledge of clinical indicators), perceived barriers, and self-efficacy in relation to DMST, as well as the influence of the work environment (healthcare constraints and facilitators). The focus of this project was behavioral intention to identify and report DMST. Figure 3.1 incorporates the proposed hypotheses with the conceptual model for this study. The study was guided by the following objectives and hypotheses.

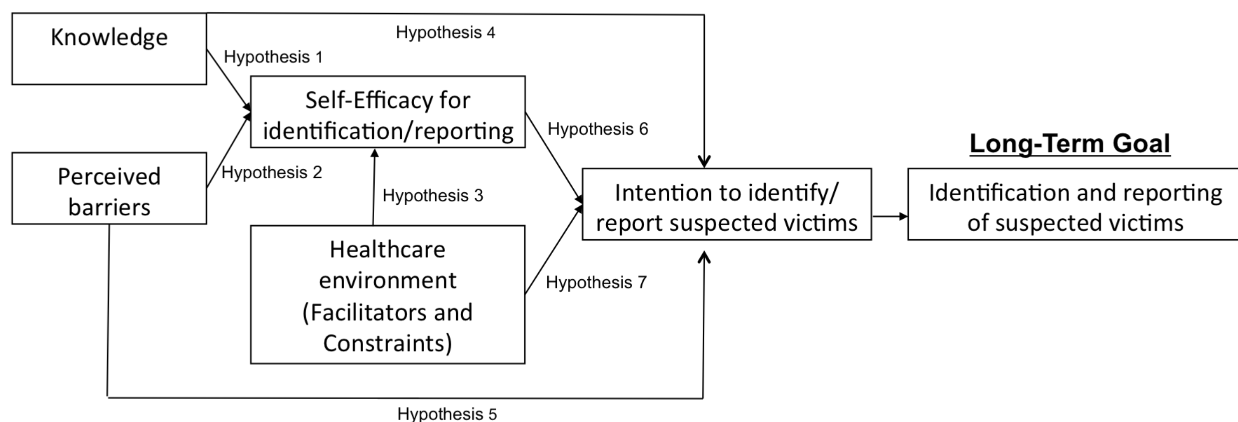

Figure 3.1: Conceptual Model with Hypotheses

Objective 1 – Self-Efficacy: Identify personal and environmental factors that increase or decrease a provider's self-efficacy to identify and appropriately assist victims of sex trafficking.

Hypothesis 1: Participants who report more knowledge on the topic will report higher self-efficacy than participants who report less knowledge (general DMST knowledge and knowledge of clinical indicators).

Hypothesis 2: Participants who perceive fewer personal barriers will report higher self-efficacy than participants who perceive more barriers.

Hypothesis 3: Participants with more positive views of their external healthcare environment (more facilitators) will report higher self-efficacy scores than participants who have more negative views of their environment (more constraints).

Objective 2 – Intention: Identify the factors that influence a provider's intention to identify and report victims of sex trafficking at varying levels of certainty that a patient is a victim.

Hypothesis 4: Participants who report more knowledge will report greater intention to identify and report a suspected victim than participants with less knowledge (general DMST knowledge and knowledge of clinical indicators).

Hypothesis 5: Participants who report fewer perceived barriers will report greater intention to identify and report a suspected victim than participants who report more perceived barriers.

Hypothesis 6: Participants who report greater self-efficacy to identify and report victims will have a stronger intention to identify and report victims than participants with less self-efficacy.

Hypothesis 7: Participants who report more positive views of their healthcare environment (more facilitators) will have stronger intention to identify and report victims than participants with more negative views of their healthcare environment (more constraints).

Objective 3 – Exploratory Analysis of Effect of Demographic Variables: Explore the influence of demographic and professional characteristics—age, gender, years of experience, occupation, work setting, and healthcare specialty—on proposed constructs.

3.2 Phase 1 (Qualitative)

Study Design and Setting

For the first phase of the study, I interviewed physicians, midlevel providers (nurse practitioners and physician assistants), nurses, social workers, and caseworkers at Child Protective Services (CPS). Using qualitative, semi-structured interviews, participants answered questions on their level of awareness of DMST, knowledge on the signs of victimization, skills to report if victimization is suspected, influence of worksite policies and other environmental factors playing a role in identification and referrals. I also asked about their perceived needs regarding future training. CPS workers were asked about their experiences working with the medical community and their needs from healthcare professionals to address sex trafficking in local communities.

Sample

Twenty-one people participated in Phase 1: three nurses, four social workers, two midlevel providers, eight physicians, and three caseworkers at CPS. With this sample, I reached saturation across groups (Mason, 2010). Saturation refers to the point in interview process where more data are not leading to more information. Having a sample of 21, with individuals representing each of the five specialties for variability, I had a sample that was large enough to ensure most ideas and important information was discovered, without having a sample size that was so large that the data becomes repetitive and redundant.

Purposeful sampling promoted a deeper understanding of the perspectives of healthcare professionals who have had a long experience in the workforce and particularly those who may have had some contact with victims of trafficking. Interviewees were practicing nurses, social workers, midlevel providers, physicians, and CPS caseworkers working in the United States.

Procedures for Recruitment

Participants were recruited through networking, through Physicians Group of Southeastern Ohio and through Quality Care Partnerships. All potential participants were contacted via email by the administrative coordinators of Physicians Group of Southeastern Ohio and Quality Care Partnerships, and other healthcare providers who volunteered to assist with recruitment. Included in the initial email was the informed consent letter. If individuals elected to participate, they sent the signed informed consent letter directly to me, along with their contact information. Interviews were scheduled after a signed informed consent letter was received.

Interview Guide

The constructs identified in the conceptual model were used to develop the interview guide for Phase 1 (Appendix E). A semi-structured interview was used to understand participants' level of awareness of the problem, knowledge on the signs of victimization, potential barriers to identifying and reporting possible victims, knowledge of procedures to report suspected victimization, worksite policies and other environmental factors playing a role in identification, and opinions regarding future training. Social workers that worked with trafficking victims were asked about the role of healthcare providers and what information they wanted the healthcare profession to know about working with this population. In addition, participants reviewed a first draft of the Phase 2 survey for comprehension, accuracy and completeness.

Analysis Plan

The focus in qualitative data analysis is to identify meaningful themes. Qualitative data analysis involves working with the data, organizing it, breaking it into manageable units, coding it, synthesizing it, and searching for patterns or themes. Using a constant comparative method (Glaser & Strauss, 1967), interview data were examined to identify themes in participant responses. The goal of the data analysis in Phase 1 was to identify themes and patterns that emerged from the open-ended interviews.

Interview transcripts were individually read and coded manually to attain a surface level content analysis of data, as well as to circumvent formulating any assumptions about the data. I performed the initial coding, and Dr. Orpinas read the transcripts to refine the coding and uncover patterns that cut across the preponderance of data.

Creation of Quantitative Survey for Phase 2

After Phase 1 was completed, interview analysis assisted in preparing for the survey used in Phase 2. Before Phase 1 began, a survey draft for Phase 2 was created using previous literature in order to have a starting point and outline of a survey. Following the completion of Phase 1, I examined the qualitative data looking for themes and common responses. Using the most common responses from participants, I modified or created survey items for each of the constructs in the conceptual model.

For survey items regarding general DMST knowledge and knowledge of clinical indicators, questions were based on previous literature and external sources since these items were based on fact and not opinion. Perceived barrier items combined interview responses and items adapted from a scale used to survey school nurses' perceived barriers to identifying adolescent dating violence victims (Khubchandani et al., 2013). The self-efficacy and healthcare

environment scales were based on interview responses. Some items were modified from the original draft, while others were written based solely on the responses from participants.

After I completed the final draft of the Phase 2 survey, four Phase 1 participants read over the survey and provided their opinions and feedback. These individuals were asked to provide feedback on terminology used in the survey, items included, and any other opinions they may have had on the survey before it was distributed. Once the survey was finalized, Phase 2 of the study began.

3.3 Phase 2 (Quantitative)

Study Design and Sample

Phase 2 was quantitative and consisted of an online survey. Healthcare providers answered questions about each construct of the conceptual model related to DMST.

The target population for Phase 2 consisted of nurses, social workers, midlevel providers (nurse practitioners and physician assistants), and physicians who are currently practicing in the United States. Nurses had to be certified as a LPN, RN, or BSN to participate; medical assistants were excluded. Social workers had to have received a BSW or MSW to participate, but a license was not part of the inclusion criteria. Midlevel providers had to be board certified nurse practitioners (NP) or physician assistants (PA). They did not have to have a specialty to participate. Physicians had to be a MD or a DO and be board certified to practice medicine in the United States. These groups and specific certifications were selected due to their likelihood of encountering a potential victim of DMST, the education these professions receive through school and continuing education, and the amount of time they spend with patients.

Recruited specialties were primary care providers, including pediatrics, family practice, obstetrics/gynecology (OB/GYNs), emergency medicine, and internal medicine. Providers in

these specialties are the most likely to see female patients at the primary age for DMST victimization, approximately 11-14 years of age. Inclusion criteria for recruitment regarding practice setting included healthcare providers working in private practice, in-patient hospital, emergency room, urgent care, and federally qualified health centers (FQHCs) and other community health clinics. These practice settings were selected due to the likelihood that a possible victim would seek medical treatment in one of these settings. Participant's location and geographic setting was not restricted in the inclusion criteria since human trafficking is not limited to a certain type of area or geographic location (Reinhard et al., 2012).

Sample size was calculated using G*Power 3.1 software (Faul, Erdfelder, Buchner, & Lang, 2009; Faul, Erdfelder, Lang, & Buchner, 2007). The test used to create the sample size was linear multiple regression, fixed model, with a single regression coefficient. Using the small effect size of .20, an alpha of .05, and the power of .80, the total sample size for healthcare providers needed was specifically 54.

Procedures for Recruitment and Data Collection

Recruitment. Participants were recruited through networking, Physicians Group of Southeastern Ohio, and through Quality Care Partnerships. Participants were contacted via email in October 2015 with the initial invitation to participate and the web link to the Qualtrics survey. All possible participants were contacted via email again in December 2015 with the same invitation to participate and survey web address.

Data collection. Survey data were collected using the web-based survey data collection software Qualtrics. Qualtrics software allowed tracking of the status of survey completion for every participant. Data was downloaded into SPSS for analysis.

Measures

Table 3.1 summarizes each construct, description of each measure, response format, Cronbach's alpha if a scale, and final variable to be analyzed. Appendix A presents the measurement manual and final participant survey.

General DMST Knowledge. Ten items measured participants' knowledge of the topic of sex trafficking, health consequences, reporting procedures, and awareness of the National Human Trafficking Resource Center. Items were written in the form of statements, and response categories were *true*, *false*, or *unsure*. Participants received one point for each correct response; incorrect responses or *unsure* were coded as 0. Scores were added; thus, the final score could range between 0 and 10 points, with higher scores indicating more general DMST knowledge.

Knowledge of Clinical Indicators. Twelve items measured participants' knowledge of signs and symptoms that a patient is a possible victim of domestic minor sex trafficking. Items were written in the form of statements, and response categories were *yes*, *no*, and *unsure*. Participants received one point for each correct response; incorrect responses or *unsure* were coded as 0. Scores were added; thus the final score could range between 0 and 12 points, with higher scores indicating more knowledge of clinical indicators.

Perceived Barriers. Seven items measured participants' perception of potential perceived barriers to reporting for healthcare professionals, including being unsure if the patient is a victim, a perception that the victim did not want or need any help, and a lack of time. Items were written in the form of statements, and response categories were *not at all true* (1), *a little true* (2), *pretty much true* (3), and *very much true* (4). The internal consistency was very low demonstrating that the scale did not measure a single construct. Thus, no scale value was computed; each item was analyzed individually.

Self-Efficacy. Six items measured the participants' confidence in their ability to identify, assist, and report suspected trafficking victims. Items were written in the form of statements, and response categories were *not at all true* (1), *a little true* (2), *pretty much true* (3), and *very much true* (4). To calculate the scale, scores were averaged. Thus, scale scores could range between 1 and 4 points, with higher scores indicating higher self-efficacy. The internal consistency of the scale, measured with Cronbach's alpha, was .88.

Healthcare Environment (Facilitators and Constraints). Six items measured views of the factors external to the person that impact identification and reporting of trafficking victims either positively (facilitators) or negatively (constraints). These factors included organizational structure and policies, the presence of multidisciplinary work teams at the organization, and a time/work schedule at a hospital or physician's practice. Items were written in the form of statements, and response categories were *not at all true* (1), *a little true* (2), *pretty much true* (3), and *very much true* (4). Scores were averaged to calculate the scale. Lower scores indicated that the participant disagreed with the statement and viewed it as an environmental constraint. Higher scores indicated that the participant agreed with the statement and viewed it as an environmental facilitator. The internal consistency of the scale, measured with Cronbach's alpha was .83.

Intention. Three items measured the participants' intention to identify and report suspected victims. Intention to report was based on certainty level of the participant that a patient was a victim of DMST. The first level of intention, *Intention if Certain*, was the intention to identify and report if absolutely certain that a patient was a victim of DMST. The second level of intention, *Intention if 50/50 Chance*, was the intention to identify and report if there was a 50/50 chance that a patient was a victim of DMST. The third level of intention, *Intention if Unsure*, was the intention to identify and report if uncertain that a patient was a victim of DMST. Items

were written in the form of statements, and response categories were *not at all true* (1)*, a little true* (2)*, pretty much true* (3)*,* and *very much true* (4). Mean scores were calculated for each individual intention item. Lower scores indicated that the participant had a lower intention to identify and report a victim, while higher scores indicated that the participant had a higher intention to identify and report a victim.

Demographic Information. Seven items collected information on the age (open ended), years in practice (open ended), gender (Male or Female), occupation (Physician, Midlevel Provider, Nurse, Social Worker, Other), practice type (Private Practice, Community Health Center, Hospital-Inpatient, Emergency Room, Urgent Care, Other) specialty (Family Practice, Pediatrics, OB/GYN, Emergency Medicine/Trauma, Internal, Generalized, Other), and geographic location description of each participant (Large City, Mid-Size City, Suburb, Town, Rural).

Table 3.1. Brief Description of Theoretical Constructs

	Construct	Description of Measure	Response Format	Internal Consistency	Final Variable to be Analyzed
1.	General DMST Knowledge	10 items measuring overall knowledge.	*True*, *False*, or *Unsure*.	N/A	Sum of correct responses ranging from 0 to 10.
2.	Knowledge of Clinical Indicators	12 items measuring overall knowledge of clinical indicators.	*Yes*, *No*, or *Unsure*	N/A	Sum of correct responses ranging from 0 to 12.
3.	Perceived Barriers	6 items measuring perceived personal obstacles to identifying and reporting victims.	Four-point scale with anchors of 1 to 4 representing *Not At All True* to *Very Much True.*	α=.38*	Mean score of each individual item.
3.	Self-Efficacy	6 items measuring self-efficacy or participants.	Four-point scale with anchors of 1 to 4 representing *Not At All True* to *Very Much True.*	α=.88	Self-efficacy scales calculated as the average of the 6 items; individual items.
4.	Healthcare Environment (Facilitators and Constraints)	6 items measuring views of the external healthcare environment.	Four-point scale with anchors of 1 to 4 representing *Not At All True* to *Very Much True.*	α=.83	Environment scale calculated as the average of 6 items; individual item.
5.	Intention	3 items measuring intention to identify and report a victim. Each item describes a different level of certainty that patient is victim.	Four-point scale with anchors of 1 to 4 representing *Not At All True* to *Very Much True.*	N/A	Mean score of each individual item.
6.	Demographic Information	7 items measuring age, years in practice, gender, occupation, practice type (setting), specialty, and geographic description of location.	Various response options depending on demographic information collected	N/A	Sum and percentage score of each demographic variable.

* No scale was calculated due to low internal consistency.

Analysis Plan

SPSS (Version 22.0) was used for data management and statistical analysis. A two-tailed 0.05 significance level was used for all statistical tests. The statistical analysis followed five steps. First, the internal consistency of perceived barriers, self-efficacy, and healthcare environment scales was examined using Cronbach's alpha. Second, I described the characteristics of the sample using frequencies by gender, participant occupation, healthcare specialty, practice setting, and type of geographical location. The mean and standard deviation were calculated for number of years in practice, participant's age, general DMST knowledge, knowledge of clinical indicators, perceived barriers, self-efficacy, the healthcare environment, and intention. Third, I examined the bivariate association between variables, using Pearson's correlation. Of particular interest were the correlations between each of the three levels of intention and the clinician characteristic predictor variables (general DMST knowledge, knowledge of clinical indicators, perceived barriers, self-efficacy, and the healthcare environment).

Fourth, multivariate analyses were run to test the seven hypotheses. To test Hypotheses 1, 2 and 3, a single multiple linear regression was run to examine the relationship between the clinician characteristic predictor variables and the variable of self-efficacy. Hypothesis 1 conjectured that general DMST knowledge and knowledge of clinical indicators would have a positive relationship with self-efficacy. Hypothesis 2 postulated that the more perceived barriers a participant reported, the lower their self-efficacy would be. Lastly, Hypothesis 3 assumed that positive views of the healthcare environment would be positively related to self-efficacy; the more environmental constraints reported by participants, the lower the self-efficacy scores.

To test Hypotheses 4-7, three multiple linear regression models were run to examine the relationship between the clinician characteristics (general DMST knowledge, knowledge of clinical indicators, perceived barriers, self-efficacy, and healthcare environment) and the three intention variables (intention if certain, intention if 50/50 chance, intention if unsure). A regression model was run for each intention variable. Post-hoc moderation analysis was done to examine if there were any moderating variables dictating the relationship between self-efficacy and intention. Hypothesis 4 stated that lower general DMST knowledge and knowledge of clinical indicators would lead to lower intention to identify and report DMST victims. Hypothesis 5 proposed that fewer perceived barriers would result in greater intention to identify and report suspected victims. Hypothesis 6 assumed that self-efficacy and intention were positively related, with a higher self-efficacy score predicting greater intention to identify and report possible victims. Hypothesis 7 was analyzing the effect of healthcare environment, with more positive scores about the healthcare environment (facilitators) positively impacting intention to identify and report and more negative scores about the healthcare environment (constraints) negatively impacting intention to identify and report.

The third objective of this study was to explore the influence of demographic and professional characteristics on the proposed constructs. After examining sample size for each demographic variable and their individual categories, only two demographic variables were determined to have large enough sample sizes to analyze their individual categories separately. These were occupation and gender. Frequencies and means for general DMST knowledge, knowledge of clinical indicators, self-efficacy, the healthcare environment, and intention were analyzed, examining the differences between categories for both demographic variables.

After descriptive analyses were examined for each demographic variable, the multiple linear regression models previously conducted for objectives 1 and 2 were conducted again, splitting the data by gender. Gender was the only demographic variable with large enough sample sizes in variable categories to conduct more extensive analyses. This portion of the analysis explored if the relationship between the clinician characteristic predictor variables and the variable of self-efficacy (objective 1), as well as if the relationship between the clinician characteristics and the three intention variables (objective 2) were different between genders.

CHAPTER 4

RESULTS

This chapter is divided into two sections. The first section presents the results from Phase 1: qualitative interviews. This section describes the sample and emergent themes. The second section of this chapter presents the results from Phase 2: quantitative survey.

4.1 Phase 1: Results from the Qualitative Interviews

Phase 1 was conducted to explore the views, experiences, and ideas of various healthcare providers regarding their role in working with victims of domestic minor sex trafficking (DMST). This phase provided baseline data that assisted with the development of the survey for Phase 2. Each interview began with an overview of the project, including why I am interviewing healthcare providers and what the different phases of the research study entail. I also described how the data from Phase 1 would inform Phase 2. The results from Phase 1 are presented in two sections: overview of the participants and major topics and themes within the topics.

Overview of Participants

In total, 21 healthcare providers participated in Phase 1. They varied in geographical location, practice setting, years in practice, specialty, and gender. The sample consisted of 8 physicians, 2 midlevel providers, 3 nurses, 4 social workers, and 3 caseworkers from Child Protective Services (CPS). Table 4.1 presents the demographic characteristics of the participants.

Table 4.1 Phase 1 Participants

Pseudonym	Gender	Occupation	Specialty	Work Setting
Liza	F	CPS Case Worker	None	CPS
Lissette	F	CPS Case Worker	None	CPS
Jamie	F	CPS Case Worker	None	CPS
Gina	F	Midlevel Provider	Family Practice	FQHC
Scott	M	Midlevel Provider	Family Practice	Urgent Care
June	F	Nurse	General Nursing	Hospital
Bob	M	Nurse	Emergency Medicine	Emergency Department
Bella	F	Nurse	Women's Health	Hospital
Arthur	M	Physician	Family Practice	Private Practice
John	M	Physician	Emergency Medicine	Emergency Department
Ryan	M	Physician	Family Practice	Private Practice
Shawna	F	Physician	Family Practice	Private Practice
Alice	F	Physician	Pediatrician	FQHC
Tucker	M	Physician	Pediatrician	FQHC
Edward	M	Physician	Family Practice	Private Practice
Natalia	F	Physician	Emergency Medicine	Emergency Department
Sarah	F	Social Worker	Homelessness	Community Agency
Jay	F	Social Worker	Medical Social Worker	Emergency Department
Aubrey	F	Social Worker	Female Perpetrators	Community Agency
Jackie	F	Social Worker	Female Victims of Trauma	Community Agency
Amy	F	Social Worker	Social Justice	Community Agency

Topics and Themes

The interview covered 13 topics: (1) information heard about domestic minor sex trafficking, (2) where participants first heard about domestic minor sex trafficking, (3) clinical indicators of domestic minor sex trafficking, (4) handling of a suspected case, (5) reporting of a suspected case, (6) perceived barriers to identifying victims of sex trafficking, (7) perceived facilitators to identifying and reporting sex trafficking victims, (8) helpful aspects of the work environment, (9) constraints caused by the work environment, (10) problems with patients, (11) the importance of healthcare providers in working with victims of sex trafficking, (12) necessary changes in the healthcare system that would improve the care, and (13) advice to healthcare providers. This last topic was not an original part of the interview but emerged from social workers who had experience with this population.

Topic 1. Information Heard about Domestic Minor Sex Trafficking

Participants had a wide array of responses when asked what they had heard about sex trafficking and where they have heard this information. Four themes emerged under this topic (Table 4.2).

Table 4.2: Topics and Themes Pertaining to Information and Knowledge

Topic	Themes
Information heard about domestic minor sex trafficking	• Human trafficking is an epidemic, more frequent than commonly known • Anyone can be a victim, but most victims are low SES, runaways, young • Most trafficking victims are international persons or come from large US cities (e.g., Toledo, OH & Atlanta, GA)
Where participants first heard about DMST	• Information came from the news and media sources • Information came from education and professional trainings
Clinical indicators of DMST	• Signs of physical or sexual abuse are present • The patient has reproductive health issues • There are signs of premature sexual activity • The patient is in the presence of a suspicious person • There are signs of addiction • The patient has mental health issues

Human trafficking is an epidemic. Many participants referenced the prevalence of human trafficking. Several of the participants mentioned they heard human trafficking is a problem in the United States, many using the word *epidemic* to describe the situation. Sarah described her knowledge of the prevalence, saying, “I have heard it is quite a problem. Quite an epidemic... It’s a continual persistent problem with children throughout the whole country.” Scott stated, “The statistics do surprise me, how often and how much there is in the United States”. John mentioned public knowledge, explaining, “I know that it’s more common than the general public probably knows.”

Anyone can be a victim, but most victims are low SES, runaways, and young. Several healthcare providers explained things they had heard about victims and their characteristics. Arthur described, “Well, it involves minors and sometimes immigrants and kidnapped victims… People in abused relationships.” Tucker explained his perceptions and

preconceived notions of a typical trafficking victim, explaining, “[It is] more prevalent among disadvantaged, lower socioeconomic people. And I also think it’s more prevalent with runaways-young people who runaway from their families.” John mentioned his surprise that it could happen to anyone, saying, “… there is a lot of people who grew up here who are part of regular families who become involved in it.” Alice also mentioned this impression of a victim, citing an experience she had in medical school:

> I remember my first experience with it in med school; actually being somewhat surprised that that is something that can happen… Because it was my first exposure to it, this was a girl who had been [living] in suburbia, middle class, and, so I remember that had really taken me by surprise. It really was something that occurred in the U.S., but could occur despite racial backgrounds, economic backgrounds, despite all kinds of things.

Most trafficking victims are international persons or come from large US cities (e.g., Toledo, OH & Atlanta, GA). When I mentioned sex trafficking, many participants immediately mentioned international victims. John said, “I mean, people typically think about people coming in from overseas, trafficked here.” Alice explained, “My first thought going in to it when I was a med student was… when it came to sex trafficking, I would be looking at people who had been brought from overseas or illegal immigrants.” Also having a similar initial thought process on the topic, before working for an anti-trafficking organization, Jackie said, “My first experience was thinking about it in terms of international victims and people from other countries being brought to the U.S.”

When asked about what they had heard about sex trafficking, particularly of American minors, providers also mentioned specific cities and locations as being impacted more than others. First, a common opinion was that trafficking was happening primarily in large cities. Tucker said, “I think of it as a problem that is more prevalent in the urban setting.” Liza also mentioned the location of a large city, but expanded her thought saying, “We think of sex

trafficking in big cities, but it could be anywhere. People are in a bustling area, and things go unnoticed."

Some providers mentioned specific cities when describing the types of locations common for sex trafficking. Being from Ohio, Edward was surprised at the prevalence of victimization in Toledo, Ohio:

> [I heard] that Toledo has what I think the national media and state media said was a high level of activity in that area. That surprised me because you really just think of boarder states and high population areas, like New York City, LA, or San Francisco, but not Toledo, Ohio.

Also from the Midwest, Aubrey mentioned a specific location that is known for its prevalence of sex trafficking of minors, "As living in the Midwest, I live along a major corridor for sex trafficking from kids from Ohio to Canada, up through Michigan." With her experience as an ER physician in downtown Atlanta, Natalia also noted location when explaining what she had heard about the topic:

> I know a lot of my colleagues have [worked with a trafficking victim]. Especially being in Atlanta, since it is just… I mean, I know Atlanta is pretty big… I mean, as far as I've heard, there is a lot of trafficking going on. Like in Atlanta, [the hospital] told us to be very cognizant.

Topic 2: Where Participants First Heard about Domestic Minor Sex Trafficking

When asked where participants first heard about sex trafficking in the United States, two primary themes emerged: information came from the news and media sources and information came from education and professional trainings (Table 4.2).

Information came from the news and media sources. The majority of participants mentioned they first heard about trafficking from the news, the media, or from television. Edward said, "Most readily, on television and in the news, the media. Probably everything I have heard has been in local and state newspapers and television programs." Several participants

specifically mentioned the Hollywood movie, *Taken*, as one initial way they heard about sex trafficking. One participant mentioned social media as his introduction to the topic. Scott described, “I have a friend who posts a lot of stuff on Facebook about it. And it’s becoming more of a hot topic, so I would get most of my information on Facebook on it.”

Information came from education and professional trainings. If the participants did not hear this information through a news outlet or through a media channel, they first heard about sex trafficking through an educational experience. The three CPS caseworkers mentioned that they received training on human trafficking through the Department of Social Services. Amy first heard about it while working on her bachelor’s degree:

> I learned about human trafficking, labor trafficking, and sex trafficking when I was in undergrad. I had a class, and there was an organization called Women at Risk, and they came in to one of my social justice classes and spoke about human trafficking.

Two physicians learned about it during their residency, specifically during lecture series. John explained, “With my residency education, we have lectures every week, and that has been brought up before as something we need to be aware of.” Alice said, “When I did my residency with [children’s hospital], we actually did have this as a part of our lectures… We had some people actually come to talk with us about sex trafficking.”

Topic 3: Clinical Indicators of Domestic Minor Sex Trafficking

Many of the interview participants mentioned different clinical indicators that they would suspect they would see in a possible sex trafficking victim. Participants discussed six different indicators (Table 4.2).

Signs of physical or sexual abuse are present. Several participants discussed seeing possible signs of physical or sexual abuse among potential victims of sex trafficking. A common response among participants was that they would see bruising, physical deformities, or genital

trauma among possible victims. In addition to seeing signs of abuse, Jackie, a social worker who works specifically with trafficking victims also said to be aware of a history of sexual abuse:

> [We see] very, very high rates among people that [anti-trafficking social workers] work with have a history of childhood sexual abuse. I think that is definitely a key factor because when somebody has been abused as a child, it really is not that big of a jump to go from saying 'this person is forcing me to have sex with them and it's against my will', and then they grow up knowing that that's a norm and that they're not in control of their bodies. And then when they get older, they realize they can make money doing the same thing. It's this weird connection that's not a big jump for them to start getting involved in prostitution.

The patient has reproductive health problems. In addition to signs of abuse, many practitioners said that they suspect they would see a variety of reproductive health problems among possible victims of sex trafficking. Participants explained that their suspicion of possible sex trafficking would increase if their patients came to them with a sexually transmitted disease (STD), pelvic issues, unintended pregnancy, or other issues related to the genital area that are not typical for adolescents and teens to experience. Ryan said, "The first thing I would think of is there would usually be some type of adnominal or pelvic complaint. Problems urinating… Usually something to get some attention in the genital area, but it would be vague." Scott described, "Especially with young children, if they're having discharge or abrasions or frequent… [urinary tract infections]."

When asked about clinical indicators of a possible victim of sex trafficking, John recounted a time where he thinks he did encounter one in his emergency room, saying, "There is one patient I can remember… She had really vague complaints that eventually got down to basically an STD check in this visit."

There are signs of premature sexual activity. It was not uncommon for participants to assume that they would see early signs of sexual behaviors. Many of the practitioners explained that they assumed they would have patients presenting with signs of engaging in sexual activity

before what the practitioners believed was a *normal* age. The participants who mentioned this explained that they would be suspicious if they suspected sexual activity among patients younger than 14 years old. Gina described this phenomenon as, “premature sexual promiscuity”.

The patient is accompanied by a suspicious person. A large number of participants assumed that if they had a possible sex trafficking victim in need of medical attention, this potential victim would be in a medical setting with a person older than the possible victim who had a suspicious relationship with the patient. Bella assumed that the relationship would be based on gender, saying, “Older men with younger women who [come] into clinical settings for STDs, birth control, and termination of pregnancy…” would be suspicious to her. Arthur explained, “The relationship of the adult who would bring them in to the office would be suspect, because we do try and clarify that relationship.” Bob described his opinion, elucidating, “Maybe there’s a very protective person who doesn’t quite seem like they would match somebody that the patient would be associated with.”

John told the story of a patient who was possibly a victim, describing, “She had the warning signs they warned us about. She was with somebody else. She was with another female who was not the same race as her, who was a little bit older than her, and who answered most of her questions for her.” Alice said, “Obviously somebody coming in with somebody kind of person with them who didn’t make sense, as far as what kind of role they were in or who seemed like they were kind of shielding them from asking questions.” Gina’s suspicions were very similar to Alice’s and the experience that John had, saying, “If they are there with a caretaker, quote unquote, that isn’t a parent and they seem to look to that person for answers or they won’t speak for themselves, certainly you would think that something might be going on.”

Amy said that the relationship is very important to be cognizant of because of the element of control that usually exists within those relationships:

> Another sign would be if someone is being controlled. So you can tell how a person is if there is somebody that's with them, constantly asking them questions... If the person isn't able to give answers of their own, that would be another indicator. [That's] a huge indicator in itself.

There are signs of addiction. All providers who were familiar with this type of victimization mentioned the presence of addiction among girls and women in the commercial sex industry, and how signs of addiction are a very important clinical indicator when trying to identify these victims. Alice believed that the drug abuse could be a reason they entered trafficking, saying, "Any history of drug abuse or anything like that that could have gotten them in to a bad situation." Jackie mentioned that drugs may have played a role in these girls and women entering the sex trade, but many of their addictions began after they were enslaved:

> Most women we worked with did have some sort of addiction. A lot of the time, it was the trafficker that got them addicted to that substance, but sometimes, it was that they were using substances to numb the pain of the trauma they went through in the experience, as well. And I can say that that is a pretty typical thing, for addiction to be a part of the picture.

Amy echoed Jackie's response, citing very similar experiences with her patients seeking freedom from sex trafficking, saying, "A person who is exploited or trafficked, there is also a huge relationship with addiction. That is another indicator." Natalia assumed that if she saw a victim of sex trafficking, that person would be a current addict, describing, "[If] they have marks all over them. Or they have trackings from using IV drugs."

The patient has mental health issues. The most common responses among the healthcare providers when asked about clinical indicators of sex trafficking victimization were references to mental and emotional health issues. Many of the respondents explained these mental health concerns as actual clinical diagnoses, while others mentioned behaviors that would

make them concerned about their mental health status. Shawna believed that she would see diagnosable conditions among these children, explaining, “I think you’re going to see signs of mental health issues. Signs of depression or anxiety. May see people who range on suicidal issues depending on where they are in the situation. [They] may also present with a lot of social anxiety.”

Based on a previous experience with a victim, Jay explained that she thinks that these mental health issues would be more translated into behavior. She explained, “[The patient] was not forthcoming with information, she was very frightened, very withdrawn…” June had a similar opinion:

> Anxiety is a big thing. Like, how’s their mental status. You know, when you’re talking to them and asking them uncomfortable questions, are they kind of fidgeting? Are they looking away? You know, do they answer real quick and get defensive?

Gina assumed a child could be a victim if, “They’re skittish, and quiet and standoffish.” John explained, “If they don’t want to look you in the eye… Just generally quiet, not answering questions, skirting around questions that you’re asking.” Jackie said that it is important to take note of the behaviors of the children, explaining, “I mean the obvious thing would be if somebody just seems generally fearful and maybe not being very open… and they look uncomfortable or fearful in some way, that would be a big indicator.”

Topic 4: Handling of a Suspected Case

The next two topics discussed what a provider would do if they suspected a patient was a victim of DMST. Table 4.3 displays these two topics and the themes that emerged.

Table 4.3: Topics and Themes for Handling and Reporting DMST

Topic	Themes
Handling of a suspected case	• They want to discuss the patients' home life • They would involve social worker or similar specialist • Involve an attending physician or supervisor before making any decisions • Have an open, honest discussion with the patient
Reporting of a suspected case	• Practitioners would involve Child Protective Services • They would notify law enforcement • Referrals to community resources would be made

Four themes emerged when participants were asked how they would handle a suspected case of DMST (Table 4.3). Some of the physicians said that they would want to **discuss the patients' home life** as a part of investigating what could possibly be going on in that setting. Arthur said, "I would ask them how life is in their homes… If I thought there were issues of emotional stress, I would ask them what might be going on inside of their home." Edward explained, "I would need to assess what was going on at home. I would probably be upfront enough that I would question the patient about it… to see if [the response] would make me more suspicious."

Several different providers mentioned **involving a social worker or similar specialist**. Those providers who mentioned the potential involvement of a social worker worked in an environment in which a social worker was employed as a part of the multidisciplinary healthcare team. Alice said that having a social worker employed at her community health center was a vital asset in this scenario, describing, "I am fortunate enough that I actually have a social worker who is in our clinic 24/7, so he would be a great service."

The two emergency room physicians also mentioned the important presence of social workers or similar specialists who can work with a patient. John explained, "I would go to talk to

one of the social workers and tell them that I was suspecting before I just flat out confronted the people about it or anything. I would talk to the social worker first and see what they thought my next best option would be.” While Natalia did not specifically mention a social worker, she did discuss the importance of bringing in a person who specializes in interviewing vulnerable children when investigating a possible sex trafficking victim in her emergency room:

> If we think [the child] has been abused, we ask very basic, general questions. But the forensic interview for a child has to be done by… not by a physician. It has to be done by a trained interviewer because, if we attempt to do a detailed forensic interview on them and really ask them questions, sometimes, it can lead to them putting ideas in their head or lead to them creating a story in their mind. So we have [CPS] provide an interviewer… I mean, [CPS] goes through tons of training when it comes to interviewing a child.

Jay, an emergency room social worker, explained what she would do when the referring emergency room physician asked her to come in and speak with a patient:

> First, I would try to establish a relationship and help the person be comfortable with me. I would ask a lot of open-ended questions and try to reassure the person that I was there to help and [in the case of an adult victim] that the conversation would be confidential if need be, but that I was concerned for their safety.

The 3 caseworkers from CPS also explained that they have specialists that they would refer a case to if they suspected any type of sexual abuse. Lissette said, “I would report it to our assessment unit, the screeners. And then they would refer it to other people.” Liza explained, “The person who does the interviewing for sexual abuse would take it on. And then, it would go in that direction.”

Before reporting to any authority, several of the younger providers mentioned that they would **involve an attending physician or supervisor** before doing anything else regarding the patient. Sarah noted, “If the situation were to arise… I would imagine I would go to my supervisor first, the unit manager, and see what she advises.” If the patient was specifically a child, John said, “If it was a minor, I would talk to my attending doctor, like the doctor who is in

charge of the emergency department." When a suspicious case comes in to her hospital, June described, "That's basically where we would get our supervisors involved. I have a unit supervisor, but then, there's also a whole hospital supervisor that would get involved."

Lastly, the social workers who specialize with this population explained that if they suspected that a patient was a victim of sex trafficking, the first thing that needs to be done is have an **open, honest discussion with the patient**. Jackie said that it is important to first talk with the possible victim and encouraging them to discuss their situation:

> I would recommend just asking the person about it. And pulling them aside to talk to them alone is definitely key so that they can be more open about what's going on. I would recommend pulling them to the side and just asking questions that are guiding towards that, but not like… Like if you ask a trafficking victim, 'are you a trafficking victim', they're not going to know what that means… So asking questions like, 'Is anybody controlling you right now? Do you feel like you can come and go as you please from you living situation? Is anybody forcing you to do work that you don't want to do?' Just [ask] broad questions that open up that conversation.

Aubrey emphasized the importance of discussing the situation with the person. However, she explained that she would take a slightly different approach to that discussion:

> I am very careful with the way that I ask question because a lot of women are very protective with that information and are very fearful. I am very careful with the way that I ask it. And so, in general, I'll put information out there. I'll say, you know, 'in my experience, when someone is insisting on these things, such and such could be going on. There are a range of indicators that a woman may be unsafe, so if you're feeling that way, this is a person you can call.'… And being creative in how we talk about it so it's not as direct, but it's a way that really takes the burden off of her. That's the approach. And, you know, [it's] really empowering to her. Calling on her expertise.

Topic 5: Reporting of a Suspected Case

Three themes were evident in every provider's response when asked how they would report a suspected case of DMST (Table 4.3). Every provider who is a mandated reporter said that they would have to **involve Child Protective Services** if they suspected that any form of abuse, including sex trafficking, was happening to a juvenile patient. Gina emphasized, "We

would have to call Child Protective Services. If [the abuse] is blatant, we would hold them in the office, call CPS, and let them address it." John had the same sentiment, stressing, "If it was a minor, that might be something that we have to contact CPS to at least see if they want to come in [to the Emergency Room] and evaluate the child or see if there are any open cases involving that child." Aubrey also said, "As a mandated reporter, I have to report it. I am mandated to report it to Child Protective Services; we don't call the police. We call CPS."

Even though, as mandated reporters, healthcare providers are only required to notify CPS, several participants mentioned that they would only or also **notify the police department** if they had a suspected sex trafficking victim in their presence. Jay said, "[I would] call into the police. Get them involved." Bob mentioned, "First thing would be to notify the police officers at the hospital. Then we could bring it up to, like, the city police…" Amy, who specifically works with this population, said "Definitely something that I would do is call the police and report it that way." Jackie shared that opinion, explaining, "If [a referring person] has [a potential victim] there with them, and they really are suspicious, I would go ahead and call the police because they can respond faster." In addition to notifying CPS, Arthur explained why he would also notify law enforcement:

> I would probably call child services locally. And if I suspected there was a direct threat, I would probably call the sheriff… If I felt the child was in imminent danger, I would probably call the sheriff. That's, in my opinion, a legal requirement of physicians, to protect their patients.

Shawna also said that she would call the police, but that decision would be based on the specific situation. She said, "[I would] probably start with either CPS, depending on how concerned we were. Or the sheriff or city police depending on where these folks lived. So it just depends on how high the suspicion was."

The caseworkers at Child Protective Services explained that their process of reporting cases involving any type of abuse requires them to involve law enforcement. Jamie underlined, "We are required to report that to law enforcement." Lissette explained the process that would happen at CPS, saying, "As soon as someone says that they may have been sexually abused, we have the sexual abuse case worker deal with it. We [also] involve the police or the sheriff's department."

Reporting to either local law enforcement or child protective services would both end up with the police being involved in the case. Aubrey mentioned that this could be problematic to actually helping a victim of sex trafficking. She underscored, "A lot of times, women are not going to get involved with law enforcement. They don't trust them." All of the social workers who specialized with this population all mentioned that the involvement of law enforcement, while possibly necessary, could make it more challenging to assist victims due to the victims' views of members of law enforcement and their fear and distrust of police.

A third theme did emerge when asked about reporting suspected cases of sex trafficking, but it was only mentioned by social workers. **Making referrals to community resources** was a common theme to emerge among social workers who were educated on the topic. If the victim was an international victim, Jay mentioned a local community resource that she would turn to, saying, "I have talked with folks at Tapestry in the past… [In the past], I contacted Tapestry to send someone out… I was on the phone trying to establish a report and trying to make plans for the person's safety." If she were to encounter a potential victim, Aubrey mentioned a general plan of how she would help the individual:

> I help provide them with as many resources as I can… Having at least 3 or 4 different resources for different things… If they can have alternative shelter… If they can feel safe talking to other women in a group… Providing the safe space and safe resources.

Jackie and Amy are both Anti-Trafficking Caseworkers with Salvation Army. If there is a suspected case of human trafficking, both social workers explained that the victim should be referred to their organization. Referrals to their organization can be done through the National Human Trafficking Hotline. Amy said, "The National Human Trafficking Hotline gets redirected to our hotline for this region." Jackie explained, "That's what the 24-hour crisis hotline is for… You can call through the hotline and just leave a tip about the situation that you think is unsafe, or any information that you think is a trafficking situation."

Topic 6: Perceived Barriers to Identifying Victims of Sex Trafficking

When asked to discuss their personal perceived barriers to identifying and reporting victims of sex trafficking, the majority of the participants rebutted, saying that if they suspected anything, there would be no barriers to reporting. The challenges for them were regarding identification of potential victims. Three different themes emerged when providers discussed this topic (Table 4.4).

Table 4.4: Topics and Themes for Personal and Environmental Facilitators and Constraints

Topic	Themes
Perceived barriers to identifying and reporting victims	• A lack of education and knowledge inhibits identification • Concerns that signs of a trafficking victim would be missed • There is silence surrounding the topic
Perceived facilitators to identifying and reporting victims	• Priority is placed on the importance of helping children • Having *that* feeling when seeing a patient • There is no hesitation about reporting and being wrong • The personalities and goals of providers aid identification behaviors
Helpful aspects of the work environment	• Extensive screening occurs for each patient • A multidisciplinary team, particularly involving a social worker is in place • Policies and protocols are in place at the organization
Constraints caused by the work environment	• A lack of or problems with screening at the organization • Providers received no training or necessary education • No policy or protocol is in place at the organization • No one is talking about the topic in the profession • No social workers or necessary personnel are present in the work place • Providers experience a lack of time • Relying on someone else for identification or referral is problematic
Problems with patients	• The patient is lying or withholding information • The presence of addiction • Aggression, refusal of help, and being a *Deserving Survivor* playing a role in identification

Lack of education and knowledge inhibit identification. The most common theme emerging from this topic was the providers' lack of experience and knowledge. When asked about this, Edward said, "I don't think ignorance is the right word, but just not being familiar with what the process is or what process would be most helpful to the child." Scott explained, "There is probably not enough education out there for providers… I still work under the

umbrella of my hospital, but I have never seen anything as far as continuing education hours, people talking about how to monitor for this within our practices, and what to do." Jackie highlighted that this lack of education and knowledge could lead to a misconception about what trafficking is and who are the victims of the commercial sex industry:

> I think the biggest barrier would just be, like, a lack of awareness of what trafficking is. And I think that there is just a lot of societal misunderstandings about prostitution because I think some people could hear that this person is involved in prostitution and just think, 'Oh, they're a prostitute. They're choosing to do this.' But if they were educated about human trafficking, they would know that they are probably under pimp control.

Amy said something very similar, reasoning that the lack of knowledge is leading to incorrect opinions on trafficking:

> I think a lot of people have false pretenses about what human trafficking is. And so, I think that when ladies come in that appear to be in prostitution… I think that people don't understand that it could be trafficking. Before I got involved in working in human trafficking, I didn't realize the huge connection between human trafficking and prostitution.

Concerns that signs of a trafficking victim would be missed. For several different reasons, providers thought that they could easily miss the signs that someone is a victim of sex trafficking. Arthur mentioned his lack of training that could influence his ability to identify the signs of a victim:

> Whether or not I am not well enough trained to identify some of the subtle nuances that might not be overtly evident. It would be a lack of awareness of some of the subtle indications instead of the overt indications [that a child is a victim of sex trafficking].

Gina also noted that it could be challenging to identify a victim if the indicators are not overt, saying, "If it's subtle. If there is a subtleness, you may not always pick it up." Alice explained, "I think it's just that identifying that person, and being able to recognize those signs when they are there can be challenging."

In addition to the subtleness of the signs, some providers believed that signs of domestic minor sex trafficking could be easily confused as other issues facing adolescents and teenagers. Tucker said, “Many of the signs and symptoms could be consistent with other adolescent issues. It would be difficult to sometimes tease those apart.” Bella expressed what she thought was a personal challenge for her when working with a potential victim:

> It’s very hard to tell [sex trafficking] from abuse. Also, it’s very hard as a clinician to separate that a child who is 16 has the legal right to women’s health services, but is also minor and [can be deemed] a victim of sex trafficking if they are prostituting under 18.

Lastly, some providers blamed not being able to recognize the signs on the limited number of possible trafficking victims that could also be patients. Jay said, “I do think that we don’t see enough of a volume to really know how to best recognize the issues.” June also explained, “I might miss some of the big signs of trafficking because I am not used to seeing things… You know, it’s really hard to tell sometimes.”

There is silence surrounding the topic. A large number of providers explained their opinions about the lack of conversation surrounding the topic and that this silence acts as a personal barrier to helping these victims. Jay explained, “The issues with sex trafficking don’t come up enough to feel like I have strong enough relationships with individual practitioners in the community based on calling in to [local] agencies.” June said, “I’m not real familiar with those patients because you don’t see them all the time.” Ryan asserted that the silence on the problem was the root cause of the lack of awareness in the medical field:

> Believe it or not, we have never had this discussion come up in any of my meetings or the classroom all of those years ago. This is just not a topic that comes up. We are unfamiliar because nobody talked about it to teach us about this.

The silence surrounding the topic among healthcare providers is causing many of the participants to not even have this as a possible scenario when working with a patient. Tucker

said, “I have to tell you, I have never thought about this. I would say the biggest personal barrier is a lack of awareness. I think I might not have even thought about it without you bringing it up.”

Topic 7: Perceived Facilitators to Identifying and Reporting Sex Trafficking Victims.

When asked about perceived barriers, many of the participants also explained personal factors that would assist them in helping victims of trafficking. Four different themes were identified (Table 4.4).

Priority is placed on the importance of helping children. It was noted by some of the participants that providers naturally want to help children more than they want to help adults. John explained, “I mean, when things involve kids, you automatically want to protect them more.” Natalia also highlighted the perceived personal need to help children, saying, “We care more about children because they have more potential years of life.”

Having *that* feeling when seeing a patient. Some providers mentioned having some sort of feeling or intuition that something is happening that would encourage them to investigate the situation involving their patient. Arthur said, “If you have a high index of suspicion, you may not know exactly what it is, but you’re going to pursue it.” Ryan explained, “It’s just your own… something’s just not right [feeling] we have to rely on.” Scott mentioned, “Part of the art of medicine is getting the feel. Trying to read the person and the people in the room while you’re in there. And that kind of helps tip things off.” Aubrey said, “A lot of it, I think, it’s that instinct… A subconscious idea.” Also using the concept of instinct, Jamie explained, “I just think sometimes, you know, it’s almost human instinct that makes you wonder. Even when I have seen younger people out… You know, I just think there’s that instinctual part there.

There is no hesitation about reporting and being wrong. Several of the providers specifically mentioned that they would rather report and be incorrect than not report and miss an

opportunity to help someone. Edward said, “I wouldn’t have any hesitation to report or to try to get a child help.” Alice explained, “Probably for most people, a barrier for reporting would be being afraid that they were wrong. However, I usually don’t worry about it too much. I would rather report and have them decide there was nothing going on than anything else.” Shawna was very passionate about the importance of reporting and not fearing being incorrect:

> I am not very hesitant on those kinds of things. I have children’s services and APS and the sheriff on my speed dial, and we call them a lot. I don’t mind being wrong. I always tell people that if I am wrong and you’re safe, then I am okay with that. I have a lot of people say, ‘Well, you’re just a little overzealous there.’ And I say, ‘That’s fine! If you’re okay, then I don’t mind being wrong’.

The personalities and goals of providers aid identification behaviors. Several providers mentioned that people go in to these professions because they have a natural urge to help people, particularly those who cannot help themselves. This passion helps them want to do all they can to help possible victims of sex trafficking. Aubrey explained, “Social workers have an idea… We’re all in this, in general, I believe, to do the right thing.” Natalia also highlighted how the personalities of many providers encourages those in the healthcare profession to do all they can to help every patient:

> No doctor doesn’t want to find these patients and help these patients. And no doctor wants to miss these patients. We all went in to this because we wanted… Like, [emergency medicine] specifically, I think attracts a certain personality and a certain political allegiance and a certain… Like, usually, people in emergency medicine are liberal. Usually, not all, but usually. Usually, we have an interest in the underserved population. It’s what we do every single day.

Topic 8: Helpful Aspects of the Work Environment

Participants discussed the helpful aspects of the work and external environment that facilitated their ability to identify and report possible victims of sex trafficking. This topic was regarding anything outside of the individual provider that could assist in these situations. Three themes emerged from participant responses (Table 4.4).

Extensive screening occurs for each patient. Many providers explained that in their practices, they do some sort of in depth or additional screenings that could help them identify potential victims of sex trafficking. Arthur mentioned how the new exchange products for the Affordable Care Act could introduce screenings that would facilitate identifying possible victims:

> [We're] trying to initiate annual examinations that really start to get into greater depth of some of the issues that might touch on the potential for screening [sex trafficking] out. More mental health issue screening programs, but it gets into a lot of depth and some of the questions would help tease out the possibility you're talking about.

Shawna also explained how mental health screening could assist in identifying victims:

> We have started screening everybody that comes through the office with a PH29 screening, so we are screening everybody for depression issues right now. So I think if there was something like [sex trafficking] going on and someone didn't want to tell us or didn't want to talk to us, their depression screener may show up positive, so we need to ask a few more questions… And maybe our depression screener may help s piece some of that out if we needed to.

Alice discussed a different type of screening they do at her Federally Qualified Health Center that could help identifying victims, saying, "The major thing I would say that we have in place is we have safety screening questions that we go over with all of our patients." June also mentioned how her hospital does some type of screening with every patient, explaining, "The nurses ask these questions to people and even though they may not answer honestly, there are questions asked in place before I even see the patient."

A multidisciplinary team, particularly involving a social worker is in place. A large number of providers explained how having a team of different professions and disciplines assists to effectively help a possible victim of sex trafficking. Gina said, "We have a team that will come on board and help. We also have pediatricians available… I always have one available to consult."

A more common team consisted of physicians and nurses, such as the participant, and a social worker or case manager who works in the participant's organization. John mentioned, "We have really good social workers that are in our emergency department until midnight every night." Alice praised the social worker in her organization:

> I am fortunate that I actually have a social worker who is in our clinic 24/7. So he would be a great service… We do have a really good network between the social worker. We also have counselors who are available to us that can do counseling if needed.

Edward also emphasized the importance of having access to a team of social workers, saying, "I would just call the social workers. We have 7 or 8 in the hospital that I would have access to and I would just pick their brain about what we should do next. I have confidence in the team approach." Bob explained that in his emergency room, he benefits from a team that includes law enforcement, saying, "[We have] police officers at the hospital. We do have a case manager in the ER and at least during day shift hours, there is always one available in the hospital." Natalia's ER has a similar set-up, as she explained, "Usually at every ER there is a 24-hour social services that you would get in touch with, and they would help us contact the police department, and whoever would need to help [the patient]."

For programs specifically for trafficking victims, the social workers relied on a multidisciplinary team to meet all of the needs of this population. Jackie highlighted the importance of this multidisciplinary approach while explaining how the Salvation Army Anti-Trafficking Program addresses the care of each trafficking victim:

> We offer holistic case management, which means pretty much any area of life they could possibly need help with, we're going to help them with that… We have a clinic that we work with that has all types of doctors. So it's a one-stop shop where we can get pretty much any of their needs taken care of at this clinic. We work with [this clinic] because it is quick and easy access, but we also have a really goo partnership with [another hospital] in the city. Some of those nurses will come in to the drop-in center. There is usually one medical provider at the drop in center in case someone needs some sort of health appointment or has questions about something.

Policies and protocols are in place at the organization. While not as common, some participants did explain that they had some type of policy or protocol in place in their organization that would help them identify, report, and protect a possible victim of sex trafficking. When mentioning the adolescent screening, Alice described a policy in place, saying, “For all of our adolescent patients, we have the standard protocol of those [safety] screenings being done with just them in the room.” Echoing that concept, Scott said, “If we have suspicions, we’re allowed to ask [the adult] to leave the room.”

Regarding policies and protocols that affect the environment, providers who work in hospitals explained the different things in place in their organizations that would assist them when working with any vulnerable patient. June discussed the idea of a privacy patient and how her hospital keeps their presence totally confidential and private:

> We have patients who are considered private patients where if they say they don't want a certain visitor, we actually try to get some Facebook photo, Instagram… some kind of picture of this person they don’t want to see and we post it at the nurse’s station. And we let everyone know, ‘hey, if you see this person, call security ASAP.’ If they want visitors and they’re a privacy patient, we have them use a privacy word. So, like a safe word.

Bob also reviewed his emergency room’s protocol for how they would address a patient that needed to remain private and confidential:

> There are certain things we could do, like black out the name on the screen so that somebody else would call in looking for the patient, they wouldn’t know that they’re there. Sometimes, we can move them to a different room from where they came in to or first treated and try to help them that way.

Bella explained the protocol her hospital has regarding referrals and helping patients see the necessary providers depending on their situation. She explained, “We have a program in the children’s clinic for assessment by pediatrician in the clinic if the child or their siblings are taken to any emergency room for any kind of assault.” Natalia highlighted the important difference in

policies and protocols that will be found at a children's hospital's emergency room versus an adult emergency department:

> I think on the children's side, we're much more cautious… Things are slower. Their volume is not as high. They have way more providers, way more nurses. Like, things work better in children's ERs... If you're a clinician in a children's ER and the child comes in, the nurses know what they're doing. If I am really concerned [about a patient], I'll move the patient in to a room that has a door and try to talk to them. And I'll just bring them back if I am not concerned anymore.

As a social worker in an emergency department, Jay was extremely aware of every policy pertaining to a victim of violence since she would be asked, as a part of the team approach, to be involved in every case. She explained:

> If someone is coming in, we have policies and procedures in place, and if someone is… has been harmed physically and appears that a crime is in place, I consult with [the necessary members of law enforcement]. We have policies in place in terms of when to call the police. And of course, we have policies related to elder and child abuse. And there are social work policies relating to the types of assessments that we do with domestic partner abuse, neglect, things like that.

Topic 9: Constraints Caused by the Work Environment

On the opposite end of the spectrum from helpful facilitators, participants highlighted problems in their work and external environment that could constrain their abilities to identify and report potential victims of sex trafficking. Seven themes emerged (Table 4.4).

A lack of or problems with screening at the organization. Many providers explained that in their work place, they either lack screening entirely or current screening practices had problems. In his private practice, Arthur explained, "We don't have any specific screening parameters. We have no definitive questions or screenings on entry that pertains right to [sex trafficking]." Scott said that even if he wanted to do some additional screenings at his urgent care center, he does not have that ability, citing, "We have limited testing. We don't have any rape kits or anything like that." Even if the screening is available, in situations like Gina's, other

problems may be encountered while trying to do additional screening. She said, “It [is] difficult to screen the patient for sexual activity, especially in private.”

Providers received no training or necessary education. Among the problems listed among providers, many said that they attribute a lack of identification of victims to an absence of training and education they received as a part of their job. Scott described the issue in the most detail, saying, “There hasn’t been really any strong teaching or resources on what to look for or what to do. I know trafficking is very real, and we really don’t have any education on it.”

No policy or protocol is in place at the organization. Most providers did not work in an organization that had a policy or protocol for working with sex trafficking patients. Jay explained, “To my knowledge, we don’t have a policy specific to sex trafficking.” Bob said about his ER, “I am not sure if we have anything specifically related to [sex trafficking] in the policies.” Scott mentioned, “I would say that the policies and procedures that are in place are pretty much minimal.” Aubrey, who wrote the policies regarding sex trafficking victims for her organization, said the following about those policies: “I don’t remember what [the policies] said. It’s very formal, ‘cause you know, policies and procedures are very formally written out… From a practical approach, I honestly just don’t remember what they say.”

No one is talking about the topic in the profession. Many providers said that an issue in their work environment regarding the topic of sex trafficking is that no one is talking about it. Sarah explained, “There is really no attention brought to it. There is really no discussion of it… You know, it’s never spoken of really.” Ryan highlighted that because of the silence healthcare providers lack awareness: “We are just not familiar enough with it. It’s not a topic that even comes up generally speaking. So I guess one of the problems would be that nobody has any familiarity with it.”

No social workers or necessary personnel are present in the work place. While the providers who did have access to social workers or caseworkers thought that was an asset in their work environment, the providers who lacked the necessary multidisciplinary staff as a part of their team believed that this was an external barrier to appropriately assisting victims of sex trafficking. Alice mentioned, "A lot of people who are working in private practice… they don't necessarily have a social worker… They don't have things in place to help them identify, to help them deal with it quickly, to help them do that extra leg work." Tucker echoed those sentiments, saying, "In a private practice, it would be more difficult because there isn't immediate access to a social worker." Scott explained that having an additional staff member would be helpful, describing, "The one thing we do lack is a case manager who knows the ins and out of this." As an emergency room social worker, Jay explained that having any point in a shift where there is no social worker or only having one on-call is just as bad as not employing one at all:

> We don't have 24/7 coverage of social work in my emergency department. And on weekends, there are people who are on call. So their expertise and understanding of resources is perhaps a little more limited than mine, and mine is limited.

Providers lack time. One of the most common issues in the providers' external environments is a lack of time during their workday. Gina said, "The amount of time we have to see patients… We are trying to do a lot in a limited amount of time." Scott highlighted, "Just the volume of patients we see. Sometime working short staffed. You know, you might not spend as much time with the client as we would like to." Alice described time-related problems and how that can overpower physician suspicions:

> A lot of people who are working in private practice, you know, they have time constraints. They may think to themselves that something seems strange, but they don't have time to go into it. [They've] got 10 other patients here, and then keep going.

Tucker explained, “Time-related problems. In the setting where you have limited time with each patient… The pressure of keeping to a schedule to see the patients that you’re seeing and then accommodate a problem like this would be difficult.” Additionally, given the time constraints, June mentioned how it is easy to miss something saying, “Something gets missed because of time constraints…Because my patient load is 4 patients. You know, with 4 patients you’re doing everything… Things get missed.”

The most descriptive and complex complaints about time constraints as a significant problem in the work environment came from the emergency room physicians who expressed multiple problems with how emergency room schedules are structured. John explained how the lack of time he can spend with patients hinders his ability to recognize small details:

> Being in the emergency department, [residents are] forced to see 7 patients every shift. You don’t always have the time to sit down and talk with someone. They’re there for a sprained ankle, and maybe if you had a half hour to sit down and talk with them, you could identify some warning signs, but with the pace that we’re forced to go at, that does hinder us from recognizing signs of that.

As an emergency room attendant, Natalia is given more responsibility under the same types of time constraints affecting all emergency room staff. She explained how the pressure surrounding time constraints comes from the hospital leadership and the overall healthcare system itself:

> I mean, number one, it’s just the volume and flow in the ER. It’s just very difficult to really take time and do a full… Like the way everything is moving in healthcare, we’re getting more and more… It’s way worse than it has ever been in the ER. Every minute, every second, we’re with a patient. [And] there’s 50 people in the waiting room… It’s so stressful. I get emails from my bosses every day, ‘you need to see this many patients an hour, we need to move the flow.’ And everybody is getting them. And it’s hard because [the hospital executives] don’t want anybody in the waiting room. Their priority is how many patients are in the waiting room, because that’s what the ER is graded on… We’re rewarded for speed.

She then had more to say about time constraints in the emergency room and how that is hurting all providers' abilities to help vulnerable patients coming through the department:

> You know, if you spend 15 or 20 minutes [with a single patient], you're screwed for the rest of your shift. You ask any provider. When they see an alleged sexual assault, an ASA exam, on the board, it's like the most painful thing because it takes you out! Like, that patient is going to be there forever! Two-hours just for the exam and it hurts us. And I hate that because it's not like we don't care about the patient, we do! We absolutely care about her or him. But it's hard because you want the patients who are going to be able to see a physician quickly, whether they're sick or not.

Relying on someone else for identification or referral is problematic. In addition to time, a large number of providers explained that due to the structure of their office, hospital, or organization, they have to rely on someone else in their work place to identify someone as a potential sex trafficking victim in order for them to look in to it. For Jay to see any patient in her emergency room, a physician or nurse has to identify a problem that requires social services, and then request her assistance:

> I can't see every person coming through the emergency room setting. So I am relying on other clinicians to help me to identify people who are at risk. So depending on the clinicians who are on, some folks might be more attuned to those kinds of issues and more comfortable asking questions that, you know, would lead to identification. So you know, I am not pointing fingers. I am just saying that we're all in this together.

Natalia had the same opinion about the nurses in her emergency room, explaining that she has to rely on their ability to identify underlying issues in patients:

> If [nurses and staff] don't see parents and kids a lot, they don't know the questions to ask. They are our eyes and ears. The nurses are the ones who get the initial triage information that'll tunnel us for better or for worse… If the triage nurse doesn't do [necessary questioning and examination], or misses [the issues], then [physicians] often assume that whatever [the nurse] wrote down is [the patient's] chief complaint. And we will totally miss [any other issue].

Similar to the issues some providers experience in the emergency rooms, caseworkers and other CPS staff also have to rely on the expertise, identification, and referral practices of

other people to step in and work with a potential sex trafficking victim. Jamie explained that this process of relying on referrals makes it so CPS never sees a large number of children in need:

> We have to receive a referral. We can't go out and act on instinct. We almost have to see enough ourselves to be able to turn in a referral or receive a referral. Because of how CPS is designed, we go out based on the referrals we receive. So that's where the process starts. If we don't receive some sort of referral, and from what I have seen and heard about human trafficking, that stuff is kept so undercover—on the down low—that neighbors don't even know that it's going on. So the likelihood that something is going to be reported to us is going to be very low. So that's kind of sad because a lot of it is going on we're not even aware of.

Additional Comments. Several providers stated unique problems not mentioned by other participants, but were definitely important to highlight as issues that exist in the medical work environment. While these comments may not be themes for this research study, they highlight the difficulty that healthcare providers face when trying to work with potential sex trafficking victims. As an urgent care provider, Scott highlighted an important challenge urgent care and emergency room providers may experience, saying, "We're in the odd position where we don't know [the people coming in to the center]. We are seeing them for the first time." When looking at the work environment, Aubrey also described a problem that could affect every work place:

> I think every work environment has its own culture. And I think there are certain cultures that encourage innovation and some that don't. And when a culture doesn't encourage innovation and thinking outside of the box, it doesn't help getting to the root cause of issues.

Jamie had a lot of positive things to say about the resources that CPS could offer a potential victim, but had concerns about how they would house a child who is a potential victim of sex trafficking:

> I wonder if there are limitations, because with our foster homes that we have licensed, I wonder which homes would be willing to take a child who has been a victim and what kind of problems would that open up. Would our foster homes be willing to [take in a sex

> trafficking victim]? What kinds of questions would we [as CPS] have to answer? And things like that. So that could be tricky.

Natalia explained that, among other issues in her emergency department, the goal of making emergency medicine a business is hurting patients, particularly those like sex trafficking victims:

> The money that's put in to [the department] and the effort that's put in to teaching is only put in to things that profit the hospital. And hospital systems don't profit off of spending time interviewing patients and figuring out if they're being abused, of if they're depressed, or if they're having some underlying issues going on. They make money off of diagnosing strokes and not missing things like heart attacks. Getting people invested in [cases that don't make the hospital money] is very difficult.

Topic 10: Problems with Patients

As a part of problems in their work and external environments, several participants highlighted specific problems regarding working with a possible victim of sex trafficking and the difficulties the actual patient may bring to the medical encounter. Three themes emerged (Table 4.4).

The patient is lying or withholding information. Some providers stated that even in a perfect work environment, if the patient is lying or withholding information, there is not much the provider can do. June said, "We screen for it, but whenever you screen for things with patients, they don't always tell the truth." Edward mentioned, "I don't really think somebody in my practice would talk to me openly about sexual or physical abuse." When the patient is asked questions regarding abuse, Natalia explained that it is challenging to really get an accurate and honest story from any patient trying to hide something:

> I think the hardest part would really be to get them to tell me what's going on… The problem is that we can't force those patients to do anything. And so, they have to want to get out of that circle. I think with patients involved in sex trafficking, I think it's hard because they… They're not seeking help. They're crying out, but not seeking it, if that makes sense. Like, they're giving you all of the signs that subconsciously they really

> want someone to help them, but they're scared to do it and embarrassed, and they won't often answer your questions.

John described that patients will either withhold information or be dishonest about their situations:

> There [are] questions, like 'do you feel safe at home?' 'Is there anyone you're afraid to go home to?' Things like that. 'Do you have a good living situation?' If that's all answered no, you're kind of in a tough spot because you don't really have anything concrete to go on.

With a child, all a provider has to do is call CPS, regardless of proof and honest answers from the patient. However, if the patient is dishonest with the provider, there is a possibility that he or she will be dishonest with the CPS caseworker. Liza explained, "Well, the child themselves. If they're not going to disclose anything, [that] would be a barrier." Jamie agreed with that statement, saying, "As far as younger children, I would think that the perpetrator would have such a hold on that situation that I think it would be really hard for the exposure [of victimization] to come out."

The presence of addiction. The two anti-trafficking social workers explained that the hardest part about working with a victim of trafficking is the added difficulty of substance abuse and addiction. Jackie discussed that the presence of addiction in a sex trafficking victim is almost guaranteed and makes it significantly more challenging to get them the services they need:

> I guess probably just substance use and addiction [are they biggest problems]. Because, we could provide whatever service they could possibly need and get them connected to any service they would need. But if they're using, they just might fall off the face of the earth and we don't hear from them again.

Amy agreed that addiction is one of the most difficult elements of working with a sex trafficking victim:

> Because addiction is a huge part of trafficking, and when somebody isn't ready, or they're scared, that is a huge barrier because they're not ready to face the unknown. Because their trauma and their trafficking and their addiction are what they've known…

> And so that's their negative coping skill, but that's their only coping skill that they feel. And so that's a huge barrier when they're not ready. And I can't help them if they're not ready to help themselves.

Aggression, refusal of help, and being a *Deserving Survivor* playing a role in identification. A few providers described how the difficult behavior of sex trafficking victims makes it challenging to help them and to want to help them. Amy said that DMST victims are possibly the most challenging type of sex trafficking victims to work with, saying, "My domestic minors are a little more unwilling to receive services, so they're a little bit harder to get them talking." Aubrey discussed how the behavior of the person and preconceived notions of how people in need of help should be inadvertently affects the help that they may be given:

> Social workers have this idea of what a *deserving survivor* looks like. And by that, I mean somebody who is really a victim or is really worthy of help. And by that, they're easy to work with, they're forthcoming with information, they're going to appreciate the help they get… These subconscious ideas of what a deserving person is… [It] absolutely gets in the way of providing services because if someone is difficult, someone doesn't show up, someone is telling you to f**k off, someone is doing G*d knows what… Human nature is to say, 'Fine! If they don't appreciate me, then I am not going to help them!'

It is not just social workers who operate on preconceived notions about people. Natalia explained that due to the time constraints and environment in the ER, providers rely on preconceived notions to get through their patient load:

> In the ER, we are kind of taught to stereotype. Not in a bad way, but we're taught to make assumptions about patients. Because often, they come in and they're altered and they can't give us a history. So you just look at them and are essentially judging them. It's just constantly triaging in your head what's important, what's necessary, what's not, who is in danger, and who's not.

Topic 11: The Importance of Healthcare Providers in Working with Victims of Sex Trafficking

When asked about the importance of healthcare providers, every participant expressed that healthcare providers were important in the identification and reporting of sex trafficking victims. Three themes emerged (Table 4.5).

Table 4.5: Topics and Themes about the Healthcare Profession

Topic	Themes
The importance of healthcare providers in working with victims	• Providers receive extensive training beyond the general population • The relationships with patients increase chances for identification • Provider visits may be the only opportunity to get help
Necessary changes in the healthcare system that would improve care	• Education and training for healthcare providers is needed • New protocol and policies are needed in healthcare settings • Increasing and improving resources for healthcare providers is needed • Establishing community and referral relationships should be a priority • There is a need for a screening tool

Providers receive extensive training beyond the general population. Some providers said that their role in assisting victims of sex trafficking was important because they have had more training than the general population, and may be able to identify subtler signs of victimization than most people. Scott explained, "I think that the signs can be subtle sometimes and maybe the average person may not be able to pick up on it. But we're supposed to be trained to pick up on subtleties and the inconsistencies of stories." Jackie said something similar, mentioning the need to be able to identify subtle indicators, saying, "Regardless of the location or type of medical center, I think, it's all about being able to identify and see the red flag so that you can address it with the victim."

Some providers believed that medical training also increases the opportunity to actually address the needs of a sex trafficking victim. Ryan indicated that the needs of sex trafficking victims would fall into many different areas specific to medical care:

> [Sex trafficking] crosses a number of different areas. Specialists and general medicine- we're familiar with psychiatric and psychological effects from physical issues. So you're dealing with your current traumatic stress disorder, as well as post-traumatic stress

> disorder. You know, one or both. As well as physical complaints... If there is any physical abuse… So we are familiar with dealing with the physical *and* the psychological pieces of things.

The relationships with patients increase chances for identification. Many of the participants stated that the healthcare provider's role in this situation is important because of the types of relationships providers establish with their patients. As Edward described:

> You establish relationships with people. When they have a problem, they call you. And sometimes, you think, well, this isn't really a medical problem, so what are you calling me for? But they expect you to at least give them some direction… I think it's because doctors are seen in a certain way, as the person patients can go to.

In the emergency room, particularly in major cities, Natalia explained why the relationships between providers and patients are so important:

> The patients who come in [to the emergency room] for small things often are the ones who we have to reach out and be like… This may be the only time that they are going to see a physician in years. This one small interaction could make a huge difference in their life. And, like, we really have to set out and try as hard as we can.

Jay emphasized how it does not matter the location of the provider. As long as a good relationship can be formed with the patient, the opportunity to help them out of a bad situation may be more attainable:

> [The healthcare provider's role is important] because people will bond. Patients will bond with various people… It almost doesn't matter what their clinical role is. It's about the comfort level that they establish with the person. And it can be anyone. It's important for all of us to be attuned to their needs.

Another important aspect to the relationship between the provider and the patient is the physical and emotional state providers are often seeing their patients in. John explained, "We see people when they're kind of at their most vulnerable." Additionally, Bryan said, "[Healthcare providers] should always be an advocate for the patient and do what's best for them and try to protect them from whatever serious situation they're in."

Provider visits may be the only opportunity to get help. The most common theme found in the responses to this topic was the idea that healthcare providers' roles are important in the identification and reporting of sex trafficking victims because they may be the only opportunity for a patient to get help. As Arthur explained, "Because it might be one of the only opportunities for somebody in legitimate society to have contact with [victims]." Alice also thought healthcare providers could be the only opportunity to receive help:

> Every opportunity we do have to identify is important. Depending on the situation, it may not be the case that there is much exposure necessarily to anybody other than [providers] if they are coming in for treatment for healthcare needs, infections, that sort of stuff where they would need to seek treatment. So we may be one of the few people who actually get a chance to have interaction depending on the exact situation.

Jamie expressed the importance of healthcare providers as an important point of contact to begin getting help for an abused child:

> [Healthcare providers] would be a mandated referral source. They would be the front liners really for seeing it and then, if they can identify it... Even when they don't have evidence, they can suspect it and make the referral and that is something that we can go from there.

Not only could emergency rooms be the only opportunity for a patient to get identified as a sex trafficking victim, Natalia thought that ERs could be the only opportunity for this population to ever receive any sort of healthcare:

> Our job in the ER, we're the ones who are often going to be the point of care for all marginalized populations and all people who don't have primary care. They don't have help. They're usually… I would say 75 of my patients everyday are uninsured, they have no primary care, a lot of them are homeless, or they're drug users, or they're alcoholics, or they're abused… We are often the only other people that they will encounter on a deep level and talk to them who aren't involved in what's going on.

Jackie also echoed the importance of the ER as an opportunity to identify victims of sex trafficking, stating that they are often a referral service for the anti-trafficking program:

> The hospital is where a lot of [victims] are going to be identified 'cause they were beaten up by their pimp, or they overdosed, or they were raped by a john. So there are a lot of

> reasons they would be at a hospital, and if they can get identified and connected to services, then they can get out of the situation, or at least know there are options when they decide to get out of the situation.

Topic 12: Necessary Changes in the Healthcare System that Would Improve Care

As the last stage of the interview, participants were asked what they think should be changed in the current healthcare system that would improve identification and reporting of sex trafficking victims. Five themes materialized from this topic (Table 4.5).

Education and training for healthcare providers is needed. The most common response among the participants was the need for more education and training on the topic of sex trafficking for healthcare providers. Sarah explained, "I do think trainings are important. I think that it is important to educate people. I think that it is important to make social workers and healthcare professionals aware of the fact that it is a growing problem." Shawna described that more education and trainings are important because as the problem grows, people need to be made more aware of what is happening and how they can help victims:

> I just think that if people were made more aware! Again, I think there has to be more education on the incidence and prevalence of the problem… It has a lot to do with not knowing that the problem is existing, not knowing how to screen for it and look for it, and then once you find it, not know what to do with it.

Amy felt strongly about the need for education among healthcare providers:

> I think, first of all, education about human trafficking should be in place. The first step is to educate people about what human trafficking is. I think that education about human trafficking should be definitely improved and more of a requirement. I think human trafficking education is definitely something that is needed and should be mandated.

Along with healthcare providers, members of CPS also indicated that training should be mandated for all caseworkers. Lissette explained, "Some trainings are mandated [for CPS workers], like domestic violence. So sex trafficking training, I think should be mandated." Jamie

also believed that sex trafficking training should be required for all caseworkers at CPS, and also explained what healthcare providers need to receive more training on:

> I definitely think it should be something mandated. Like the domestic violence training we have to do every 2 years. So I think it would be a good idea just so we can stay informed of the current situation. I think some types of training for the healthcare system that [providers] would know the signs and symptoms, things to look for in possible victims.

Ryan agreed that more education and trainings be made available to healthcare providers, but he believed that these trainings needed to come from a national organization:

> The American Osteopathic Association and the American Medical Association, and things like that. [They] probably need to spearhead a national educational program and put a big effort into providing speakers who are properly trained, so everybody across the U.S., all of the doctors and healthcare workers are getting the same information regarding things to look for and how to report things.

Edward indicated that education should be increased on the topic in medical schools in order to keep up with new findings about the American healthcare system:

> We are spending all of this money on trying to make people healthier, and we really only have a 10-15% of an effect on them. I don't know how current training is, but I know when I went through school, it was all about the medicine and not about changing behavior or any behavioral issues. So I think it should be taught in medical schools.

New protocol and policies are needed in healthcare settings. Many of the participants stated that various protocols, policies, and programs needed to be established or improved to improve the healthcare that victims of sex trafficking receive. Arthur said, "Having protocol at [sites of medical contact] when people are getting screened as new patients." At CPS, Jamie thought that updating their policies and protocol, and being more prepared to use them, would increase the effectiveness of CPS in these situations:

> Maybe on our front, it would probably be more beneficial to be more proactive and knowing what services would we set up for a victim, to have protocol for that, because I am not sure if we [as CPS] have really though that through.

Several participants suggested specific policies or protocols that they thought should be in place. For instance, John stated that his hospital should change its policy on asking people to leave the exam room so that providers can be alone with the patients:

> If you really suspect something like [sex trafficking], and you wanted to confront the patient about sex trafficking, [we need] a way to force the people that [the patient] is with to leave the room. At this point, we have to request that, if they're there with a guy or another girl, we can ask them if they mind if we talk to the patient alone for a few minutes, and the patient and their friend, they can say no. And they will stay in the room. I think it would be a lot easier to talk to people about things if we were alone with them.

Amy thought there should be a policy in place at healthcare facilities mandating them to give out resources to potential victims of sex trafficking:

> I think another policy would be to start passing out cards for the human trafficking hotline because once you realize what trafficking is, the next step would be to know what to do when you suspect trafficking. So to give information about services that provide trafficking-specific services.

Tucker explained that it might be helpful if national medical protocol was changed, specifically medical billing codes:

> If a physician incorporated [a trafficking screening] into the [patient's] visit at the right time and for the right reason, there is a CPT, current procedural terminology, code for a health risk assessment… Then that would be linked to some payment for them administering the tool. And that helps overcoming a barrier of the physician's time and energy and work that is done in doing this. They're getting paid for it.

Increasing and improving resources for healthcare providers is needed. Some providers agreed that more resources are needed; however, there was no clear consensus on what that resource needed to be. Alice indicated that more human resources are needed, saying, "Finding a way to provide more access to a social worker, counseling—across medicine—the more helpful it would be." Scott also expressed the need for additional human resources at all urgent care facilities, recounting, "As far as having a case manager, it would be nice just being in contact with a case manager or have one that could float to the [urgent cares] if we needed their

services so we wouldn't always have to send [patients] to the emergency room." Lissette similarly recognized the need for trained resources in healthcare settings, describing, "I know the hospitals have social workers, and I am not sure of the health department, but I think that they need a victims' advocate for children in some of the places."

When considering other types of resources healthcare providers need, Bella explained that there was a need for, "grant funding for training." Tucker mentioned the need for an easier way to access resources, explaining, "I would think a user-friendly way for the practitioner who could be the access point for help to access the help and resources available."

Establishing community and referral relationships should be a priority. Another common sentiment among providers is the need to improve relationships and communication between various healthcare providers and between healthcare professionals and the community in which they work. Gina was emphatic about improving the relationship between the community and her community health center, hoping that an improved relationship would help bring juvenile patients in to see her when they are in need:

> Any kind of outreach that can be done. Education to our young, adolescent population, whether in school or through community resources, just to make them aware. And then letting them know that the healthcare providers are here and they can come to our clinic. And potentially providing some resources for them to come into our clinic, because a lot of times, money can be a factor… A lot of it is just educating that population.

Also mentioned was the need to improve relationships between providers. Alice highlighted, "Facilitating good communication between doctors, CPS, and agencies to help that sort of stuff." Bella explained the need for both better communication between providers and better communication among community members and organizations, saying, "There needs to be a cross-discipline sharing of grassroots efforts in various sites that have worked."

There is a need for a screening tool. It was important for many providers that some type of screening tool be established that could assist in their effort to identify sex trafficking victims. Tucker said that a screening tool is important, especially if a provider wants to bill for the appointment, explaining, "So if you were to develop a standardized, scorable tool that helps practitioners identify possible trafficking… When I say a tool that would be useful, it couldn't have too many questions. It could be 2-3, maximum 5 questions." Scott agreed, saying, "I think the most obvious is you need some type of screening tool. It would be nice to have something that is pretty standardized across the board. You have some standardized kind of questionnaire."

June also thought that a screening tool would be extremely helpful, describing, "Maybe additional screening tools, we ask every patient if they have been abused in the last year. You know, suicidal ideation. Possibly ask them question on trafficking and always have an opportunity when they first get there." As bothersome as some are, Natalia thought that a screening tool could help find the cases that would normally fall through the cracks at the emergency room:

> There is like a million little questionnaires that people have to ask [a patient]. And it's like, do we need to really dig into every patient and ask them that, or just the patients that we think may have suicidal ideation? But that's how we catch people. That's how we save people. If there was some question or some way to the triage nurse… Whoever is doing the triage… Maybe a little reminder, a little flag can pop up in the EMR just to remind you to look for signs of this.

Alice also indicated that adding questions about sex trafficking to routine screening could help identify those patients who are normally challenging to identify:

> It may be useful to add into our screening questions a specific question or some specific questions that are geared not just feeling safe in the home, abuse, that sort of stuff, but, you know questions that would be geared specifically toward identifying sex trafficking.

Topic 13: Advice to Healthcare Providers

The three experts in human trafficking and female victimization had pieces of advice that they believed was important for providers to know when potentially working with this population.

Aubrey's advice was to look at everything and not just accept things based on how they are initially presented:

> I think the major thing is to really to look… Context. Always looking for the bigger picture of what's really going on, rather than what the referring incident is or the stated incident is. I mean, 9.5 times out of 10, it is something much bigger and much more complex than we can ever really imagine.

Jackie explained that it is important to understand the complicated relationship between the victim and perpetrator, and how that affects the victim's mindset and perceived ability to leave:

> I guess I wish that people were aware of the dynamics in a relationship between a trafficker and a victim, and the dynamic that drugs play in that. And knowing that it's not necessarily a choice for most people. I think that would change the way they react and respond to the situation. Because if the trafficker is there, they're not going to be open. And even if the trafficker's not there, it's an abusive relationship, so they're very likely to still go back to the trafficker because they believe that they're in a relationship with them or they have feelings for them. Or, it's like Stockholm Syndrome. They have these trauma bonds with this person who has done horrible things to them, so they end up going back. So if they can… If people can be aware of that and approach victims differently based on that, I think that would be really effective.

Amy described the need for healthcare providers and members of the general population to develop a comprehensive understanding of human trafficking:

> I think that a lot of people have false pretenses about what human trafficking is. I think that when ladies come in that appear to be in prostitution, I think that people don't understand that it could be trafficking. So a better understanding of what it looks would be would be really, really helpful.

In summary, a variety of opinions exist among healthcare providers regarding sex trafficking, their role in identification and reporting, the facilitators and constraints that exist in their work environment, and what needs to be changed in the healthcare system in order to

improve identification and reporting practices. Most participants reported a good level of awareness on the topic and understanding of clinical indicators of a possible sex trafficking victim. Participants reported a wide range of personal perceived barriers that could negatively impact their own ability to identify a victim, while most interviewed did not foresee anything that would stop them from reporting. As far as work and external facilitators and constraints, participant responses varied, but most indicated that the problems they identified were out of their control, primarily existing at the organizational level. All of the providers explained that their role in the identification and reporting of sex trafficking victims was extremely important.

4.2 Phase 2: Results from Healthcare Provider Survey

Sample

Sixty-four persons opened the survey, and 59 started the survey. Of these 59, one person completed only one scale; most participants completed the whole survey. As shown on Table 4.6, the majority of respondents were women (5 participants did not indicate their gender). Among occupations represented in the sample, the majority were physicians (33%), followed by nurses (20%). The providers' specialties varied, with the largest portion of the sample specializing in family practice (25%), followed by emergency/trauma (17%). Most providers worked in a private practice setting (27%), followed by community health centers (20%) and emergency departments (13%). The geographic location also varied, with the majority working in large cities (36%), and the fewest participants working in a suburb of a large town. The average number of years in practice was 13.8 years. The average age of participants was 41.7 years of age.

Table 4.6: Healthcare Provider Demographic Information (n=59)

	N	%
Gender		
Female	39	60.9
Male	15	23.4
Occupation		
Physician	21	32.8
Nurse	16	25.0
Midlevel provider	11	20.4
Social worker	6	9.4
Specialty		
Family practice	16	25.0
Emergency/Trauma	11	17.2
Other	7	10.9
Pediatrics	6	9.4
Internal	5	7.8
Generalized	5	7.8
OB/GYN	3	4.7
Practice Setting		
Private practice	17	26.6
FQHC	13	20.3
Other	9	14.1
Emergency department	8	12.5
Hospital inpatient	6	9.4
Urgent care	1	1.6
Type of Location		
Large city	23	35.9
Town	17	26.6
Rural area	8	12.5
Mid-size city	3	4.7
Suburb of a large city	2	3.1
Mean Years in Practice	13.8 years	SD =12.92
Mean Age	41.7 years	SD =11.39

Analyses of Items and Scales

This section describes the frequencies and means by items and scales for general DMST knowledge, knowledge of clinical indicators, perceived barriers, self-efficacy, healthcare environment, and intention.

General DMST Knowledge. The number of correct responses ranged between 3 and 10, with a mean of 7.10 (SD = 1.85). Figure 4.1 shows the responses by item and percentage of each response to each item. Note that *true* was the correct response for all statements. The majority of participants correctly recognized that victims could come from small towns. However, less than half knew that trafficking could exist without any force and that homicide is the primary cause of death for trafficked minors. Figure 4.1 details responses to each item.

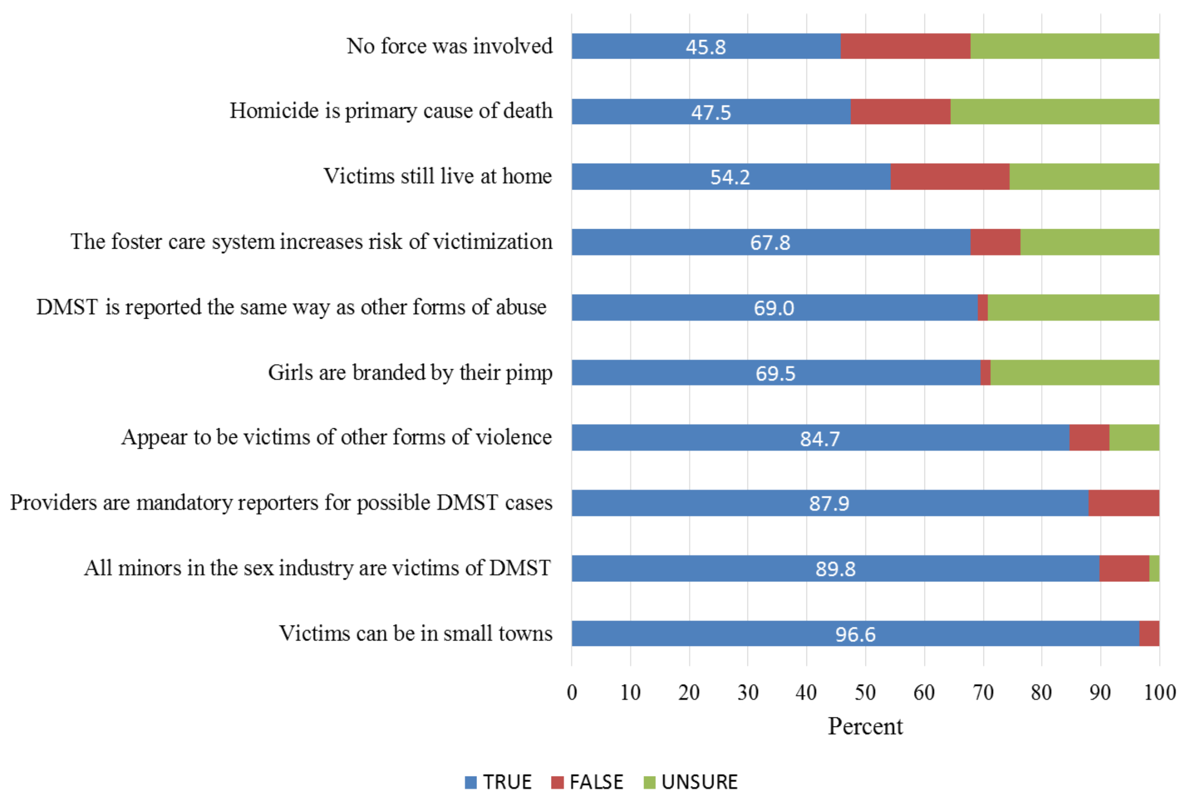

Figure 4.1: General DMST Knowledge by Item and Response Category

Knowledge of Clinical Indicators. The number of correct responses ranged between 4 and 12, with a mean of 9.97 (SD=2.27). Note that *yes* was the correct response for all statements. Almost all of the participants knew that a lack of eye contact and signs of physical abuse were clinical indicators of DMST. However, only slightly more than 60% knew that rude or aggressive behavior and signs of branding (unique tattoo or jewelry item) were clinical indicators of DMST. Figure 4.2 details responses to each item.

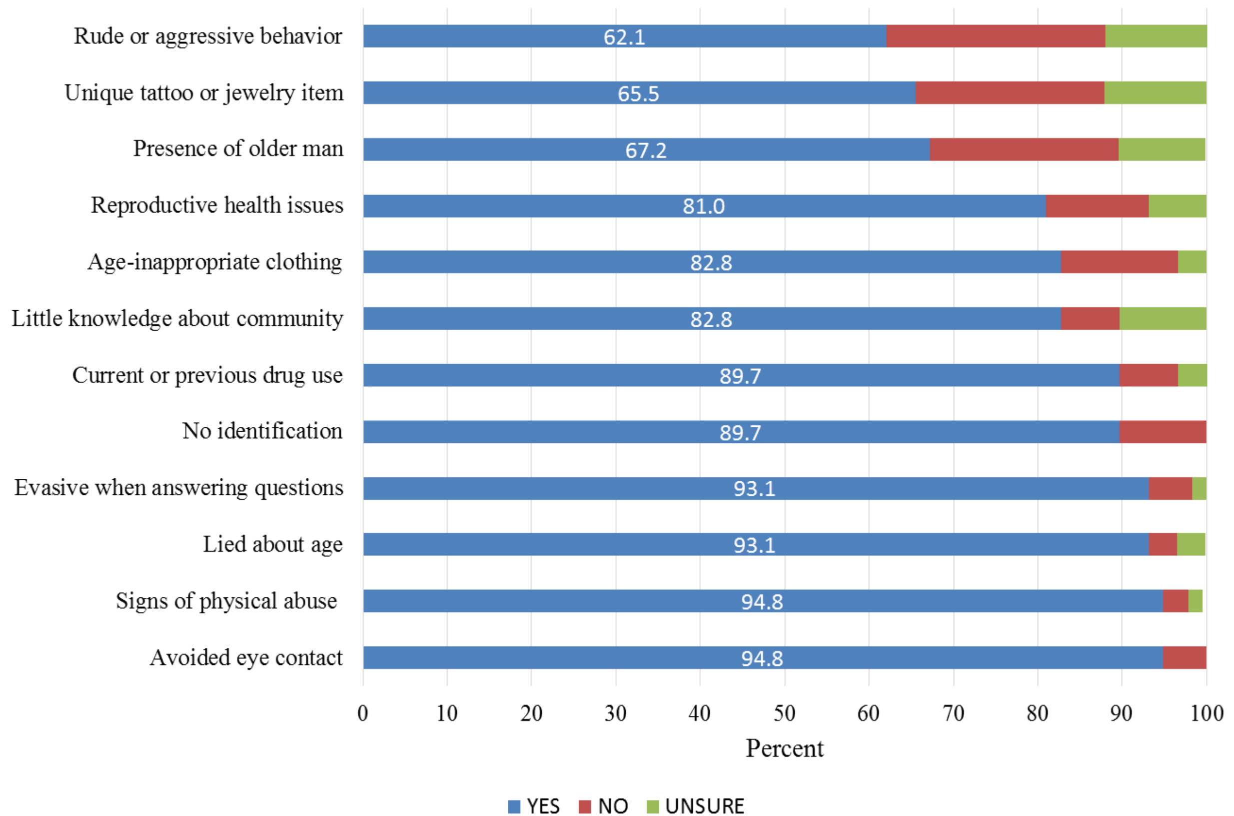

Figure 4.2: Knowledge of Clinical Indicators by Item and Response Category

Perceived Barriers. Table 4.7 displays the mean and standard deviation for each item for perceived barriers. Higher scores indicated that the statement was a perceived barrier. The greatest perceived barrier was the challenge of determining the situation for a patient when that patient is difficult to work with. Another perceived barrier was not having enough time with each

patient. The responsibility to identify victims and importance of DMST as a clinical topic were low perceived barriers.

Table 4.7: Perceived Barriers Scale Means and Standard Deviations

Perceived Barrier	Mean	SD
Not a responsibility to identify victims	1.67	.83
DMST is a minor issue	1.79	.99
Not wanting to help a rude patient	2.09	.88
Identifying DMST is not a priority for me	2.43	.88
Lack of knowledge on how to report DMST	2.71	.90
Not having enough time	2.91	.73
The challenge of a difficult patient	3.05	.80

Note: Scores range from 1 (*Not at all True*) to 4 (*Very Much True*)

When analyzing the reliability of the perceived barriers scale, the internal consistency was found to be unacceptable, with α=.38. An exploratory factor analysis showed two factors, but Cronbach's alpha was still low (<.50) for each subset of items. Due to this poor reliability score, it was determined that individual items did not measure a single construct. Thus, perceived barriers was removed from the remaining analyses.

Self-Efficacy. The overall mean was 2.05 (SD=.62). Table 4.8 displays the mean and standard deviation for each individual item in the scale. Self-efficacy scores to every item in the scale were relatively low, with no item having an average score above 2.4. The highest self-efficacy score was for determining if a child is being abused. The lowest self-efficacy scores were reported for the items referring to sex trafficking. The lowest self-efficacy scores were for differentiating between other forms of abuse and DMST, and accurately identifying DMST victims.

Table 4.8: Self-Efficacy Scale Means and Standard Deviations

Self-Efficacy	Mean	SD
Confident in ability to differentiate abuse and DMST	1.70	.76
Confident in ability to accurately identify DMST victims	1.75	.64
Confident in ability to appropriately treat DMST victims	1.86	.76
Confident in ability to identify victims of violence	2.25	.79
Confident in ability to appropriately report suspected DMST victims	2.36	.98
Confident in ability to determine if child is being abuse	2.39	.78

Note: Note: Scores range from 1 (*Not at all True*) to 4 (*Very Much True*)

Healthcare Environment (Facilitators and Constraints). The overall mean was 1.71 (SD=.64). Because this scale was measuring whether the item in the scale was seen as a facilitator or constraint in the external environment, participants with higher scores (*pretty much true; very much true*) saw the item as a facilitator; participants with lower scores (*not true at all; a little true*) disagreed with the statement and saw the item as a constraint. Table 4.9 displays the mean and standard deviation for each item. Overall, scores were relatively low, with no item having an average score above 2.4. The greatest facilitator was having a suitable work environment for working with DMST victims. Workplace provision of education on working with DMST patients and workplace protocols and policies for working with DMST patients had the lowest scores, indicating that these were seen as the largest constraints.

Table 4.9: Environment Scale Means and Standard Deviations

Environment	Mean	SD
Work place has provided education on working with DMST patients	1.31	.70
Work place has protocol/policy for working with DMST victims	1.45	.79
DMST identification is a priority at work place	1.56	.74
Work schedule provides necessary time with patients	1.73	.87
There are multidisciplinary teams at the work place to help with victims	1.84	1.05
Work environment is suitable for working with DMST victims	2.36	.95

Note: Scores range from 1 *(Not at all True*) to 4 (*Very Much True*)

Intention. *Intention if Certain* measured intention to report if the provider was absolutely certain that a patient was a victim of DMST. *Intention if 50/50 Chance* measured intention to report if the provider thought there was a 50/50 chance that a patient was a victim of DMST. *Intention if Unsure* measured intention to report of the provider was unsure if a patient was a victim of DMST. Table 4.10 displays the mean and standard deviation for each intention item. Also displayed is the percentage of the sample that selected *pretty much true* or *very much true* as their response. The strongest intention to report was when the providers were certain that a patient was a victim of DMST (*Intention if Certain*). The lowest intention to report was when the providers were unsure whether the patient was a victim of DMST (*Intention if Unsure*).

Table 4.10: Intention Means and Standard Deviations

Intention to Report Based on Level of Certainty	Mean	SD	Percent Reporting '*pretty much true'* and '*very much true'*
Intention if certain	3.91	.29	100%
Intention if 50/50 chance	3.09	.82	75%
Intention if unsure	2.00	.98	33%

Note: Scores range from 1 (*Not at all True*) to 4 (*Very Much True*)

Objective 1: Self-Efficacy

The first objective of this study was to identify the personal and environmental factors—general DMST knowledge, knowledge of clinical indicators, and healthcare environment—that increase or decrease a provider's self-efficacy to identify and appropriately assist victims of sex trafficking. First, I examined the correlation among general DMST knowledge, knowledge of clinical indicators, and healthcare environment—the three predictor variables—and self-efficacy (Table 4.11). General DMST knowledge and knowledge of clinical indicators were not

significantly correlated with self-efficacy. More positive views of the healthcare environment were positively correlated with higher levels of self-efficacy, $r(57)=.45$, $p<.01$.

Table 4.11: Correlation Matrix

Variable	M	SD	1	2	3
1. Knowledge	7.10	1.85			
2. Clinical Indicators	9.97	2.27	.19		
3. Healthcare Environment	1.71	0.64	.28*	.04	
4. Self-Efficacy	2.05	0.62	.05	.02	.45*

*Correlation significant at the .05 level

Second, a regression analysis was performed to examine the association between the clinician characteristic predictor variables and self-efficacy (Table 4.12). General DMST knowledge did not significantly predict self-efficacy scores, $b=-.07$, $t(50)=-.54$, $p=.59$. Additionally, knowledge of clinical indicators did not significantly predict self-efficacy scores, $b=.03$, $t(50)=.21$, $p=.83$.

Views of the healthcare environment significantly predicted self-efficacy scores, $b=.46$, $t(50)=3.55$, $p<.01$. The predictor variables explained a significant proportion of variance in self-efficacy scores, $R^2=.20$, $F(3,50)=4.26$, $p<.01$. Both analyses showed that participants who reported more positive views of their work environment (more healthcare facilitators) also reported higher levels of self-efficacy.

Table 4.12: Regression Analysis Summary for Characteristics Predicting Self-Efficacy

Variable	B	SE B	β	t	p	95% CI
Knowledge	-.03	.05	-.07	-.54	.59	[-.18, .07]
Clinical Indicators	.01	.04	.03	.21	.83	[-.07, .08]
Healthcare Environment	.47	.13	.46	3.55	.001	[.20, .74]

Note. $R^2=.203$ (n=54, p=.009)

Objective 2: Intention

The second objective of this study was to identify the factors that increase or decrease a provider's intention to identify and report victims of sex trafficking at varying levels of certainty that a patient is a victim of DMST. In order to achieve this objective, Pearson's correlation and multiple linear regression were calculated.

Table 4.13 shows the Pearson's correlation scores among the four clinician predictor variables (i.e. general DMST knowledge, knowledge of clinical indicators, self-efficacy, and healthcare environment), as well as all three intention variables. For *Intention if Certain*, none of the predictor variables were correlated with the intention. *Intention if 50/50 Chance* was negatively correlated with general DMST knowledge, $r(57)=-.30$, $p<.05$. Lastly, more positive views of the work environment was positively correlated with *Intention if Unsure*, $r(57)=.37$, $p<.01$.

Table 4.13: Correlations for Intention Based on Level of Certainty

Variable	M	SD	1	2	3	4
Intention if certain	3.91	.29	-.22	.01	.11	.17
Intention if 50/50 chance	3.09	.82	-.30*	-.10	.22	.17
Intention if unsure	2.00	.98	-.22	.04	.37**	.23
Predictor Variables						
1. Knowledge	7.10	1.85				
2. Clinical indicators	9.97	2.27	.19			
3. Healthcare environment	1.71	.64	.28*	.04		
4. Self-efficacy	2.05	.62	.05	.02	.45*	

**Correlation significant at the .01 level
*Correlation significant at the .05 level

Multivariate regression analyses were conducted for each of the different intention items. Table 4.14 displays the multiple linear regression summary for *Intention if Certain*. For *Intention*

if Certain, none of the clinician predictor variables significantly predicted level of intention if the provider is certain that a patient is a victim of DMST.

Table 4.14: Regression Analysis Summary for Clinician Characteristics Predicting Intention if Provider is Certain that a Patient is a Victim

Variable	B	SE B	β	t	p	95% CI
Knowledge	-.04	.25	-.27	-1.89	.07	[-.09, .00]
Clinical Indicators	.01	.02	.05	.36	.72	[-.03, .04]
Self-Efficacy	.06	.07	.13	.85	.40	[-.08, .20]
Healthcare Environment	.05	.07	.10	.66	.51	[-.10, .20]

Note. R^2=.094 (n=54, p=.293)

Table 4.15 displays the multiple linear regression summary for *Intention if 50/50 Chance*. General DMST knowledge significantly predicted level of intention scores, *b*=-.34, *t*(49)=-2.50, *p*=.02. Opposite of what was hypothesized, general DMST knowledge negatively predicted intention scores, denoting as general DMST knowledge scores decreased, intention to report increased. None of the other predictor variables significantly predicted level of intention if the provider thinks there is a 50/50 chance that a patient is a victim of DMST. However, the predictor variables explained a significant proportion of variance for *Intention if 50/50 Chance* scores, R^2=.19, $F(4,49)=2.87$, $p<.05$.

Table 4.15: Regression Analysis Summary for Clinician Characteristics Predicting Intention if Provider Thinks There is a 50/50 Chance that a Patient is a Victim

Variable	B	SE B	β	t	p	95% CI
Knowledge	-.15	.06	-.34	-2.50	.02	[-.29, -.04]
Clinical Indicators	-.04	.04	-.10	-.77	.44	[-.11, .08]
Self-Efficacy	.07	.18	.05	.36	.72	[-.31, .46]
Healthcare Environment	.37	.19	.29	1.95	.06	[-.01, .79]

Note. R^2=.187 (n=54, p=.035)

Table 4.16 displays the multiple linear regression summary for *Intention if Unsure*. Two predictor variables significantly predicted *Intention if Unsure*. General DMST knowledge

significantly predicted level of intention scores, *b*=-.31, *t*(49)=-2.35, *p*=.02. As with the previous level of intention, general DMST knowledge negatively predicted intention scores. Opposite of what was hypothesized, as general DMST knowledge scores decreased, intention to report increased.

Healthcare environment also significantly predicted *Intention if Unsure*, *b*=.31, *t*(49)=2.13, *p*=.04. As providers reported more healthcare facilitators in their work environments, their intention to report increased. The other variables did not predict level of intention for *Intention if Unsure*. However, the predictor variables explained a significant proportion of variance scores, R^2=.21, *F*(4,49)=2.02, *p*<.05.

Table 4.16: Regression Analysis Summary for Clinician Characteristics Predicting Intention if Provider is Unsure that a Patient is a Victim

Variable	B	SE B	β	t	p	95% CI
Knowledge	-.15	.06	-.31	-2.35	.02	[-.34, -.06]
Clinical Indicators	.01	.05	.03	.30	.77	[-.07, .15]
Self-Efficacy	.21	.19	.15	1.08	.29	[-.34, .53]
Healthcare Environment	.43	.20	.31	2.13	.04	[.19, 1.10]

Note. R^2=.21 (n=54, p=.02)

Self-efficacy did not predict level of intention in the initial regression analyses. Post-hoc probing of possible interaction was done to examine if there were any moderating variables dictating the relationship between self-efficacy and intention. At a significance level of .05, the only analysis that was significant was testing if general DMST knowledge moderated the relationship between *Intention if Unsure* and self-efficacy (Table 4.17). Following the Aiken and West (1991) procedure for probing the interaction, results indicated there was a significant interaction between self-efficacy and general DMST knowledge in predicting *Intention if Unsure.* The interaction term between general DMST knowledge and self-efficacy was added to

the regression model, accounting for a significant proportion of the variance in *Intention if Unsure*, R^2=.23, $F(3,50)=4.96$, $p<.01$.

Table 4.17: Regression Analysis Summary with Moderator for General DMST Knowledge, Self-Efficacy, Predicting Intention if Provider is Unsure that a Patient is a Victim

Variable	B	SE B	β	t	p	95% CI
Knowledge	-.13	.06	-.28	-2.20	.03	[-.25, -.01]
Self-Efficacy	.40	.17	.29	2.36	.02	[.06, .74]
Interaction Term (Self-Efficacy*Knowledge)	.25	.10	.31	2.47	.02	[.05, .45]

Note. R^2=.23 (n=54, p=.04)

General DMST knowledge moderated the relationship between self-efficacy and *Intention if Unsure*. Examination of the interaction plot (Figure 4.3) showed that higher levels of self-efficacy and higher levels of general DMST knowledge resulted in greater *Intention if Unsure*. For participants with low general DMST knowledge, *Intention if Unsure* was similar for those with low self-efficacy and high self-efficacy scores. However, participants with high general DMST knowledge and greater self-efficacy had the greatest intention to report possible victims.

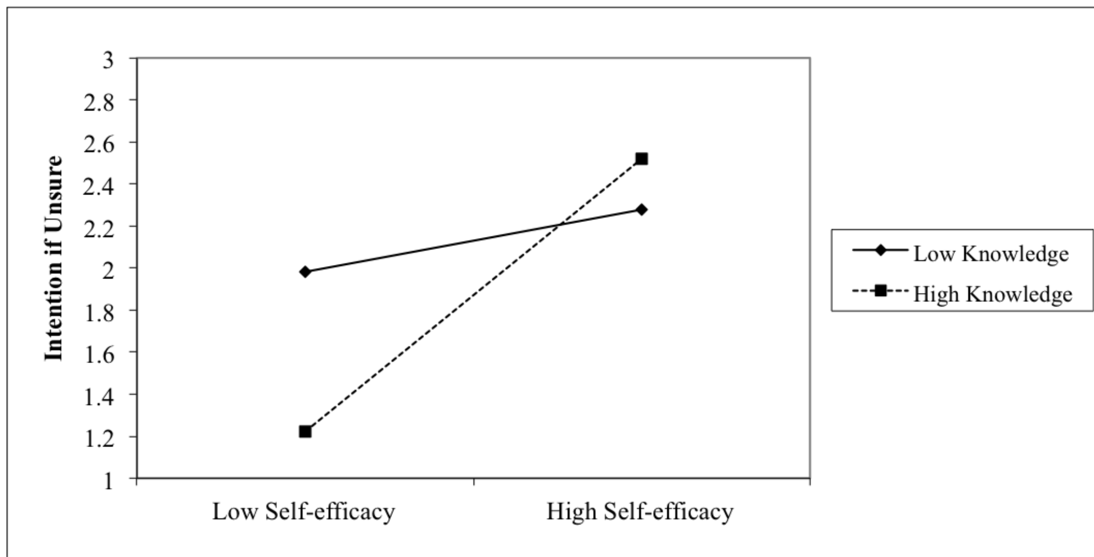

Figure 4.3: Interaction Plot of Self-Efficacy and General DMST Knowledge

Objective 3: Exploratory Analysis of Effect of Demographic Variables.

The third objective of this study was to explore the influence of demographic and professional characteristics—specifically occupation and gender of the clinician—on intention to report. These two demographic variables were selected because their sample sizes were large enough to conduct further exploratory analyses. Frequencies and means of items and scales for general DMST knowledge, knowledge of clinical indicators, self-efficacy, the healthcare environment, and intention were analyzed, examining the differences for both demographic characteristics. The multiple linear regression models previously conducted for objectives 1 and 2 were conducted again, splitting the data by gender.

Occupation. Twenty-one physicians, 11 midlevel providers, 15 nurses, and 6 social workers completed this phase of the study. Differences in means and frequencies for general DMST knowledge, knowledge of clinical indicators, self-efficacy, the healthcare environment, and intention were analyzed based on occupation. The sample sizes of each occupation category were too small to conduct multiple linear regression analyses. Table 4.18 displays means and standard deviations for general DMST knowledge, knowledge of clinical indicators, self-efficacy, the healthcare environment, and the three levels of intention by occupation.

Table 4.18: Scale Means and Standard Deviations, Split by Occupation

	Physicians		Mid-level Providers		Nurses		Social Workers	
Variable	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
General DMST Knowledge	7.10	(1.49)	6.36	(2.42)	7.50	(1.79)	7.67	(1.75)
Knowledge of Clinical Indicators	9.81	(1.99)	10.64	(1.80)	9.13	(2.83)	10.17	(2.40)
Self-Efficacy	2.02	(0.69)	1.98	(0.52)	2.02	(0.66)	2.38	(0.58)
Healthcare Environment	1.51	(0.42)	1.31	(0.25)	2.08	(0.78)	2.13	(0.73)
Intention if Certain	3.90	(0.30)	4.00	(0.00)	3.87	(0.34)	3.83	(0.41)
Intention if 50/50 Chance	3.14	(0.79)	2.91	(0.70)	3.13	(0.89)	3.50	(0.55)
Intention if Unsure	1.76	(0.77)	1.91	(0.83)	2.19	(0.91)	2.00	(1.01)

Physicians had correct general DMST knowledge scores ranging between 4 and 10, with a mean score of 7.10 (SD=1.49). The range in scores for midlevel practitioners was between 3 and 10, with a mean score of 6.36 (SD=2.42). Nurses had a range in scores between 5 and 10, with a mean score of 7.50 (SD=1.79). Social workers had the greatest knowledge scores ranging between 5 and 10, with a mean score of 7.67 (SD=1.75).

For knowledge of clinical indicators, physicians had a mean score of 9.81 (SD=1.99), with a range of scores between 5 and 12. Midlevel providers had the greatest knowledge of clinical indicator scores ranging between 6 and 12, with a mean score of 10.64 (SD=1.80). Nurses had the lowest knowledge of clinical indicator scores ranging between 4 and 12, with a mean score of 9.13 (SD=2.83). Lastly, social workers had scores ranging between 6 and 12, with a mean score of 10.17 (SD=2.40).

Midlevel providers reported the lowest overall self-efficacy, with an overall mean score of 1.98 (SD=.52). Social workers reported the highest overall self-efficacy score, with an overall mean score of 2.38 (SD=.58). The highest self-efficacy score for midlevel providers, nurses, and

social workers was for determining if a child is being physically or sexually abused. The highest overall self-efficacy score for physicians was for appropriately reporting a suspected victim of DMST. The lowest overall self-efficacy score for all four occupations was for differentiating between a victim of DMST and a victim of another form of abuse. Physicians also had a lower self-efficacy score for appropriately treating victims of DMST, while nurses had a lower self-efficacy score for accurately identifying victims of DMST.

Social workers had the highest overall healthcare environment score, with a mean of 2.13 (SD=.73). The lowest overall healthcare environment score was from midlevel providers, with a mean of 1.31 (SD=.25). The lowest healthcare environment score for physicians and midlevel providers was for work place protocol for working with victims of DMST. Nurses and social workers had the lowest healthcare environment score for the work place provision of specific education for working with victims of DMST, indicating that this was the largest constraint for these two occupations. Providers in all four occupations reported the highest healthcare environment score for suitability of work environment for working with victims of DMST.

The greatest intention to report for all four occupations was when the providers were absolutely certain that a patient was a victim of DMST (*Intention if Certain*). The lowest intention to report for all four occupations was when the providers were unsure if the patient was a victim of DMST (*Intention if Unsure*).

Gender. Thirty-nine women and 15 men participated in this phase of the study. Table 4.19 displays the overall mean and standard deviation for general DMST knowledge, knowledge of clinical indicators, self-efficacy, the healthcare environment, and the three levels of intention by gender.

Table 4.19: Scale Means and Standard Deviations, Split by Gender

	Men		Women	
Variable	Mean	(SD)	Mean	(SD)
General DMST knowledge	7.20	(1.57)	7.10	(1.93)
Knowledge of clinical indicators	10.00	(1.96)	9.74	(2.41)
Self-efficacy	2.03	(0.61)	2.06	(0.65)
Healthcare environment	1.50	(0.46)	1.78	(0.69)
Intention if Certain	3.93	(0.26)	3.90	(0.31)
Intention if 50/50 Chance	2.87	(0.83)	3.23	(0.74)
Intention if Unsure	1.73	(0.80)	2.06	(0.87)

General DMST knowledge and knowledge of clinical indicators scores were similar between genders. For the general DMST knowledge questions, number of correct responses ranged between 3 and 10, with a mean of 7.10 (SD = 1.93) for women. For men, correct responses ranged between 5 and 10, with a mean of 7.20 (SD=1.57). For knowledge of clinical indicators, women had scores ranging between 4 and 12, with a mean score of 9.74 (SD=2.41). Men had scores ranging between 5 and 12, with a mean score of 10.00 (SD=1.96).

For self-efficacy scores, the overall mean was 2.06 (SD=.65) for women. For men, the overall mean was 2.03 (SD=.61). The greatest self-efficacy score for women was for determining if a child was being abused. The greatest self-efficacy score for men was for appropriately reporting a suspected DMST victim. Both men and women reported the lowest self-efficacy for differentiating between a victim of abuse and a victim of DMST.

There were similarities between average scores for the healthcare environment scale when comparing each gender. For women, the overall mean was 1.78 (SD=.69). For men, the overall mean was 1.50 (SD=.46). The greatest facilitator in the work environment for both genders was the suitability of the work environment for working with victims of DMST. The

lowest healthcare environment score for both women and men was the provision of specific education on working with DMST victims, indicating this was the largest environmental constraint for both genders.

The greatest intention to report for both genders was when the providers were absolutely certain that a patient was a victim of DMST (*Intention if Certain*). The lowest intention to report for all four occupations was when the providers were unsure if the patient was a victim of DMST (*Intention if Unsure*).

To examine whether gender played a role in the multivariate results, the multiple linear regression models that were previously conducted for objectives 1 and 2 were conducted again, splitting the data for gender. These findings are for each gender and potential differences between genders; these analyses do not describe statistical differences between genders in the factors leading to self-efficacy or behavior change. Additionally, given the small sample size of men, the results only signify a finding for this study, and are not generalizable to the general population.

Table 4.20 displays the results of the regression analysis summary for the clinician predictor variables predicting self-efficacy, split by gender. General DMST knowledge and knowledge of clinical indicators did not significantly predict self-efficacy scores for either men or women. The association between the healthcare environment and self-efficacy remained statistically significant for both genders. For men, views of the healthcare environment significantly predicted self-efficacy scores, $b=.73$, $t(11)= 3.53$, $p<.01$. For women, views of the healthcare environment significantly predicted self-efficacy scores, $b=2.5$, $t(34)= 2.48$, $p<.05$. Additionally, the predictor variables explained a significant proportion of variance in self-

efficacy scores for men, R^2=.55, F(3,11)=4.41, p<.05. This finding was not significant for women.

Table 4.20: Regression Analysis Summary for the Clinician Predictor Variables Predicting Self-Efficacy, Split by Gender.

	Men			Women		
Variable	B	SE B	β	B	SE B	β
Knowledge	-.02	.08	-.05	-.02	.06	-.06
Clinical Indicators	.04	.06	.13	-.00	.04	-.01
Healthcare Environment	.96	.27	.73**	.40	.16	2.5*
R^2	.55			.15		
F	4.42*			2.08		

*p<.05. **p<.01

No significant findings were found after conducting the regression analysis for clinician characteristics predicting *Intention if Certain*, splitting the data based on gender. The results of the regression analysis summary for the clinician predictor variables predicting *Intention if 50/50 Chance*, split by gender, are displayed in Table 4.21. There were differences between genders. For men, none of the predictor variables significantly predicted level of *Intention if 50/50 Chance*. For women, two predictor variables significantly predicted *Intention if 50/50 Chance*. General DMST knowledge significantly predicted level of intention scores for women, b=-.42, t(33)=-2.55, p=.02. Healthcare environment also significantly predicted level of intention scores for women, b=.39, t(33)=2.31, p=.02. When this analysis was conducted with both genders, healthcare environment did not significantly predict level of intention scores. For women, the predictor variables explained a significant proportion of variance in *Intention if 50/50 Chance* scores, R^2=.25, F(4,33)=2.72, p<.05. This finding was not significant for men.

Table 4.21: Regression Analysis Summary for Clinician Characteristics Predicting Intention if Provider Thinks There is a 50/50 Chance that a Patient is a Victim, Split by Gender

	Men			Women		
Variable	B	SE B	β	B	SE B	β
Knowledge	-.06	.16	-.12	-.16	.06	-.41*
Clinical Indicators	-.12	-.13	-.28	-.01	.05	-.02
Self-Efficacy	.67	.57	.48	.03	.19	.02
Healthcare Environment	-.64	.77	-.35	.44	.19	.39*
R^2	.17			.25		
F	.51			2.72*		

*p<.05. **p<.01

Table 4.22 displays the results of the regression analysis summary for the clinician predictor variables predicting *Intention if Unsure*, split by gender. There were significant differences between genders. For men, self-efficacy significantly predicted intention, b=.92, $t(10)$=2.99, p=.02. When this analysis was conducted with both genders, self-efficacy did not significantly predict level of intention scores. For women, two predictor variables significantly predicted *Intention if Unsure*. General DMST knowledge significantly predicted level of intention scores for women, b=-.44, $t(33)$=-2.82, p=.01. Additionally, healthcare environment significantly predicted level of intention scores for women, b=.42, $t(33)$=2.51, p=.02. For women, the predictor variables explained a significant proportion of variance in *Intention if Unsure* scores, R^2=.28, $F(4,33)$=3.14, p<.05. This finding was not significant for men.

Table 4.22: Regression Analysis Summary for Clinician Characteristics Predicting Intention if Provider is Unsure that a Patient is a Victim, Split by Gender

	Men			Women		
Variable	B	SE B	β	B	SE B	β
Knowledge	.12	.12	.22	-.20	.07	-.44**
Clinical Indicators	.05	.09	.13	.01	.05	.03
Self-Efficacy	1.21	.41	.92**	.02	.23	.02
Healthcare Environment	-.72	.54	-.41	.55	.22	.42*
R^2	.57			.28		
F	3.28			3.14*		

*p<.05. **p<.01

CHAPTER 5

DISCUSSION

This study assessed the awareness and needs of healthcare professionals regarding domestic minor sex trafficking (DMST). The purpose of the study was to examine the individual and environmental characteristics that impacted a provider's intention to identify and report DMST victims within a clinical setting. I hypothesized that participants in this study who reported more knowledge, fewer personal barriers, and more positive views of their external work environment would report higher self-efficacy to identify and appropriately assist victims of sex trafficking. I also hypothesized that greater knowledge, fewer personal barriers, more self-efficacy, and more positive views of the work environment would increase a provider's intention to identify and report victims of sex trafficking at varying levels of certainty that a patient is a victim. Another objective of the study was to explore the role that demographic variables played in the survey results.

In the first phase of this dissertation, 21 semi-structured interviews were conducted with healthcare providers working in a variety of occupations and specialties. The interviews covered 13 topics. Within each of these topics, specific themes emerged. The findings from Phase 1 of the study assisted in the elucidation of factors impacting a healthcare provider's perceived ability to work with DMST victims, and intention to identify and report victims. Providers indicated that they had an important role in helping victims, but personal and environmental factors impeded their perceived ability to accurately identify DMST victims. The findings from the qualitative

interviews in Phase 1 were valuable in developing the quantitative survey instrument used to collect data in Phase 2.

The knowledge of healthcare providers on the topic of DMST is not well documented (Reinhard et al., 2012). The majority of healthcare workers have little awareness and knowledge about human trafficking (DHS, n.d.). In the only previous study examining provider knowledge in this context, general DMST knowledge varied between 40% and 78% depending on the question (Reinhard et al., 2012). When examining knowledge level of healthcare providers in regards to domestic violence, low levels of knowledge were found for both physicians and nurses in several samples (AbuTaleb, Dashti, Alasfour, Elshazly, & Kamel, 2012; Alsafy, Alhendal, Alhawaj, El-Shazly, & Kamel, 2011; Viera, Dos Santos, & Ford, 2012). Additionally, in their study of school nurses, Khubchandani et al. (2013) found that the majority of participants had little knowledge on adolescent dating violence and on their role in helping victims, with the average percentage of correct answers totaling to less than 60%.

Contrary to my expectations, for this study, general DMST knowledge and knowledge of clinical indicators were relatively good. In the interviews, most participants were aware that DMST is a problem in the United States and that victimization can happen anywhere. Bob described it as “a bigger problem than people realize”. Liza explained, “We think of sex trafficking in big cities, but it could be anywhere. People are in a bustling area. And things go unnoticed.” However, some participants incorrectly perceived that many victims were primarily taken by force. As Jamie described, “…it seems that the children who are trafficked…are kidnapped or something and brought to this country. Or that maybe children from this country would be taken to another country… when they are taken captive.” Additionally, few providers mentioned the role that maltreatment or the foster care system plays in increased risk for

victimization. For the survey responses in Phase 2, the lowest number of correct responses for general DMST knowledge questions were regarding that trafficking could exist without any force, homicide is the primary cause of death for trafficked minors, many victims still live at home when entering the commercial sex industry, and many victims are recruited from the foster care system.

The lowest numbers of correct responses for survey questions regarding knowledge of clinical indicators were for rude or aggressive behavior, signs of pimp branding, and the presence of an older, unrelated male at a medical appointment. These findings were supported by the responses in Phase 1, in which most of the participants explained that they expected to see signs of physical and emotional trauma, but only one described the possible presence of a suspicious male and none mentioned possible pimp branding. These specific indicators are what sets DMST victims apart from other victims of violence, and they are often overlooked or missed as clinical indicators. As Arthur described, "[There is] a lack of awareness of some of the subtle indications that [a child is a DMST victim]."

While the literature on provider self-efficacy regarding DMST is limited, low self-efficacy among healthcare providers has been found from researchers examining this topic. Cull, O'Connor, Sharp, and Tang (2005) found that only 13% of emergency room physicians surveyed felt confident in their ability to identify a trafficking victim. Reinhard et al. (2012) found that less than 12% of their participants felt comfortable identifying a victim of DMST in their clinical practice. Self-efficacy scores were also low in this current study. Scores were particularly low on items specific to DMST. Only 21% felt pretty confident in their ability to appropriately treat a victim of DMST, 14% felt pretty confident or very confident in their ability to differentiate between a victim of child abuse and a victim of DMST, and 10% felt pretty confident in their

ability to accurately identify a victim of DMST. Responses from Phase 1 illustrated these findings. As Bella explained in her interview, "It's very hard to differentiate [DMST] from abuse. It's hard to determine how to separate that from sex trafficking." Tucker described, "So many signs and symptoms would be consistent with other adolescent issues. It would be difficult [for me] to tease [abuse and DMST] apart."

Participant's views of their healthcare environment were primarily negative in both phases of the current study. Responses from the interviews indicated that not having a multidisciplinary team, limited time, unclear or nonexistent policies, and lack of training were the largest constraints to assisting DMST victims. As Arthur highlighted, "It's really a matter of training for me and my nurses… [The organization] has no policy or training to really identify [DMST]." Edward clarified his issue with organizational policy, saying, "Just not being familiar with what process would be most helpful to the child. I'm not familiar with policies I don't use on a daily basis." Alice explained, "[Providers] don't have things in place to help them identify [DMST], to help them deal with it quickly, to help them do that extra leg work." In terms of scheduling problems, Tucker described, "The pressure of keeping to a schedule to see patients that you're seeing and then accommodate a problem like this would be difficult." Gina echoed this sentiment, explaining, "We are trying to do a lot in a very limited amount of time."

In survey responses, participants also had negative views of their work environment, with very few of the items listed in the scale rated as facilitators among this sample. Many participants did state that their work environment was suitable for working with victims of DMST, with almost 50% selecting *pretty much true* or *very much true* as their response. In contrast, reflecting views highlighted in the Phase 1 interviews, the majority of participants stated that they have not received education specific to working with the DMST population

(80%), their workplace does not have a policy for working with victims (70%), they do not work with a multidisciplinary team that can make it easier to identify and assist victims (55%), and their work schedule does not provide necessary time with each patient to determine if someone is a victim (51%). In Phase 1, Scott explained this lack of training best, saying, “There hasn’t been really any strong teaching or resources on what to look for or what to do. I know trafficking is very real, and [healthcare providers] really don’t have any education on it.”

The lack of education being the largest environmental constraint is consistent with previous research findings. Reinhard et al. (2012) found that the greatest problem was that participants did not know how to identify or report a victim, indicating that providers may lack education needed to identify DMST victims in their clinical practice. When examining adolescent dating violence identification among school nurses, the greatest environmental constraint identified as a system-level barrier to assisting victims was also a lack of education provided to school staff (Khubchandani et al., 2013). Other constraints included a lack of protocol on how to respond to the incident and a lack of organizational knowledge about the level of dating violence happening in the school (Khubchandani et al., 2013). Unsupportive work environment, lack of protocols, and limited work autonomy have been identified as environmental constraints when working with victims of intimate partner violence (Lawoko et al., 2014). Additional environmental barriers to screening for substance abuse in patients are physician time constraints, non-supportive organizational priorities, and lack of communication among staff members (Rahm et al., 2015).

As I hypothesized, more positive views of the healthcare environment resulted in greater self-efficacy. While previous studies have not examined the association between the environment and self-efficacy pertaining to DMST or human trafficking, research studies examining the

relation between these two variables among healthcare providers have had similar findings. After improved policies and protocols for working with victims of intimate partner violence were implemented in health clinics, provider's reported an increase in their self-efficacy to identify and assist victims (Ambuel et al., 2013). Higher self-efficacy among healthcare workers has been associated with improved job performance and more positive views of the work environment (Mache et al., 2014). Environmental facilitators and self-efficacy were positively associated among medical students when examining academic success in medical school courses (Egbert, 2013). Additionally, when environmental facilitators (i.e. quality training materials and good management) were in place for primary care providers, self-efficacy to assess child behavior increased (Turner, Nicholson, & Sanders, 2011). The current study highlights that to increase self-efficacy to identify and assist DMST victims among healthcare providers, improvements need to be made to the healthcare work environment. If providers have more positive views of their work environment, their self-efficacy to help these young victims will improve.

At the time of this writing, no studies have examined the effect of clinician characteristics (i.e. general DMST knowledge, knowledge of clinical indicators, self-efficacy, and healthcare environment) on intention to report victims of DMST. Previous research in related areas supported the notion that clinician characteristics impact intention to report victims of other forms of violence. When examining why most physicians seeing children and adolescents did not screen for intimate partner violence, lack of knowledge was the strongest predictor (Borowsky & Ireland, 2002). Environmental, system-level facilitators can improve identification and reporting behaviors by making professional decisions and behaviors easier to accomplish (Ambuel et al., 2013). In their study determining a healthcare provider's readiness to screen for intimate partner violence, John et al. (2010) concluded that higher self-efficacy was linked to increased screening.

Additionally, Ehrenberg et al. (2014) found that low self-efficacy was one of the primary factors reducing the likelihood that a healthcare provider would investigate if a patient is a victim of intimate partner violence. For healthcare providers to intend to screen for victimization among their patients, they need to have the necessary knowledge and the confidence in their ability to identify and help victims (Chapin et al., 2011).

No individual factors predicted the providers' intention to report if they were certain the patient was a victim of DMST in Phase 2. Interview responses indicated that there was not anything specific that would motivate a provider to identify and report DMST victimization if there was a high level of certainty that victimization was happening. As Arthur said in his interview, "If you have a high index of suspicion, you may not know exactly what it is, but you're going to pursue it." If she were certain victimization was happening, Sarah had a similar opinion, stating, "I don't know if there would be anything personally that would keep me [from reporting]. The moral and ethical thing to do as a social worker would be to report it." Ryan described, "At this point, it's just your own… something's just not right [feeling] we have to rely on."

Surprisingly, self-efficacy only significantly predicted *Intention if Unsure* when the data were divided by gender or when the moderator of general DMST knowledge was present. Contrary to my hypothesis and theoretical foundation for this study, self-efficacy did not predict intention to report for the overall sample. It did, however, predict male healthcare providers' intention to report if they were unsure if a patient was a victim (*Intention if Unsure*). As male participants' self-efficacy increased, their intention to report also increased.

When post-hoc moderation analysis was conducted, it was found that level of general DMST knowledge moderated the association between self-efficacy and *Intention if Unsure*.

Consistent with previous research on a variety of other health-related topics (Guilfoyle, Karazsia, Langkamp, & Wildman, 2012; Hess, Teti, & Gardner, 2004; Ward, 2012), the interaction effect of self-efficacy and knowledge significantly predicted behavioral intention. The results suggested that higher levels of general DMST knowledge heightened the strength of the association between self-efficacy and *Intention if Unsure*. This finding is theoretically supported by social cognitive theory. According to this theory, self-efficacy and behavior are positively associated when knowledge is greater (Bandura, 1977, 1989).

General DMST knowledge predicted intention to report at two different levels of certainty, however knowledge and intention were negatively correlated. For both *Intention if 50/50 Chance* and *Intention if Unsure*, as knowledge decreased among participants, intention to report actually increased. While opposite of what was hypothesized, this finding can be understood within the context of clinical training and recommendations for primary healthcare providers. Primary care providers, including pediatricians and family practice practitioners, provide routine medical care, and if a medical issue presented to them is outside of their specialty or training, they are encouraged or required to refer patients to a specialist in the field (Hertz, 2014). Research on primary care provider referrals vary widely (Franks, Zwanziger, Mooney, & Sorbero, 1999); however, some researchers have examined the link between intention to refer to specialists and personal level of knowledge and certainty. For example, researchers have found that as ambiguity of possible cancer risk increased in patients, primary care providers were more likely refer those patients to specialists (Pedersen & Vedsted, 2015). Additionally, a lack of certainty and knowledge increase providers' referral and reporting behaviors due to the concern over malpractice (Gamble, 2012). If providers have limited knowledge about a disease or they are uncertain whether a patient is experiencing a health issue,

they are likely to report to a specialist to avoid getting sued for malpractice if something is missed or misdiagnosed (Gamble, 2012).

Many participants in Phase 1 of this study mentioned something akin to this relationship between lack of knowledge, lack of certainty, and patient referral. For example, John explained that if he suspected possible trafficking, he "…would go to talk to one of the social workers and tell them that I was suspecting… I would talk to the social worker first and see what they thought my next best option would be." Additionally, Sarah noted, "If the situation were to arise… I would imagine I would go to my supervisor first, the unit manager, and see what she advises." It can be postulated that the less familiar a provider is with the complexity of identifying and caring for a DMST patient, the more likely he or she is to report the possible victim to an individual or organization who would have more knowledge and skills to handle the situation.

Along with general DMST knowledge, the healthcare environment also significantly predicted *Intention if Unsure*. As providers reported more healthcare facilitators in their work environments in Phase 2, their intention to report increased. These survey results reinforced interview responses in Phase 1. Providers who had a multidisciplinary team at their organization viewed this team as an extremely helpful facilitator to assisting DMST victims. Edward explained, "We have 7 or 8 [social workers] in the hospital that I would have access to and I would just pick their brain about what we should do next. I have confidence in the team approach." Alice highlighted multiple healthcare facilitators in place at her organization, saying, "I am fortunate that I actually have a social worker who is in our clinic… We [also] have safety screening questions." The same was said for providers who work in an environment with protocols for handling a possible DMST victim. As Jay described, "We have policies and

procedures in place… We have policies in place in terms of when to call the police. We have policies related to… child abuse."

While never studied in the context of human trafficking, the relation between behavioral intention and views of the external environment has been found in previous literature. System-level constraints such as a lack of organizational protocol and scheduling constraints are a primary reason why healthcare providers do not screen for intimate partner violence during medical appointments (Minksky-Kelly et al., 2005). As organizations develop clear policies and provide training pertaining to intimate partner violence to healthcare workers, intention to assist victims increased (Ambuel et al., 2013). Facilitators such as screening tools or prompts in the patient medical record increased screening and identification of intimate partner violence victims (Hamberger et al., 2010). School nurses who had specific protocols at their school pertaining to responding to an incident of adolescent dating violence assisted more victims than school nurses at schools with no protocol (Khubchandani et al., 2013). External facilitators can be empowering for individuals, positively encouraging them to perform a specific behavior (McAlister et al., 2008). If an environment does not encourage the performance of a behavior by, for example, lacking the necessary tools, resources, and support, a behavior like identifying victims of DMST is less likely to occur (Bandura, 2002). Environmental constraints in the work environment need to be removed for healthcare providers to increase behaviors related to identifying and assisting victims of violence (Ambuel et al., 2013).

It is important to note that results were different when quantitative analyses were split based on gender. Healthcare provider referral behavior and factors influencing this behavior has been found to vary based on gender of the medical practitioner (Franks, Williams, Zwanziger, Mooney, & Sorbero, 2000). For this study, general DMST knowledge and healthcare

environment only predicted *Intention if 50/50 Chance* and *Intention if Unsure* for female participants. As previously mentioned, the only factor predicting one level of intention for men (*Intention if Unsure*) was self-efficacy, a result not found for women. Intention to report at each level of certainty was higher for women, with 82% describing they were *pretty likely* or *very likely* to identify and report for *Intention if 50/50 Chance* and 39% saying they were *pretty likely* or *very likely* to identify report for *Intention if Unsure.* Fewer men felt the same for both *Intention if 50/50 Chance* (60%) and *Intention if Unsure* (20%). While challenging, gender-targeted interventions aimed at increasing behavioral intention could be beneficial. However, in the absence of this possibility, including activities in interventions aimed at improving all three factors (general DMST knowledge, self-efficacy, and healthcare environment) would be important to increase behavioral intention among both male and female healthcare providers.

The conceptual model and theoretical basis for this study was useful to identify research questions but not all of the hypothesized theoretical associations were supported. As I predicted using my theoretical framework, environment was positively associated with both self-efficacy and behavioral intention. The association between environment and self-efficacy is supported by social cognitive theory, which explains that individual factors like self-efficacy operate in accordance with perceived environmental facilitators and constraints (Bandura, 1998). According to social cognitive theory, individual factors like self-efficacy operate in accordance with perceived environmental facilitators and constraints (Bandura, 1998). Social cognitive theory also explains that no amount of learning, knowledge, skill-building, or goal setting will lead to a behavior change without an appropriate and helpful external environment (Bandura, 2002). If an environment does not encourage the performance of a behavior by, for example,

lacking the necessary tools, resources, and support, a behavior change is unlikely to occur (Bandura, 2002).

The theoretical relation that I proposed between knowledge and intention was not what I was expecting. I hypothesized that knowledge and intention would have a positive association with behavioral intention based on health behavior theory. The connection between knowledge and behavior is supported by both social cognitive theory and integrated change model. While knowledge by itself does not lead to behavior change, knowledge is a precondition for change (Bandura, 2004). Motivation to perform a certain behavior is largely influenced by a person's level of knowledge (de Vries et al., 2005). Because my findings were opposite of what health behavior theory proposed, more barriers and facilitators to healthcare provider referral behaviors need to be explored. While theory highlighted that in general, knowledge and intention are positively connected, there may be other theoretical constructs that help explain why healthcare providers do or do not refer patients to specialists.

The most surprising theoretical finding for this study was that self-efficacy and behavioral intention were not related without the presence of a moderator. According to health behavior theory, the mostly likely association I was going to find was between self-efficacy and intention. Self-efficacy is regularly identified as a predictor of clinical performance among healthcare providers (Zhu et al., 2013). Bandura (1989) illustrated that nothing has greater influence on individual behavior than the individual's confidence in his or her ability to perform a behavior correctly and effectively. The greater the self-efficacy a person has, the more effort that person will put into the behavior in question (Bandura, 1988). Because this theoretical relation was not found in this study, another theoretical component or moderator may have been missing from the theoretical model. Since theory and previous studies highlight that this

association should exist, researchers should further explore whether other construct moderate this relation.

Limitations

This study had some limitations. The study was exploratory. Replication is needed to determine whether these findings are consistent with healthcare providers in the general population. Additionally, the survey in Phase 2 was self-reported; therefore, reporting bias may have influenced the results. This study may also have been affected by response bias, as providers who had an interest in the topic of DMST may have been more likely to respond to the survey.

The sample size for the quantitative survey was small. The sample size was appropriate for the power analysis detecting the small effect size of .20, and was also suitable for an exploratory study. However, the results from the survey reflect only a small proportion of healthcare providers in the United States and cannot be generalized to the larger population. Because the study had three dependent variables, MANOVA would have been the ideal statistical analysis but could not be used due to the small sample size.

The distribution between genders was unbalanced. Two-thirds of the respondents were female, so more information on DMST in healthcare settings is needed from male providers. Obtaining the perspective of men and women is especially important since there may be significant differences between genders regarding what is predicting behavioral intention. However, the distribution of the sample reflects largely the gender distribution within each health profession. With a larger sample size, gender and profession could be entered into the regression models as a predictor variables. The sample sizes for the categories for the other demographics variables were too small to make any conclusion about the role that age, years of practice,

occupation, work setting, specialty, and geographic location play in intention to identify DMST victims.

Lastly, measuring behavioral intention in research has some limitations, as not always intention and behavior do match. Intention to assist sex trafficking victims was high in this study. However, based on responses regarding actual identification of victims, providers mostly reported that they never identified or reported a victim of sex trafficking.

Strengths

Research on the topic of DMST in healthcare settings is scarce. While DMST and the role of healthcare providers has been examined in previous studies (Chisolm-Straker et al., 2012; Reinhard et al., 2012), this is the first study using a mixed-methods approach. When conducting a needs assessment with healthcare providers, using a mixed-methods approach creates a more detailed community profile of members of the healthcare community (Billings & Cowley, 1994). The qualitative portion of the study allowed for an in-depth examination of healthcare providers' views and experiences relating to DMST. The qualitative component also helped guide the creation of a quantitative survey. No survey instrument previously existed collecting data from healthcare professionals on general or clinical knowledge, self-efficacy, and external factors regarding DMST. Additionally, two scales (self-efficacy and healthcare environment) were created specifically for the purpose of research with healthcare providers in this context. The scores of both scales had good psychometric properties, as shown by the internal consistency and the exploratory factor analysis.

This study was also the first to examine personal and environmental determinants affecting a healthcare provider's intention to identify and report DMST victims. Lastly, this study obtained data from physicians, midlevel providers, nurses, and social workers. To the best

of my knowledge, this is the first study including more than just one occupation in the sample population. The results of this study expand the current scientific knowledge of the personal and environmental factors affecting healthcare providers' intentions to identify and report DMST in a clinical setting.

Conclusions

As the problem of DMST in the United States rises to the forefront of public health concern, it has become increasingly important to study the role that healthcare providers play in helping these children escape a trafficking situation. The current study serves as a needs assessment, investigating the perspective of healthcare providers in respect to sex trafficking and DMST victims. The data generated by this research display determinants of behavioral intention to identify and report victims of DMST in a clinical setting.

This study contributes to an extremely limited body of scientific research examining the personal and environmental factors that affect healthcare professionals' intention to identify and report possible victims of DMST they see in their clinical settings. The long-term goal of this research is to develop effective interventions that will improve the knowledge, self-efficacy, and work environment of healthcare providers, increasing the number of DMST victims who are identified and receive necessary services. Based on these results, interventions targeting healthcare professionals should incorporate more education on DMST victims, their medical needs, their clinical characteristics, and venues for reporting suspected victims of trafficking. As a part of these interventions, an environmental component needs to be initiated, improving the policies and organizational environment for healthcare providers seeing patients who could possibly be DMST victims. More research and targeted interventions could increase the number

of children saved from DMST and assist in making progress toward ending the enslavement of children in the United States.

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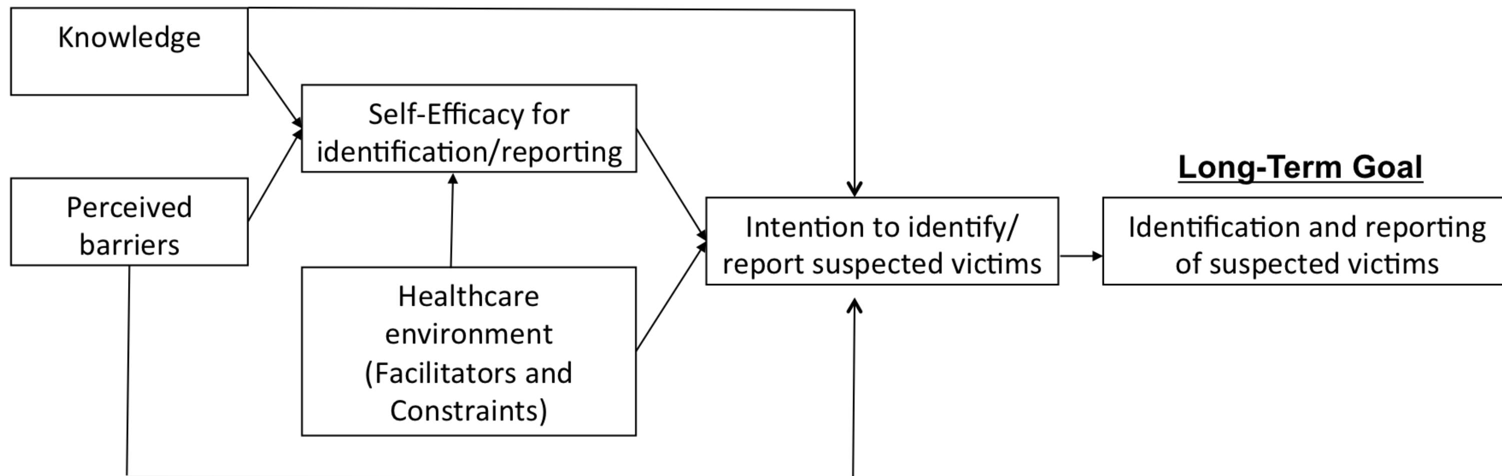
APPENDIX A: CONCEPTUAL MODEL AND SCALES



	Construct	Description of Measure	Internal Consistency	Reference	Final Variable to be Analyzed
1.	General DMST Knowledge	10 items measuring overall knowledge.	N/A	Adapted from Reinhard et al., 2012	Sum of correct responses ranging from 0 to 10.
2.	Knowledge of Clinical Indicators	12 items measuring overall knowledge of clinical indicators.	N/A	Adapted from Oram et al, 2012; Reinhard et al., 2012; Zimmerman & Boreland, 2009	Sum of correct responses ranging from 0 to 12.
3.	Perceived Barriers	6 items measuring perceived personal obstacles to identifying and reporting victims.	α=.38*	Adapted from Reinhard et al., 2012; Khubchandani et al., 2013	Mean score of each individual item.
3.	Self-Efficacy	6 items measuring self-efficacy or participants.	α=.88	Developed for this study; partially based on previous liturature and Phase 1 responses.	Self-efficacy scales calculated as the average of the 6 items; individual items.
4.	Healthcare Environment (Facilitators and Constraints)	6 items measuring views of the external healthcare environment.	α=.83	Developed for this study; partially based on previous liturature and Phase 1 responses	Environment scale calculated as the average of 6 items; individual item.
5.	Intention	3 items measuring intention to identify and report a victim. Each item describes a different level of certainty that patient is victim.	N/A	Developed for this study; partially based on previous liturature and Phase 1 responses	Mean score of each individual item.
6.	Demographic Information	7 items measuring age, years in practice, gender, occupation, practice type (setting), specialty, and geographic description of location.	N/A	Adapted from Reinhard et al., 2012	Sum and percentage score of each demographic variable.

*No scale was calculated due to low internal consistency

General DMST Knowledge
Response categories: *True*, *False*, *Unsure*
Prompt: We want to find out more about your experience working with victims of trafficking. The following questions ask about what you know about trafficking. Select the answer that best describes how you feel about each statement.

Contains 10 items; designed for this study: items 2 and 10

1. Many youth in America enter the commercial sex industry while still living at home and going to school
2. Anyone under the age of 18 working in the commercial sex industry in the U.S. is considered a victim of sex trafficking
3. Most American children involved in the sex industry enter the trade without force (meaning they were not kidnapped and forced in)
4. Sex trafficking occurs in small towns
5. Sex trafficking is frequently associated with involvement in the foster care system
6. Sex trafficked girls can often clinically appear to be victims of child abuse, sexual abuse, or domestic violence
7. Girls in the sex industry are often branded by their pimp
8. The primary cause of death for girls in the sex industry is homicide
9. It is mandatory for a healthcare provider to report suspected sex trafficking
10. Reporting cases of sex trafficking of minors is done the same way as reporting suspected cases of child abuse

Knowledge of Clinical Indicators
Response categories: *Yes*, *No*, *Unsure*
Prompt: Which of the following are potential indicators of a victim of sex trafficking? Select the answer that best describes how you feel about each statement.

Contains 12 items; designed for this study: items 6 and 8

1. Patient came in with a boyfriend, not a family member
2. Patient had a unique tattoo or jewelry item
3. Patient lied about age
4. Patient had no identification
5. Patient had little knowledge about the community
6. Patient wore inappropriate clothing for age (revealing, short, or tight clothing)
7. Patient was on drugs or had a history of drug use
8. Patient was defensive, rude, and aggressive when responding to questions
9. Patient was evasive in responses to questions
10. Patient has a history of reproductive health issues
11. Patient avoided eye contact
12. Patient had signs of physical abuse

Perceived Barriers
Response categories: *Not at all true (1), A little true (2), Pretty much true (3), Very much true (4)*
Prompt: The following questions ask about what you think is personally keeping you from identifying victims of sex trafficking. Select the answer that best describes how you feel about each statement.

Contains 7 items; designed for this study: items 3 and 7

1. I know how to report sex trafficking victims
2. I feel like I have the time to determine if the person is a victim or not
3. When a patient is difficult, it makes it challenging to determine their situation
4. Identifying victims of sex trafficking is a priority for me
5. It my personal responsibility to identify and report victims
6. Sex trafficking is a minor issue compared to other health issues with which I deal
7. If a patient is rude, aggressive, or challenging to talk to, it makes me less likely to want to help them

Self-Efficacy
Response categories: *Not at all true (1), A little true (2), Pretty much true (3), Very much true (4)*
Prompt: The following questions ask about your personal confidence in working with victims. Select the answer that best describes how you feel about each statement.

Contains 6 items; designed for this study: items 1 through 6

1. I am confident in my ability to identify victims of violence
2. I am confident in my ability to determine if a child is being physically or sexually abused
3. I am confident in my ability to differentiate between a victim of child abuse and a victim of child sex trafficking
4. I am confident in my ability to appropriately treat victims of sex trafficking
5. I am confident in my ability to accurately identify a victim of sex trafficking
6. I am confident in my ability to appropriately report a suspected victim of sex trafficking

Healthcare Environment

Response categories: *Not at all true (1), A little true (2), Pretty much true (3), Very much true (4)*

Prompt: The following questions ask about your work environment. Select the answer that best describes how you feel about each statement.

Contains 6 items; designed for this study: items 1 through 6

1. My work environment is suitable for working with victims of sex trafficking
2. My work place has a specific protocol for working with victims of sex trafficking
3. The way my work environment does scheduling gives me the necessary time with each patient I would need to determine if they are victims or not
4. My work place has provided specific education on working with victims of sex trafficking
5. Sex trafficking identification and reporting is a large priority for my work place
6. There are multidisciplinary teams (different types of professionals and specialties that can work together) in my work environment that make it easier to identify and assist victims of trafficking with their individual needs

Intention

Response categories: *Not at all true (1), A little true (2), Pretty much true (3), Very much true (4)*

Prompt: The following questions ask about your intentions to identify and report. Select the answer that best describes how you feel about each statement.

Contains 3 items; designed for this study: items 1 through 3

1. If you're absolutely certain a patient is a victim of sex trafficking, how likely are you to report it?
2. If you think there is a 50/50 chance a patient is a victim of sex trafficking, how likely are you to report it?
3. If you are absolutely unsure if a patient is a victim of sex trafficking, how likely are you to report it?

Reporting

Response categories: *Not at all true (1), A little true (2), Pretty much true (3), Very much true (4)*

Prompt: If you are absolutely certain that a juvenile patient is a sex trafficking victim, how likely are you to report it to the following organizations?

Contains 4 items; designed for this study: items 1 and 3

1. Child Protective Services
2. Law enforcement
3. Local organization for victims of violence
4. National Human Trafficking Hotline

Demographic and Recruitment Variables

1. Are you:
    a. Male
    b. Female

2. What is your age? (Will write in age)

3. How many years have you been in practice? (Will write in number)

4. What is your occupation?
    a. Physician
    b. Physician's Assistant
    c. Nurse Practitioner
    d. Registered Nurse
    e. LPN
    f. Social Worker
    g. Other (Write in occupation)

5. What is your specialty?
    a. Family practice
    b. Pediatrics
    c. Obstetrics/Gynecology
    d. Emergency/Trauma
    e. Internal
    f. Generalized
    g. Other (Write in specialty)

6. Practice Setting
    a. Private Practice
    b. Community Health Center
    c. Hospital Inpatient
    d. Emergency Department
    e. Urgent Care
    f. Health Department
    g. Other (Write in setting)

7. How would you describe the area in which you practice?
    a. Large city (population over 250,000)
    b. Mid-size city (population under 250,000)
    c. Suburb of a large city
    d. Suburb of a mid-size city
    e. Town (not a major metropolitan area)
    f. Rural area

Previous Experiences
Response categories: *Yes, No*
Prompt: Please answer the following by selecting Yes or No for each statement based on your previous experiences.

Contains 4 items; designed for this study: items 1 through 4

1. I have identified at least one victim of sex trafficking throughout my career
2. I have reported at least one victim of sex trafficking throughout my career
3. I have received training in working with victims of sex trafficking that I voluntarily participated in
4. I have received training in working with victims of sex trafficking that was required by my work environment

APPENDIX B: RECRUITMENT MATERIALS

Email:

My name is Laura Colman, a doctoral student at University of Georgia. I am currently working on my dissertation and beginning data collection. I am studying the role that healthcare providers play in the identification and reporting of sex trafficking victims within clinical settings. Included in this email is the link to a survey that I am using for data collection. The survey is anonymous and confidential. The only information that I receive is the survey results; I cannot see who completed the survey or any identifying information. The survey should only take about 10 minutes to complete. If you could complete the survey, I would greatly appreciate it! Please do not hesitate to contact me with any questions or concerns. I really appreciate you taking the time to complete this survey and being a part of my dissertation research!

Survey Link to Anonymous, Confidential Survey for Healthcare Providers:
<Will link to consent form>

THANK YOU FOR PARTICIPATING!

APPENDIX C: PHASE 1 INTERVIEW CONSENT

Identification and Reporting of Domestic Minor Sex Trafficking:
The Role of Healthcare Workers

The goal of this study is to understand what influences the identification and reporting of domestic minor sex trafficking victims among healthcare providers. Results will help us develop training programs to increase services for this population. If you are a licensed and practicing social worker, nurse (LPN, RN, NP), physician assistant, or physician working in the United States, we invite you to participate in this research study. You do not have to have experience working with victims of human trafficking to participate.

If you decide to participate:

- You will be asked to complete a 30-minute interview. The interview will be about your experiences and opinions with domestic minor sex trafficking and the role that healthcare providers play in identifying victims.
- At the beginning of the interview, you can choose a pseudonym if you do not want your real name (first name only) in the transcript of the interview. Only the research team will have access to the information you provide, and none of the information will be shared unless required by law.
- With your permission, the interview will be audio recorded. The recording will be destroyed after transcribing the data. If you so choose, you can meet with Laura after the interview is transcribed to review the transcript and correct any information.
- Foreseeable risks are minimal. Some people may experience discomfort with the subject matter. Remember that you can refuse to participate, skip any questions, finish the interview at any time, or request that all of the interview data be destroyed. Your participation is voluntary.

The study is conducted by Laura Colman, MPH, CHES (740-258-2291; lcolman@uga.edu) under the direction of Pamela Orpinas, PhD, (porpinas@uga.edu) at the Department of Health Promotion and Behavior, University of Georgia. Please contact them if you have any questions. Additional questions or problems regarding your rights as a research participant should be addressed to: The Chairperson, Institutional Review Board, University of Georgia, 629 Boyd Graduate Studies Research Center, Athens, Georgia 30602; Email address: IRB@uga.edu.

By signing this form, I acknowledge that:

- I am a licensed healthcare provider (social worker, LPN, RN, BSN, NP, PA, DO, or MD) working in the United States.
- I have read the above information, and I agree to participate in this survey.
- I have received a copy of this consent form.

Participant signature ________________________________ Date _______________
Researcher signature ________________________________ Date _______________

APPENDIX D: PHASE 2 SURVEY CONSENT

Identification and Reporting of Domestic Minor Sex Trafficking:
The Role of Healthcare Workers

The goal of this study is to understand what influences the identification and reporting of domestic minor sex trafficking victims among healthcare providers. Results will help us develop training programs to increase services for this population. If you are a licensed and practicing social worker, nurse (LPN, RN, BSN), nurse practitioner, physician's assistant, or physician working in the United States, we invite you to participate in this research study. You do not have to have experience working with victims of human trafficking to participate.

If you decide to participate:

- You will complete a short survey (about 10-15 minutes). The survey contains questions about your experience with trafficking victims, as well as your perception of factors that facilitate or difficult identification and reporting. You will not need to disclose your name or other identifying information.
- Foreseeable risks are minimal. Some people may experience discomfort with the subject matter. Remember that you can refuse to participate, skip any questions, or finish the survey at any time; your participation is voluntary. Because you are completing the survey online, there is a limit to the confidentiality that can be guaranteed due to the technology itself. However, this risk is minimal as no personally identifiable information is requested.

The study is conducted by Laura Colman, MPH, CHES (740-258-2291; lcolman@uga.edu) under the direction of Pamela Orpinas, PhD, (porpinas@uga.edu) at the Department of Health Promotion and Behavior, University of Georgia. Please contact them if you have any questions. Additional questions or problems regarding your rights as a research participant should be addressed to: The Chairperson, Institutional Review Board, University of Georgia, 629 Boyd Graduate Studies Research Center, Athens, Georgia 30602; Email address: IRB@uga.edu.

By clicking the SUBMIT button, I acknowledge that:

- I am a licensed healthcare provider (social worker, LPN, RN, BSN, NP, PA, DO, or MD) working in the United States.
- I have read the above information, and I agree to participate in this survey.
- I can print a copy of this consent form.

□ SUBMIT (You will start the survey)

□ DO NOT SUBMIT (This will end the survey)

APPENDIX E: PHASE 1 INTERVIEW GUIDE

Interviewer's introduction

Hi, my name is Laura Colman; I am a doctoral student at University of Georgia. As a part of my research, I am interested in learning about the views and opinions of healthcare providers regarding the topic of domestic minor trafficking. I am exploring how healthcare providers view the topic, as well as their role in assisting victims of sex trafficking in a clinical setting. Even if you have not had experience working with these victims, I am interested in hearing your point of view on the topic. If some of these questions are uncomfortable, we can stop the interview at any time, or move on to a different question. Do you have any questions for me before we start?

Background questions

- What is your name?
- What is your occupation?
- What is your work setting? For example, private practice, hospital, etc.
- Can you describe the city or location in which you work?
- How many years have you been in practice?

Domestic Minor Sex Trafficking Questions

- What have you heard about sex trafficking of American minors?
  - Where do you hear about this type of information?
- Have you ever treated a patient who you suspected was a victim of sex trafficking?
  - If yes, what made you suspect this patient was a victim?
- What do you think are some clinical indicators that a child is a victim of sex trafficking?
- If you suspected that a child is being sex trafficking, what would you do?
  - How would you report it?
- What are some personal barriers that exist for you that you think would keep you from identifying and reporting a victim of sex trafficking?
- What systems, programs, or protocols are in place in your office/hospital/center that facilitate you in assisting victims of sex trafficking and other forms of violence?
- What are some problems in your work environment that inhibit you from identifying and reporting victims of sex trafficking?
- Have you received training specific to working with this population?
  - Would you participate in training if it was provided through your work place?
- Do you think it is important for healthcare workers to be educated on how to identify and appropriately work with these patients?
  - If so, why is the healthcare worker's role here important?

- What should be changed in the healthcare system in order to improve identification and reporting practices for sex trafficking victims?

Closing Remarks
Thank you so much for doing this interview. If I have any more questions, would it be alright to contact you? Please don't hesitate to contact me if you have any questions.