Title

Just Ask: Healthcare Provider Screening for Intimate Partner Violence and Human Trafficking Victims in Southern California

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Author

Bloom, Brittnie Elizabeth

Publication Date

2014

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UNIVERSITY OF CALIFORNIA

Los Angeles

Just Ask: Healthcare Provider Screening for Intimate Partner Violence and Human Trafficking

Victims in Southern California

A thesis submitted in partial satisfaction

of the requirements for the degree Master of Science

in Public Health

by

Brittnie Elizabeth Bloom

2014

ABSTRACT OF THE THESIS

Just Ask: Survey of Healthcare Provider Screening Procedures for Intimate Partner Violence

and Human Trafficking Victims in Southern California

by

Brittnie Elizabeth Bloom

Master of Science in Public Health

University of California, Los Angeles, 2014

Professor Chandra L. Ford, Chair

At least one in four U.S. women experiences intimate partner violence (IPV) in her lifetime regardless of personal demographic factors. Every year, 5.3 million IPV victimizations occur among women aged 18 and older, many which require medical attention. Additionally, the U.S. is a main source, destination, and transportation hub for individuals forced into human trafficking, especially women and girls. Healthcare providers could be critical in the process of screening and identifying IPV and human trafficking victims, but they may experience personal and institutionalized barriers that prevent them from doing so. A cross-sectional study was conducted on a convenience sample of healthcare providers in California (n = 148), which assessed whether healthcare providers' demographics, training, knowledge, patient characteristics, and practice setting were associated with frequency of screening, quality of screening question, and identifying victims. Findings indicate that healthcare provider characteristics are not predictive of how often a provider screens for IPV or how many women are identified as victims; however, serving low-income patients and receiving recent training are. Lastly, the specificity and depth of a screening question is unimportant; simply asking any "screening" question may open conversations in ways that enable intervention for IPV victims.

The thesis of Brittnie Elizabeth Bloom is approved.

Jessica D. Gipson

Ninez A. Ponce

Paula Tavrow

Chandra L. Ford, Committee Chair

University of California, Los Angeles

2014

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Acronyms

Intimate Partner Violence (IPV)
Domestic Violence (DV)
Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ)
The Center for Disease Control and Prevention (CDC)
United States Department of Justice (US DOJ)
World Health Organization (WHO)
National Human Trafficking Resource Center (NHTRC)
Nurse Practitioner (NP)
Physician's Assistant (PA)
University of California, Los Angeles (UCLA)

ACKNOWLEDGEMENTS

LITERATURE REVIEW

This thesis examines relationships between intimate partner violence (IPV), healthcare provider characteristics, and the factors associated with providers screening female patients for intimate partner violence (IPV) and human trafficking. In this literature review, I summarize the existing public health literature on the issues of IPV and, to a lesser extent, human trafficking to explore their assessments within healthcare settings. The section is organized as follows. First, I briefly highlight the inconsistent terminology used to name these social exposures and clarify the terms this thesis uses to discuss them. I then review the epidemiology of IPV and human trafficking in the United States among high risk and other populations. Next, I discuss the similarities between IPV and human trafficking. Though, as I show, consistent data on the true prevalence of IPV and human trafficking are lacking, I describe what is currently known about current IPV screening recommendations and practices, IPV training among healthcare providers, and barriers to IPV screening in healthcare settings.

Inconsistent IPV and Human Trafficking Terminology

Within the field of public health, IPV and other forms of violence fall within the scope of the sub-field of injury prevention. Within and between fields, however, researchers and practitioners use a variety of terms and frameworks to discuss IPV. Clarifying the differences between these terms is essential to creating standard, widely accepted definitions that can enable incidence and prevalence data to be collected accurately across time, place and populations.

National and international organizations have taken up the issues of IPV and human trafficking, but there are major inconsistencies in how the problems are conceptualized and how estimates of them are calculated. Researchers at the Centers for Disease Control and Prevention (CDC) have attempted to delineate the reasons why IPV has been so difficult to

measure. According to CDC, a consistent definition is needed in order to accurately monitor the incidence of IPV and assess trends across populations and settings [1]. The CDC maintains that accurate estimates of IPV are hampered by the: 1) lack of consensus about terminology (e.g. some healthcare providers, researchers, and organizations have not agreed on a definition; this is problematic when some definitions only consider physical injury as IPV, while others recognize that behaviors designed to control and intimidate are also IPV); 2) variations in survey methodology (e.g. sampling strategies among different surveys); 3) gaps in data collection (e.g. there is no national system in existence for collecting data on IPV); 4) different time frames used in the questions (e.g. asking about lifetime victimization verses annual victimization); 5) victims' reluctance to report victimization (e.g. victims themselves do not want to report IPV for various reasons); 6) the repetitive nature of IPV (e.g. failure to indicate if data captures number of IPV incidents or the number of victims); 7) limited populations (e.g. studies focusing on specific populations instead of IPV among overall population); and 8) survey limitations (e.g. self-report data, which may not accurately reflect the magnitude of the problem) [2].

In recent years, the World Health Organization's (WHO's) Multi-Country Study (WHO MCS) developed operational definitions for IPV to enable the healthcare field as a whole to compare rates of IPV and sexual violence data across time and settings [3]. A criticism noted in the literature is that the definition does not include male victims of IPV or specify data for LGBTQ persons [3]. In addition to the WHO MCS, there are multiple surveys in the U.S. and elsewhere that have attempted to determine the prevalence of IPV and sexual violence, such as the National Intimate Partner and Sexual Violence Survey (NISVS) [4], Demographic and Health Surveys (DHS) [5], and the Reproductive Health Surveys (RHS) [6]. Each of these surveys provide country specific data on violence against women, but the data from these sources are often inconsistent and may underreport violence against women in cross-national comparisons [3, 7].

This thesis will use the term IPV throughout to indicate the many kinds of abuse that can happen between intimate partners. IPV refers to violence between partners in a romantic relationship; however, it is often used interchangeably with other, more specific, types of abuse such as child abuse, elder abuse, spousal abuse, sexual abuse, dating violence, etc. For example, the WHO integrates IPV with sexual violence and domestic violence. Table 1 (Appendix A) provides a brief summary of terms used interchangeably in the field to refer to what I will be calling IPV. These definitions are often used interchangeably by entities such as the CDC and the U.S. Department of Justice (US DOJ): the terms "IPV," "domestic violence," "gender-based violence," and "violence against women." The term "human trafficking" is increasingly used alongside "gender-based violence"; healthcare organizations, such as the CDC and US DOJ, have added it to their roster of issues surrounding IPV and the other terms listed above. Individuals who are considered most vulnerable may differ depending on the organization and the definition an organization uses, as shown in Table 1 and discussed later.

Epidemiology of IPV

When the "behavior of another person is controlled through humiliation, intimidation, fear and/or intentional physical, emotional, social, financial, or sexual injury," they are considered a victim of IPV [8]. At least one in four U.S. women experiences IPV regardless of socioeconomic class, occupation, education level, religion, and culture [8-11]. IPV occurs among women of all ages; however, because IPV refers to abuse that occurs between intimate partners, women of reproductive age or those who have begun dating are often targeted as the population of interest and intervention. According to the US DOJ, the estimates may be higher than previously thought, with 21-55% of women in the U.S. having experienced IPV in their lifetime [12]. The National Coalition Against Domestic Violence (NCADV) estimates that about 1.3 million women are victims of physical assault by an intimate partner every year, 85% of IPV

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victims are women, and women who are between the ages of 20 and 24 are at highest risk of experiencing IPV [11]. However, data collected through the National Violence Against Women Survey estimates that there are 5.3 million IPV victimizations among women aged 18 and older every year, with more than 550,000 of those victimizations resulting in required medical attention [2]. These estimates may differ in part due to the wide range of experiences which are classified as IPV, including but not limited to physical violence, emotional abuse, sexual assault, social isolation, etc. (Table 1).

The true economic costs of IPV in the United States are unknown, but past estimations of the cost have varied from $1.7 billion to $10 billion dollars a year [2]. In 2003, the CDC estimated that untreated and undocumented cases of IPV cost the U.S. healthcare system approximately 5.8 billion dollars every year, as victims continuously return to their healthcare provider with health issues directly related to IPV [2, 8]. The CDC estimates that approximately $4.1 billion dollars are allocated for medical and mental health services as a direct result of IPV [2]. Despite the high rates of IPV and its large economic cost, healthcare and organizational response to this issue has been criticized for being "slow and inconsistent" [13].

Victims visit their healthcare provider with injuries and complaints that are not documented as directly related to IPV [8-9]. This may be because the IPV symptoms are unrecognized by the provider and thus the patient is only treated for the injuries or complaints she openly discusses with her provider [9]. These injuries and complaints include, but are not limited to, headaches, inability to sleep, anxiety, suicidal ideation, depression, post-traumatic stress disorder, eating disorders, substance abuse, gastrointestinal disorders, bladder and kidney infections, irritable bowel syndrome, asthma, pelvic inflammatory disease, pregnancy complications, sexually transmitted infections, etc. [8, 14-21].

This means healthcare professionals are treating secondary ailments, and will continue to do so, until the root cause of the issue (IPV) is identified. Most victims of IPV are not one-time

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or first-time victims; moreover, previous abuse predicts risk of experiencing abuse in the future [9, 22-24]. According to CDC data from 2010, only 21% of women who have been IPV victims at some point in their lives disclosed their victimization to a doctor or nurse, though not necessarily at the time she was experiencing IPV [25]. Early detection of IPV victimization could reduce disease, injury, and death related to abuse [19]. Many victims of IPV do not know their rights or options, and are unaware of how to find existing and relevant resources to manage or escape from their situation (i.e. legal services, counseling, temporary food and housing assistance, childcare, education, healthcare) [26]. Ultimately, addressing barriers to accessing healthcare and utilizing victim-services will improve access, identification, and referral networks, which are needed improvements to the healthcare system.

Epidemiology of Human Trafficking

Human trafficking, as defined by the United Nations Office on Drugs and Crime (UNODOC), is the "recruitment, transportation, transfer, harboring, or receipt of persons, by use of force", threats to use force, or other forms of coercion, abduction, fraud, deception, the abuse of power, abuse of a position of vulnerability, or the giving or receiving of payments or benefits to "achieve the consent of a person having control over another person, for the purpose of exploitation" [27]. The U.S. is a main source, destination, and transportation hub for men, women, and children who are forced into human trafficking. Human trafficking activities include forced labor, debt bondage, sex trafficking, etc. [28]. People are recruited and forced to work in a wide array of settings, including but not limited to, street prostitution, massage parlors, brothels, agriculture, janitorial services, hotel services, hospitality industries, construction, and elder care [28]. The U.S. State Department indicates that an increased vulnerability for trafficking victimization may occur via the use of visa programs for legally documented students and temporary workers [28]. Many children and youth who become victims of human trafficking

are runaways or homeless [28]. Data from 10 years ago estimated that approximately 1.6 million runaway youth were at risk or in danger of exploitation and trafficking within the U.S. [29].

Many entities within the U.S., such as the Department of Health and Human Services, the Department of Homeland Security, and the US DOJ, have all created their own anti-trafficking programs to help end trafficking in the U.S. Because human trafficking is a deeply personal issue that many people do not often volunteer information about, it is difficult to obtain precise or reliable measures of its prevalence [30]. Healthcare providers surveyed from around the world by Konstantopoulos and colleagues (2013) express concern that the current estimates are undercounted [30]. The International Labor Organization estimates that there are about 21 million victims of human trafficking within the world at any given time [30]. It is estimated that there are between 14,500 and 17,500 human trafficking victims who are trafficked into the U.S. every year [31]. Additionally, an estimated 200,000 youth are at risk for sex trafficking every year (e.g. are runaways or have experienced trauma or abuse in the home) [32].

The FBI estimates that human traffickers make approximately $9.5 billion dollars a year in profits from this trade; it is unclear if these profit margins are only within the U.S. or include international trafficking [33]. Other institutions, such as the Organisation for Economic Co-Operation and Development (OECD), estimate higher global human trafficking profits at $32 billion dollars a year and consider it the most lucrative crime in the world next to drug trafficking and the illegal arms industry [33-34]. These profit margins exist because there is demand. According to The Polaris Project, a lead organization in preventing human trafficking and slavery, this market is supported by people who purchase commercial sex and, in so doing, contribute to the exploitation and trafficking of children and adults to meet those demands [35]. Similarly, people who are willing to purchase goods and services from industries that depend on forced labor create profit and incentive for traffickers to continue to place human bodies on the

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market for purchase [35]. These individuals include pimps, intimate partners, family members, gangs, agricultural growers, employers of domestic servants, etc. [35].

According to the U.S. Department of State's 2007 Trafficking Person's Report, 80% of transnational victims are women and girls. According to the US DOJ, 70% of female victims are trafficked into the commercial sex industry and 30% are trafficked into forced labor [28-29]. The federal government recently initiated strategies to inform and educate the public about human trafficking, and it established a national hotline for educational and assistance purposes. In 2010, the hotline received over 11,000 phone calls, a 4,000 call increase from 2009 [28]. The National Human Trafficking Resource Center (NHTRC), since its creation in 2007, has received more than 72,000 interactions with the public via phone calls, online tips, and emails [36]. The NHTRC experienced a 259% increase in calls between 2008 and 2012 [36]. This increase may be caused by a mounting awareness of both the hotline and human trafficking; it also may be due to the increasing globalization of human trafficking (e.g. prevalence is increasing). From this data, the NHTRC found that 73% of survivors spoke English, 19% spoke Spanish, and 2% spoke Tagalog [36].

Consistent and reliable estimates of human trafficking in the U.S. are available at neither the state nor the federal level. Some estimates have been published, but human trafficking prevention organizations suggest the numbers be used only as baseline estimates due to the data collection limitations [29, 33]. With that being said, the Polaris Project's collaboration with the NHTRC indicates that California has the highest number of reported human trafficking incidents out of all 50 states [36]. In the state of California, between December 1, 2005 and March 12, 2007, 559 individuals were identified as human trafficking victims by the five California Task Forces located in San Diego, Los Angeles, San Francisco, Oakland, and San Jose [29, 33].

Similarities between IPV and Human Trafficking

Because of their similarities, human trafficking is increasingly being addressed in concert with issues of domestic violence, IPV, and gender-based violence. Terms such as "violence against women" and "gender-based violence" are broad enough to encompass both issues (Table 1) [37] as IPV and human trafficking share many core characteristics and co-occur along a "continuum of violence" [38-39]. Some organizations, such as the Vital Voices Global Partnership, now combat IPV and human trafficking simultaneously because of their many similarities [37]. For instance, the "power and control" wheel that is often used in IPV intervention or therapy-type settings (Figure 1, Appendix B) is currently being adapted to explain elements of "power and control" in human trafficking (Figure 2, Appendix B) [39-41].

The IPV power and control wheel includes eight sections to identify specific ways perpetrators use power and control[*] against an intimate partner: 1) using coercion and threats (e.g. threatening to leave or commit suicide); 2) using intimidation (e.g. displaying weapons and destroying property); 3) using emotional abuse (e.g. name calling and humiliation); 4) using isolation (e.g. controlling who a partner sees and limiting interactions outside of the home); 5) minimizing, denying, and blaming (e.g. saying the partner "caused" the abusive behavior); 6) using children (e.g. threatening to take children away; 7) using privilege (e.g. treating partner like a servant); and 8) using economic abuse (e.g. preventing partner from working or having access to money). The human trafficking power and control wheel comprises most of the same sections; however, it excludes the section on using children and it illustrates each form of control using trafficking-specific examples (e.g. for coercion and threats, the example is threatening to harm family members or the victim). The human trafficking wheel also includes sections on sexual abuse (e.g. forcing victim to have sex with the perpetrator or with strangers)

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[*] This power and control wheel assumes the perpetrator is male and the victim is female.

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and physical abuse (e.g. perpetrator hits, slaps, kicks, burns, etc.), both main components of IPV.

As indicated above and in the literature, both IPV and human trafficking are tied to issues of power and control [42]. They deprive victims of their most basic human rights. Although anyone can be a victim, most are women victimized by someone they know. They are often victimized multiple times and display some of the same symptoms after victimization as they do during the victimization. One reason for this may be that victims often are unaware of the resources, assistance, and help available to them [43]. Healthcare providers, such as physicians and nurses, could be critical in the process of identifying IPV and, increasingly, human trafficking victims, providing them with resources, and advocating for them [44].

Diverse Populations Affected by IPV

Diverse populations are affected by IPV. It affects men, but does so at much lower rates than those for women [9, 12, 16, 45]. In 2007, IPV is estimated to have caused 2,340 deaths in the United States: 1,640 among females and 700 among males [46]. Some groups of people who are seen, screened, or treated for IPV more often for various reasons, including healthcare provider biases, which will be discussed in following sections.

Male victims of IPV include men who are abused by their female partners [47] and men who are in relationships with men [48]. Other lesbian, gay, bisexual, transgender, queer (LGBTQ) persons [49-50] may also experience IPV or human trafficking, for example female victims of same-sex IPV [51]. Prevention and intervention efforts for this population are poorly understood [52]. Rates of IPV vary across other diverse groups. According to the American College of Obstetricians and Gynecologists (ACOG), rates of IPV are increasing among adolescent girls [46]. In a 2012 report, the ACOG found that one in 10 female high school students in the U.S. reported experiencing physical violence from an intimate partner in the

previous year [46, 53]. Of those who report being sexually active, 1 in 5 report dating violence [46, 53]. Individuals who are aged 65 and older are also considered a subgroup of individuals who are at an increased risk of experiencing IPV. According to the National Center on Elder Abuse (1998), approximately 66% of abuse among older women is perpetrated by an intimate partner or adult child [46, 54]. Additionally, immigrant women and women with disabilities are populations to consider when screening for IPV and violence in the home [46]. The CDC has released a list of risk factors for IPV, which includes individuals who are low income, have low academic achievement, maintain strict gender roles, and live in communities with high poverty rates [55]. Women and girls are most often documented as victims of IPV, and they are the focus of this study; however, it is important to acknowledge the diversity of persons affected by IPV.

Screening Recommendations

In public health, screening is considered a form of secondary prevention. Its purpose is to reduce the progression of disease through early detection and detect disease among asymptomatic individuals [56]. "Screening" is defined as regularly testing asymptomatic patients to identify those requiring special intervention [57], or testing for an "occult disease or a precursor state" [58-59]. In other words, "screening for disease is [used] to discover those among the apparently well who are in fact suffering" [60]. Thus, screening helps to identify individuals with a particular disease or ailment in hopes of reducing mortality and morbidity [59].

In 1968 the WHO published a list of 10 criteria for evaluating screening recommendations for any ailment or disease [60]. For a condition to be considered appropriate for screening, 1) it must be an important health problem; 2) the natural history of the disease must be well understood; 3) effective treatment must be available; 4) there must be an available test allowing the disease to be recognized in its pre-clinical phase (i.e. there should be a

detectable early stage); 5) treatment at an early stage should benefit more than treatment at a later stage; 6) the screening test should be acceptable; 7) intervals for repeating the test should be determined; 8) the costs should be balanced against the benefits; 9) the psychological and physical risks should be less than the benefits; and 10) screening procedures must make better use of medical resources than current or competing practices [59-60].

Successful screening programs are frequently directed at specific diseases, such as cancer or infectious diseases with long latency periods [59]. It is often suggested the disease have a long detectable pre-clinical phase: the point in time where a condition can be detected [58-59]. Screening tests must be inexpensive, suitable for mass use, and have low risk [59]. Additionally, the condition of interest should have high sensitivity (i.e. minimize false negatives) and have high specificity (i.e. minimize false positives) [59].

Primary and secondary prevention strategies are often the goal of healthcare providers, because they limit the incidence and prevalence of disease (primary prevention), reduce the progression of disease (secondary prevention), and reduce the need for treatment of physical injury or mental health morbidities (tertiary prevention) [56]. Some healthcare providers prefer the word "screening" to be replaced with "assessment," as the concept of IPV as a disease does not always fit well with "screening" [61]. For the purposes of this study, the word "screening" will be used because it is the dominant term used in the field when attempting to identify asymptomatic individuals.

There are many types of screening protocols and procedures. Unlike universal screening, which entails a standardized question or procedure for all women, there is also selective screening, where only high-risk groups are screened, routine enquiry, where all women are screened but the exact question and / or the mode of questioning may change depending on the provider's preference or patient's situation, and case finding, which only requires screening if indicators of the disease are present [20].

Universal screening for IPV (i.e. screening all women) in healthcare settings has been promoted for many years by the American Medical Association (AMA), the Joint Commission on Accreditations of Healthcare Organizations, among other organizations [62]. Since 1984, others have discouraged it [62]. Some providers and organizations are anti-universal screening because they believe the evidence is insufficient to verify whether or not screening truly leads to improved health outcomes for women [63]; because declines in abuse have not been indicated as a direct result of screening [64]; or because they feel screening should only be recommended when the healthcare providers have had education about IPV and know available resources for their patients, if they are in fact victims of IPV [65].

Some organizations, such as the U.S. Preventative Services Task Force (USPSTF), have changed their stance on screening recommendations [66]. In 2004, the USPSTF declared they could neither promote or discourage universal screening for IPV; however, in 2012 the USPSTF joined many other organizations, such as the Department of Health, the AMA, The Institute of Medicine, the ACOG, the American Academy of Pediatrics, the American College of Emergency Physicians, and the CDC, to advocate for routine and universal IPV screening [9, 13, 67-70]. The specific guidelines and recommendations differ for each of these organizations, but all agree on universal screening [71]. The USPSTF now support universal screening in healthcare settings because they believe it can lead to identifying women who are at risk, promote interventions that reduce violence against women, and improve overall health outcomes [70]. Some healthcare professions also believe that routine and universal screening can help avoid stigma and prejudices in screening procedures, as all women will be screened equally [9]. Universal screening entails "simple targeted questions that ideally identify most persons experiencing abuse" [16].

Screening for IPV has not been universally integrated into healthcare practices, but many organizations and hospitals have begun to implement the screening process into their

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practice [8, 23]. The non-universality of screening for IPV may be due to the differing definitions of IPV discussed earlier, and the differences in the populations and settings where screening could potentially take place (e.g. emergency departments, obstetrics/gynecology, primary care, pediatrics, etc.) [14, 16]. The following section will address the current laws and standards in the state of California.

Current Screening Practices

Many healthcare providers, including general practitioners, nurse practitioners, registered nurses, emergency room staff, obstetrics and gynecology (OGBYN) practitioners, family planning and prenatal care staff, family practitioners, and others come into contact with women of reproductive age (15-44) and adult women (20-59 years old) [72]. These healthcare providers are in a good position to screen women who may be at risk for IPV or are currently experiencing IPV [8-9, 18-19, 68, 73]. The Joint Commission on the Accreditation of Healthcare Organizations has a longstanding requirement that emergency departments 1) have a plan to educate and/or train their employees about IPV, 2) have current policies and procedures about IPV, and 3) provide documentation that screening and assessment for IPV has taken place as a standard of practice [8].

Additionally, the California State Screening Law (Health & Safety Code sections 1233.5 and 1259.5) specifies that 1) doctors, nurses, and mental health practitioners who apply for California professional licenses, have documented training in the detection and treatment of IPV, and 2) licensed clinics and hospitals must have written policies and procedures to a) use routine screening to identify IPV victims, b) document injuries and illnesses related to IPV, c) refer IPV victims to crisis intervention services, d) designate staff to implement policies, and e) have a staff that is educated on the identification and caring of IPV victims [74]. Regardless of

these requirements, the main problem is that the requirements are not implemented or enforced consistently or uniformly within emergency departments or other healthcare settings [8, 23].

The rates at which healthcare providers routinely screen patients for IPV vary from 1.5% [19], 18% [68], to 79% [75]. These percentages are quite low considering most women, both victims and non-victims, report high levels of comfort receiving IPV screening [9, 16, 63, 76-78]. An increasing number of studies have shown that routine screening generally increases patient disclosure rates up to 80% [79]. Routine screening also helps identify IPV among any patients who are unlikely to disclose IPV unless asked directly [80]. Research has shown that just asking a specific, non-general question in a supportive and non-judgmental environment can identify up to 65% of patients who have been abused [13, 81].

The questions providers use to ask about IPV can influence their detection of it. Table 2 lists selected screening questions recommended for use by healthcare providers. A study conducted by Morrison and colleagues (2000) found that adding a single screening question to healthcare provider procedures increased IPV detection rates from 0.4% to 7.5% during the study period [82]. Additionally, Freund and colleagues (1996) found that adding a self-administered question such as: "At any time has a partner ever hit you, kicked you, or otherwise physically hurt you?" increased IPV identification from 0% to 11.6% [83]. This very specific question, however, only captures IPV that occurs in the form of physical violence.

IPV screening tools are available for use by providers (e.g. HARKS approach, CAADA risk-identification checklist; Partner Violence Screen; StaT; HITS; WAST; RADAR; Abuse Assessment Screen; Danger Assessment Tool, among others), but often are not used because they have not previously been evaluated [9, 14, 16, 61, 84-86]. In 2007, the CDC published information regarding existing IPV instruments in the U.S., but it did not address the strength or the psychometric properties associated with each screening tool [87]. Rabin and colleagues (2009), therefore, conducted an analysis of IPV screening tools to examine the sensitivity,

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specificity, internal reliability, test-retest reliability, concurrent validity, and other psychometric properties of the HITS, WAST, PVS, and AAS, four of the most widely used instruments [88]. They concluded that no single IPV screening tool had well-established psychometric properties, and that additional evaluation is needed of these and other screening tools that may be in use. It is important to note that most of these screening tools are only tested among female victims. Only two studies to date have tested IPV screening tools with male populations [89-90]. We know of no studies that have examined their use among LGBTQ populations.

Measures such as the Domestic Violence Healthcare Provider Survey Scales (DVHPSS) are also available to assess the readiness of healthcare providers to screen for IPV. The DVHPSS measures readiness to screen in terms of perceived knowledge, efficacy in screening, conflicting professional roles, availability of social support networks for referral services, patient safety challenges, and general attitudes toward screening [91]. This instrument is undergoing pilot testing and validation procedures in the US and abroad in locations such as Sub-Saharan Africa and Sweden [91].

IPV Training among Healthcare Providers

IPV training may be essential for providers to identify cases of IPV; however the percentages of healthcare providers who have received training on IPV vary widely. In a study conducted in Arizona by Williamson and colleagues (2004), of the surveyed healthcare providers (n = 2,244), 34% had received training about IPV during medical school, and 23% during residency [18]. Other healthcare providers reported receiving "training" through their own self-directed reading [18]. This means many practitioners may have gone years without receiving professional training for such a pertinent health issue and others have never undergone professional training at all. Another study, focused on California primary care physicians in 1999, indicated that 22% of respondents had received training on IPV in the last 3

years [75]. Similarly, Sugg et al. (1999) found that amongst the clinicians and nurses in Washington who participated in their study (n = 270), only 22% had attended one or more educational programs focused on IPV in the past year [92]. A more recent study with a national sample (n = 2,000), which focused on pediatricians and family practitioners, found that 37% of respondents reported never receiving training about IPV [93].

The quality of IPV training is another concern that is considered in the literature. Studies have found that over 50% of respondents indicate that their training on IPV was "poor" or "fair," another indication that adequate and regular training for healthcare providers is needed [18]. Additionally, when asked, over 50% of healthcare providers reported that they "rarely" or "never" screen their patients for IPV [18]. In a study that focused on how nurses were trained for identifying and treating IPV, 44% indicated that their training was not adequate to recognize the signs or symptoms of IPV [13]. When effective and multi-level training backed by theory is put into place, studies show that healthcare providers can improve screening habits and increase identification of IPV victims [94].

Many studies have also indicated that training and education is not enough to implement or maintain consistent IPV screening or referral procedures [95-96]. Minsky-Kelly (2005) found that after multiple departments in a hospital received standardized IPV training that the post-training screening rates differed by department [73]. Findings such as this have led researchers to investigate the environmental and organizational factors that may prevent or encourage certain departments or individuals to screen, regardless of having received training [73].

Barriers to IPV Screening among Healthcare Providers

The literature on healthcare practice shows that there are barriers to IPV screening in healthcare. Potential barriers include the environment (e.g. institutional support and supervision) and the location (e.g., the physical space that a provider provides services) in which a provider

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works [95, 97]. For instance, the setting may lack the privacy necessary for a comprehensive assessment [98-100]. Additional barriers include inadequate administrative or management support (i.e. no set protocol or procedure for screening) [100-101], not having appropriate or adequate referral sources for their patients [18, 23, 68, 98, 100], the immediate problem may take precedence over screening [73], lack of education, lack of knowledge, and/or not knowing what question(s) to ask their patients [8, 14, 17, 68, 100]. Other barriers include frustration on the part of the healthcare providers: they indicate frustration if a woman has disclosed abuse and then refuses help, or after help is offered the woman returns to her abuser [80, 102].

Chamberlain and Perham-Hester (2002) found that screening was correlated with 1) whether a physician believed that IPV was an issue in the population they served, and 2) whether a physician believed they had a responsibility to screen [71, 97]. They also found that healthcare providers were more likely to screen for IPV with a direct and specific question if a woman had a physical injury indicating abuse [97]. Some healthcare providers simply do not feel that IPV is an issue in the patients they serve: Sugg et al. (1999) found that 50% of clinicians and 70% of nurses in their study believed that the prevalence of IPV among their patients was 1% or less [92].

Substantial research has been conducted about healthcare providers' knowledge, attitudes, and beliefs about IPV. When asked why providers are hesitant to screen their patients for IPV regularly or do not screen at all, providers have discussed fear of offending [8, 16-17, 19, 68-69, 100, 103-105], a sense of powerlessness to "fix" the problem [75, 102, 106], time constraints [8-9, 14, 18-19, 23, 68, 85, 99, 101, 105], lack of training [13, 16, 107], a close identification with the patient (i.e. the healthcare provider may be experiencing IPV themselves or have experienced it in the past) [19, 73, 80] or discomfort [18, 68, 100-101].

Social and cultural barriers (social norms regarding gender, tolerance of violence), and personal barriers (prejudice attitudes regarding individuals of various class, race, age, sexual

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orientation, and / or sex) may also play a role in how often or thoroughly a healthcare provider screens their patients [14, 19, 108-109]. Many healthcare providers believe screening is part of their role, but may hold victim-blaming attitudes and / or believe they have insufficient resources to assist their patients [14, 17-19, 23, 68, 110]. Sprague and colleagues, in their review of the literature, found these barriers to be consistent across all provider types [68].

Despite these barriers, institutional support and education have been shown to decrease barriers, increase screening, and increase victim identification [18-19, 68, 111-112]. According to Allen et al. (2007), providers screen more often if: 1) they believe the organization they work for supports universal screening, 2) written screening policies exist, 3) standardized procedures have been created for screening, 4) post-screening activities are available (i.e. screening or referral procedures), 5) enforcement procedures are available (i.e. the use of a chart or screen audit), and 6) identification materials, such as brochures and posters, are displayed in their working quarters [113]. This indicates some importance for healthcare institutions to implement policy-level changes, such as creating standardized procedures and enforcing them, if they are truly interested in helping identify and prevent IPV in their healthcare settings.

Other studies have found that increasing self-efficacy through changing provider knowledge and attitudes toward IPV could change barriers that providers experience. Changing provider knowledge and attitudes toward IPV has been accomplished via education and training. This helps healthcare providers learn the knowledge, skills, and confidence they need to best identify and assist IPV victims [73, 114]. Studies have found there is a positive relationship between prior training on IPV and detection of IPV by clinicians [115]. Older and more experienced clinicians and clinicians with histories of exposure to abuse, are found to be more likely to ask about IPV [80]. In many studies, healthcare providers indicate that they are interested in and willing to receive training on IPV, to use IPV materials in their practice, and are comfortable using a screening tool [18].

Other studies have suggested that identifying physicians' attitudes and responses regarding IPV should be compared to their attitudes and responses to other stigmatized health problems for which screening recommendations exist (e.g. smoking). Gerbert et al. (2002) found that IPV was screened for less than tobacco use, alcohol abuse, and HIV/STDs [17]. Sugg et al. (1999) found the providers in their study to report high levels of confidence when asking about sensitive healthcare topics such as smoking and alcohol use, but felt less confident in their ability to address physical abuse [92].

Little research has been done about identifying systemic barriers to screening and helping IPV victims [73]. The literature indicates that departments that are focused on women, such as OBGYN, exhibit more awareness of the need for screening and perceive fewer barriers, whereas departments that serve a more general population perceive more barriers [73]. This suggests that professionals within the health field may believe IPV is a "women's doctor" issue. Certain types of healthcare providers, specifically OBGYNs and physicians who practice in public settings, were more likely to screen new patients as compared to internists and physicians practicing in health maintenance organizations [75]. According to Minsky-Kelly (2005), many hospitals advocate for "family-centered" care, which goes against what is required for IPV screening: separation of the individual being screened from his/her intimate partner or family member [73].

Barriers to Human Trafficking Screening among Healthcare Providers

Many of the same factors that keep healthcare providers from screening patients for IPV hold true with screening patients for human trafficking: providers feel uncomfortable because they have a limited awareness regarding the issue [30]; low knowledge and understanding of the issue [116]; lack of training [32, 117-120]; attitudinal biases [30]; inadequate resources or uncertainty regarding the availability of resources for victims [32, 116-120], not knowing which

resources are appropriate [116, 120]; lack of familiarity with rules and regulations[118-119]; and, uncertainty regarding "in-house" procedures when victims are identified [32].

Eliminating these barriers for healthcare providers is important for human trafficking victims: studies on survivors of human trafficking in the U.S. indicate that at least half of human trafficking victims sought medical care while being trafficked [30, 121]. This could be a good opportunity for healthcare providers and their institutions to help law enforcement to identify, serve, and help victims of human trafficking. Healthcare professionals interested in human trafficking have stated that medical and public health communities should draw from successful child abuse and domestic violence / IPV programs to inform prevention strategies [30]. This emphasizes how closely connected these two public health issues are.

Lastly, one should not assume that the effects of screening are necessarily positive for every IPV or human trafficking victim. Few studies have researched the potentially adverse effects of screening; however, the available literature indicates they are non-existent [66] or low [122-123]. Gielen and colleagues (2000), collected information about women's beliefs concerning IPV screening: women indicated that screening might cause embarrassment, that women who were not victims may feel insulted, and screening may put women at risk for increased violence from their abuser [124].

Barriers to Disclosure among Victims

There is ample evidence in the field that women victims of IPV and human trafficking face a number of barriers to disclosing this information to their providers. Women report they do not seek help from a healthcare provider because they feel their injury is not serious enough, that healthcare providers are not useful or interested in discussing IPV, or they feel they could take care of their own problem [26, 80, 91]. Some women report feeling afraid or embarrassed, not having enough time or privacy during the clinical visit [26, 125-128], or are prevented from

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seeking medical attention by their partners [26]. Human trafficking victims share similar hesitancies about disclosing their status to healthcare providers. Baldwin et al. (2011) found human trafficking victims were prevented from disclosing their status due to fear, shame, language barriers, and distrust of providers due to their limited interactions with them [121].

Need for Research

The WHO states that more resources must be allocated to activities that strengthen primary prevention of IPV (e.g. creating screening policies and provider training) as well as additional research studies [72]. Raising awareness about IPV and human trafficking in the community is needed. Advocacy and prevention efforts, including healthcare provider training and competency programs, could help address the reasons for inaccuracies and underreports of these issues [30]. Finally, as leaders of the AMA and the American Academy of Pediatrics acknowledge, adequate screening tools are lacking. Despite this, they recommend routine IPV screening because failure to do so may "jeopardize the health of millions of victims" [64].

In sum, healthcare providers come into contact with women who may be victims of IPV or human trafficking victimization. Most women have positive responses to screening and a growing number of professional organizations support universal screening; however, healthcare providers seem hesitant or unwilling to screen their patients for personal, institutional, or political reasons.

RESEARCH OBJECTIVES AND HYPOTHESES

Objectives

This study sought to answer the following three questions. 1) What are the significant predictors of which providers regularly screen patients for IPV and human trafficking?, 2) Among those who screen, what are the predictors for asking a quality screening question(s)?, and 3) What are the significant predictors that lead to a provider identifying a victim of IPV or human trafficking? The following six objectives guided me in answering these questions:

1) Determine healthcare provider characteristics associated with screening for IPV and

  human trafficking;

2) Estimate the number of IPV and human trafficking victims each healthcare provider

  has identified in the past 30 days;

3) Determine how often healthcare providers screen for IPV and human trafficking;

4) Evaluate the screening questions healthcare providers use to screen for IPV;

5) Assess the amount of training healthcare providers have received on IPV

  and human trafficking;

6) Assess the knowledge a healthcare provider has about IPV.

Hypotheses

Hypotheses on IPV Screening

- H1: Provider demographics (age, sex, physician type, number of years in practice) are associated with 1) frequency of screening for IPV; 2) quality of the screening question, and 3) number of individuals who are identified as an IPV victim.
  - HI (A): Younger healthcare providers who have had fewer years in practice will have higher frequency of screening, better quality screening questions, and identify more IPV victims. Justification: As an increased amount of awareness and importance has

recently been placed on IPV training, screening, etc. those who have been more

recently inaugurated into the healthcare field may have received more recent and

updated training than their older peers with more time in the field. This goes against

what has been demonstrated in the literature [80].

- o H1 (B): Female healthcare providers will have higher frequency of screening, better

   quality screening questions, and identify more IPV victims. Justification: There are

   certain provider/patient characteristics that affect the interactions between the dyad

   [14, 108]. As this study is focusing on female victims of IPV, female healthcare

   providers may engage in activates that promote higher levels of the outcome

   variables.

- o H1 (C): Healthcare providers who are not physicians (nurses, NPs, and PAs) will

   have higher frequency of screening, better quality screening questions, and identify

   more IPV victims. Justification: Low comfort level with a healthcare provider has

   been documented as a barrier to disclosing sensitive information from patients [26];

   nurses and nurse practitioners often receive higher satisfaction ratings by patients

   when asked about their healthcare consultation [129].

- H2: The amount, type, and length of IPV training a healthcare provider has received is

   positively associated with 1) frequency of screening for IPV; 2) quality of the screening

   question, and 3) number of individuals who are identified as an IPV victim.

- H3: Patient characteristics (being considered low-income and seeking care in facilities that

   primarily serve women and children) are positively associated with 1) frequency of screening

   for IPV; 2) quality of the screening question, and 3) number of individuals who are identified

   as an IPV victim.

Hypotheses on Human Trafficking Screening

- H4: Provider demographics are associated with 1) frequency of screening for human

trafficking and 2) number of individuals who are identified as a human trafficking victim.

- H5: The human trafficking training a healthcare provider has received is positively associated with 1) frequency of screening for human trafficking and 2) number of individuals who are identified as a human trafficking victim.

- H6: Patient characteristics are associated with 1) frequency of screening for human trafficking and 2) number of individuals who are identified as a human trafficking victim.

CONCEPTUAL MODEL

In the following section, I present the study's conceptual model, which has been adapted

from a model developed by Tavrow in 2010 [130]. Tavrow (2010) created a model of how a

provider influences whether or not a client utilizes reproductive health services, with a focus on

provider attitudes and practices [130]. The model also addresses what might influence a client's

utilization of reproductive health services, independent from a provider. For this thesis, I have

focused solely on the healthcare provider side of Tavrow's model (Figure 3, Appendix B) [130].

Tavrow's model can be used to assess barriers to screening discussed in the literature

review. Barriers include components that may influence a provider's attitude, such as a

provider's 1) core beliefs regarding gender, class, race, sexual orientation of themselves and

their patients; 2) values and norms represented in the communities in which they live, grew up,

were educated, or currently practice; 3) level of empathy they have for their client; and 4)

socialization, which encompasses the type of training and education a healthcare provider has

recently received or received in the past. A provider's attitude thus influences the actions that a

provider takes. In this case, the action is screening for IPV and / or human trafficking.

According to Tavrow's model, both a provider's attitudes and actions are influenced by

four main components, which have also been highlighted in the literature review. These

components include 1) a healthcare provider's training, whether or not they are supervised or

watched over, and how clear they are about the roles they have to fill; 2) regulations and

policies their clinic or place of work has and upholds; 3) whether a healthcare provider has an

incentive to carry out a specific behavior; and 4) infrastructure issues such as the ability to have

a client in a private room and how much time the provider has with a patient.

These factors inform and organize the components that may influence and affect how

often, who, how well, and why a provider screens for IPV and / or human trafficking.

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METHODS

This section describes the population and setting in which the study was conducted, and it details the methods used to carry out the research. All research was conducted under the auspices of the University of California, Los Angeles (UCLA) for the purposes of the Master's Thesis. All research activities were approved by the UCLA Institutional Review Board (IRB) #13-001626.

Population and Setting

Every year the National Network to End Domestic Violence conducts a one-day "Domestic Violence Counts" program. In 2012, California had more calls (5,258) requesting assistance than all 50 states [132]. In 2011, there were over 10,000 IPV crimes reported by the LAPD Bureau. The California Women's Health Survey found that approximately 40% of California women experience IPV in their lifetime [133-134]. In 2004, the US DOJ provided funds for California to create multiple task forces to combat human trafficking: "As the most populous state and a diverse border state with major international harbors and airports, California remains a major site of domestic and international human trafficking" [131]. According to the FBI, Los Angeles is one of the top three destinations for child sex trafficking in the United States [45]. These considerations indicate that southern California is an optimal region for implementing healthcare-based IPV and human trafficking interventions for women patients. This study was conducted in southern California, including the Los Angeles metropolitan area.

Study Design

This was a cross-sectional study based on a survey of a convenience sample of healthcare providers in California. It assessed whether healthcare provider demographics, training, knowledge, patient characteristics, and practice setting are associated with frequency

of screening, quality of a screening question, and number of individuals who are identified as an IPV or human trafficking victim. The study also examined the frequency of provider screening and the quality of any specified screening question relative to the number of IPV or human trafficking victims identified through screening.

Sample and Sampling

Recruitment

Participants were recruited using convenience and snowball sampling of three professional networks of healthcare providers: UCLA's Women's Health Center and UCLA's Center for Health Improvement of Minority Elderly (CHIME), the Westside Domestic Violence Network, and the Annual PriMed Conference West.

UCLA's Women's Health Center and UCLA CHIME

UCLA's Women's Health Center's mission is to provide comprehensive, exemplary health education to women and families to "inform, support, and empower women to achieve their optimal level of health [135]. UCLA CHIME is housed in the Department of Medicine at UCLA. Its main purpose is "contribute to the reduction of health disparities for African American and Latinos" [136]. An email was sent out to healthcare providers associated with these two organizations. Two healthcare providers responded to the email and were surveyed. Recruitment and questionnaire completion took place between January and March 2014.

Westside Domestic Violence Network

The Westside Domestic Violence Network "serves as the authority on domestic violence policy, service provision, and standards in training for the Westside communities and is committed to expanding and enhancing services to victims of domestic violence" [137]. Drs. Paula Tavrow and Mellissa Withers contacted the Director and a recruitment email was sent out. Twelve healthcare providers responded to the email and were surveyed. Recruitment and

questionnaire completion took place between January and March 2014.

Annual PriMed Conference West

PriMed was founded to serve the continuing education needs of healthcare providers: access, usability, and affordability [138]. Their organization is geared towards improving patient outcomes through increasing knowledge for individual clinicians, but also through building relationships and collaborations through multidisciplinary medical and disease specific programs. The PriMed conference was geared towards healthcare professionals, specifically physicians, physician's assistants (PAs), nurse practitioners (NPs), and nurses.

The conference took place March 28-30, 2014 in Anaheim, CA. The majority of healthcare attendees were from California and the Western United States. Investigators approached attendees at the PriMed Conference to assess eligibility and recruit for participation utilizing IRB approved procedures and script. Interviewers included the graduate student principal investigator from UCLA and three undergraduate research assistants from the University of Southern California. One hundred and fifty-six healthcare providers agreed to participate and completed a questionnaire.

Sample

Eligible healthcare providers for the purposes of this study were primary care physicians, NPs, PAs, and nurses. The healthcare provider must be an English-speaking professional who currently treats patients at a healthcare center. A healthcare center is defined as a private, government, safety net or community clinic. This includes individuals who work in specialized healthcare fields such as orthopedic clinics, pediatrics, OBGYN, etc. Participants were eligible to enter a $150.00 raffle for completing a questionnaire.

A total of 170 questionnaires were collected. Of those collected, 148 were included in the analyses (2 from UCLA's Women's Health Center and UCLA CHIME; 11 from Westside

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Domestic Violence Network; 135 from PriMed). All 148 questionnaires included in the analysis were from eligible healthcare providers currently practicing in California who regularly see women of reproductive age in their practice. As shown in Figure 3, providers were excluded from the analyses if they did not practice in California (n=18) or did not meet the definition of an eligible provider (n=4).

Data Collection

Although participants could complete the questionnaire using a variety of formats, the mode of administration varied little. Eleven healthcare providers took the questionnaire online, one provider had the questionnaire administered over the phone, six had the questionnaire administered in person, and 130 self-administered the questionnaire in-person. Data were collected from January – March 2014.

Instrument

The instrument used in this study was adapted from a related UCLA research study [139]. The original questionnaire was created through formative research and focus groups by a research team, in conjunction with an advisory board committee of community-based organizations in Los Angeles, who specialize in issues of IPV and human trafficking. While the instrument retained most of the original content and order, some additional questions were asked. Appendix C provides the study's instrument.

This questionnaire, which was designed to take no more than 10 minutes, consisted of 37 questions, divided into six sections. The first section included basic demographic questions of the provider (e.g. sex, age, provider type, number of years in practice). The second section included questions about patient demographics (e.g. does their clinic mostly serve low-income patients). The third section assessed current screening practices and approaches to

documenting cases of IPV and human trafficking (e.g. how often they screen and what

screening question they ask). The fourth section included questions about the training a health

care provider has received on IPV and human trafficking (e.g. how much training they have

received in past five years). The fifth section included questions about how confident a

healthcare provider is in their ability to assist and identify IPV and human trafficking victims. The

sixth section included a series of ten true/false questions designed to assess knowledge about

IPV.

Measures

Dependent Variables

As described above in the hypotheses section, there were three main outcome

variables: 1) frequency of screening, 2) quality of screening question, and 3) number of

positively identified victims in the past 30 days. First, participants responded to the question,

"How often do you screen patients for IPV in your clinic" on a four point Likert-scale (Always,

Most of the time, Some of the time, Rarely) that also had additional response options that

allowed the respondent to indicate conditionality of screening (Only if showing symptoms) or

Other (e.g. At initial appointments). These responses were then dichotomized into two

categories: those that screen always or most of the time versus some of the time, rarely, only if

showing symptoms, and other.

Second, quality of screening was determined by coding open-ended responses to

"When screening female patients for IPV what is the first question you normally ask?" Two

raters discussed and determined the criteria for classifying the question as "Acceptable,"

"Unacceptable," or 'Other' based on how closely it adhered to recommended or gold-standard

screening questions identified by experts on IPV (Table 2). These categories were further

broken down into 7 categories: Highly acceptable, Moderately acceptable, Unacceptable too

general, Unacceptable too narrow, Unacceptable too technical, Did not involve IPV, or Other.

The questions that were labeled as 'other' were then categorized as a symptom based follow-up

question (e.g. the healthcare provider reported asking about a specific injury or ailment a patient

had, which is not a true screening question as the patient is not asymptomatic), or as having to

do with children and not related to a woman of reproductive age. These more nuanced

classifications were done for descriptive purposes only.

Third, respondents were asked, "In the last 30 days, how many female patients revealed

to you that they were a victim of IPV?" Response options were None, 1-2, 3-5, 6-10, More than

10, and Don't recall or Not applicable. Responses were collapsed into 0 versus 1 or more

individuals revealed they were an IPV or human trafficking victim.

Independent Variables

The main independent, or predictor, variables for this thesis were: provider gender

(male, female, or transgender), provider age (30 or less, 31-40, 41-50, 51-60, 61 or older),

provider type (physician, PA, NP, nurse), patient income level (yes/no clinic serves mostly low-

income patients), practice setting (primary care, OBGYN, pediatrics, mental health vs. other),

IPV training (in past five years, intensity of training, type of training), and IPV Knowledge

(number out of 10 correct on true/false questions). Two outcome variables (frequency of

screening and quality of screening question) were turned into independent variables in

predicting the number of positively identified IPV or human trafficking victims.

Statistical Analyses

All data were analyzed using SPSS Statistics Program version 20. In preliminary

analysis, we explored the nature of missing data, data normality, and outliers for each variable

(i.e. univariate analysis). In bivariate analysis, we explored potential confounding by provider

characteristics and examined potential associations between the predictor and outcome variables using chi-square with $p \leq 0.05$. Variables found to be statistically significant at this level were included in the multivariable statistical models to control for their role as potential confounders. We use univariate and bivariate descriptive statistics to summarize sample characteristics. The main analysis involved conducting several multivariable logistic regression analyses. Logistic regression is appropriate for analysis predicting outcomes that are binary, such as always vs. rarely screen for IPV. Multivariable models enabled us to explore the predictive quality of the data. Each model included a single outcome variable, a main predictor variable and all relevant covariates. The result of each model's statistical test was considered statistically significant if its corresponding p-value was less than 0.05.

RESULTS

In the following section, I summarize the univariate findings of the independent and dependent variables (Tables 3-4) bivariate findings (Tables 5-7) and the results of the multivariable statistical analyses (Tables 8-10).

Univariate Findings

Provider Demographics

Of the 148 providers included in the analysis, 64.2% (n=95) were female (Table 3). A little under half of the sample (48.6%, n=72) indicated they were physicians, roughly a quarter (26.4%, n = 39) were nurse practitioners (NP), a smaller proportion (17.6%, n = 26) were physician assistants (PA), and a few were nurses (6.1%, n=9) or held both NP and PA degrees (1.4%, n = 2). Providers ranged in age from younger than 30 years to 61 years of age or older. Specifically, 4.1% (n=6) were 30 years old or less, 16.9% (n=25) were 31-40 years old, 25.0% (n=37) were 41-50 years old, 27.0% (n=40) were aged 51-60, and the rest of the sample (27.0%, n=40) were aged 61 or older. Additionally, there was a variation in how many years a provider has been practicing: 11.5% (n=17) had been practicing 5 years or less, 14.9% (n=22) had been practicing 6-10 years, 27.7% (n=41) had been practicing 11-20 years, and the rest of the sample (45.9%, n=68) had been practicing 21 years or more.

Training and Knowledge in IPV and Human Trafficking

Table 3 shows providers' levels of training on IPV in the past five years. Of the 148 respondents, 38.5% (n=57) indicated they had not received any training on IPV in the past five years, 23.6% (n=35) indicated they received only one hour of IPV training in the past five years. A smaller proportion indicated they had received 2-3 hours of training (18.2%, n=27), 4-5 hours of training (7.4%, n=11), or 6 or more hours of training (4.7%, n=7). A minority (1.4%, n=2)

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responded that they did not remember how much training they had received and 6.1% (n=9) did

not respond to the question.

Table 3 also shows where they received training on IPV. Some 16.9% (n=25) indicated

they received training in medical school, 27.0% (n=40) in continuing medical education (CME),

17.6% (n=26) received training in both medical school and in CME, 2.0% (n=3) indicated they

had received training by 'other' means (e.g. during residency), 6.8% (n=10) had not received

formal training but had done their own research on IPV. Over a quarter of respondents (27.0%,

n=40) indicated they had never received training.

A majority of respondents (71.6%, n=106) indicated they had never received training on

LGBTQ IPV (Table 3). Only a small proportion had received any type of training at all on IPV

specific to LGBTQ populations: 4.7% (n=7) indicated they had received training in medical

school, 15.5% (n=23) in CME, 4.1% (n=6) in medical school and CME. A minority of

respondents (2.0%, n=3) indicated they had received training by 'other' means (e.g. at a

conference), 1.4% (n=2) had not received formal training but had done their own research, and

0.7% (n=1) did not respond to the question.

With regard to human trafficking, most respondents (77.0%, n=114) had never received

training on the subject (Table 3). Of those who had, smaller proportions of respondents

indicated they had received such training in medical school (2.7%, n=4), 10.1% (n=15) in CME,

3.4% (n=5) in both medical school and in CME, 2.0% (n=3) indicated they had received training

by another means (e.g. training at church), and 4.1% (n=6) had not received formal training but

had done their own research. Less than 1% (n=1) of respondents did not respond to the

question.

The mean IPV knowledge score was 4.31 (s.d. = 1.761) out of a possible 10.0. A

minority of providers (9.5%, n=14) answered only 0-2 questions correctly (Table 3). Most

(69.6%, n=103) answered 3-5 questions correctly. The rest of the respondents (20.9%, n=31) 6-

9 questions correctly. No one answered all 10 questions correctly.

Patient Profile

Providers were asked if the majority of the patients they serve were low-income (Table 3). A little less than half (46.6%, n=69) providers indicated that a majority of their patients were low-income and 45.3% (n=67) did not. A small proportion of respondents (4.7%, n=7) indicated that they "maybe" served low-income patients, 1.4% (n=2) indicated they "didn't know," and 1.4% (n=2) did not respond to the question.

More than two-thirds (68.2%, n=101) worked in primary care settings; 8.8% (n=13) in pediatrics; 2.7% (n=4) in OBGYN; 0.7% (n=1) in orthopedics; and, 2.7% (n=4) in mental health. No respondents reported working in an emergency room; however, 16.9% (n = 25) indicated they worked in other fields such as surgery, podiatry, nursing homes, etc.

Screening Practices

Table 4 reflects our evaluation of the first questions providers typically ask when they screen patients. It revealed that only 39.9% (n=59) of providers' usual screening questions were considered acceptable screening questions (i.e. screening questions that adhere closely to recommendations made by the American College of Obstetricians and Gynecologists, among other medical associations, Table 2). Of the 59 acceptable screening questions, 69.5% (n=41) were highly acceptable and 30.5% (n=18) were moderately acceptable. More than a quarter of respondents (27.7%, n=41) asked an unacceptable question. Of those 41 unacceptable screening questions, 65.9% (n=27) were considered too general, 22.0% (n=9) were considered too narrow, and 12.3% (n=5) were considered too technical. The rest of the providers (32.4%, n=48) either asked a symptom-based question (9.5%, n=9), a question geared towards a child (2.7%, n=4), or did not provide a screening question (20.3%, n=30). Respondents who did not

report a screening question were analyzed as if they do not screen their patients.

Table 4 lists the self-reported frequency with which providers screen for IPV. Fewer than 10% (9.5%, n=14) of providers always screen. More commonly, providers screen most of the time (17.6%, n=26), some of the time (27.0%, n=40), rarely (27.7%, n=41), only if patients show IPV symptoms (12.8%, n=19), or based on some self-reported 'other' reason (e.g. provider "doesn't see abused patients") (4.7%, n=7). Less than one percent of respondents (n=1) did not respond to the question.

Even smaller percentages screen for human trafficking. Only two percent (n=3) of providers always screen for it or screen for it most of the time (2.0%, n=3). Greater proportions screen for it some of the time (3.4%, n=5), rarely (46.6%, n=69), or only if a patient seems distressed (16.9%, n=25); however, 23% of respondents (n=34) indicated that they never screen for human trafficking. Some 5.6% (n=8) indicated 'Other' (e.g. they had never heard of the issue) and 1.4% (n=2) did not respond to the question.

Number of IPV or Human Trafficking Victims Identified

Table 4 lists the numbers of IPV and human trafficking victims providers reported identifying in the past 30 days. Two-thirds of respondents (65.5%, n=97) reported not identifying any victims of IPV and 93.2% (n=138) reported not identifying any human trafficking victims. Almost a quarter of respondents (24.3%, n=36) reported that one or two patients were identified as a victim of IPV, while only 2.0% (n=3) respondents indicated that one or two patients were identified as a human trafficking victim. No healthcare provider reported identifying more than two human trafficking victims; however, 6.1% (n=9) identified 3-5 IPV victims, 0.7% (n=1) identified 6-10 IPV victims, and 0.7% (n=1) identified 10 or more IPV victims. A small percentage (2.7%, n=4) did not respond to the IPV question and 4.7% (n=7) did not respond to the human trafficking question.

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Chi-square tests were run to test for associations between the independent and each of the three dependent variables. For some variables, the responses were collapsed to best ensure sufficient sample size. The following changes were made to variables: 1) age category 30 or less was collapsed into a 40 or less age category, while the rest of the response options remained the same; 2) provider type was dichotomized into physician vs. other; 3) IPV training in past five years was dichotomized into no training vs. 1 or more hours of training; 4) intensity of IPV education was collapsed into no education, at least one exposure to IPV education (e.g. medical school, CME, or independent research), or two or more exposures of IPV education (e.g. medical school and CME); and 5) training in IPV specific to LGBTQ populations and training for human trafficking were both dichotomized into no training vs. some training (medical school, CME, or independent research).

Table 3 provides summary data on human trafficking screening; however, due to the rarity of encountering human trafficking victims, no bivariate or multivariable analyses were conducted based on those data. Table 5 presents a representative selection of the narrative responses to open-ended questionnaire items on screening for IPV and human trafficking, and how much or what kind of training they received for IPV or human trafficking.

Frequency of Provider Screening

Table 6 shows that there were no significant associations between how often a healthcare provider screens for IPV (always/most of the time vs. rarely/only when showing physical symptoms/other) and sex (χ^2 = 2.787, p = 0.68), age of physician (χ^2 = 1.184, p = 0.757), number of years in practice (χ^2 = 4.835, p = 0.184), categorized number of correct responses on the knowledge index (χ^2 = 2.764, p = 0.251), or type of provider (physician vs. other) (χ^2 = 0.099, p = 0.071).

There were, however, statistically significant associations between how frequently a healthcare provider screens for IPV and patient- and practice-level characteristics. Specifically, among providers practicing in primary care/OBGYN/pediatric/mental health settings, 32% screened always/most of the time whereas 67% did not ($\chi^2 = 8.594$, p = 0.001). In low-income and in non-low-income serving practices, significantly fewer providers screened always/most of the time ($\chi^2 = 12.852$, p = 0.012).

Training in terms of type and intensity were also associated with frequency of screening patients for IPV. Always or most of the time screening was reported more among those with at least 1 hour of IPV training in the past five years (38.8%) as compared to those with no training (10.5%) ($\chi^2 = 13.450$, p = 0.000). Similarly, as would be expected, higher exposure or intensity of training on IPV was associated with frequency of screening: among those who received training in both medical school and CME 46.2% always/most of the time screened as compared to those who received training at medical school, CME, or via independent research (29.3%) and those who received no training (10.0%) ($\chi^2 = 10.912$, p = 0.004). Training specific to LGBTQ populations was also associated with frequency of screening. That is, 39.0% of those with some training on issues specific to LGBTQ populations reported screening always or most of the time as compared to only 22.6% of those with no such training ($\chi^2 = 4.006$, p = 0.038).

Quality of Screening Question

Table 7 shows that there were no significant differences in the quality of provider screening question (acceptable vs. unacceptable vs. other) based on age ($\chi^2 = 8.183$, p = 0.23), type of provider ($\chi^2 = 2.667$, p = 0.263), number of years in practice ($\chi^2 = 3.221$, p = 0.781), or practice setting ($\chi^2 = 3.901$, p = 0.142). Two test statistics approached statistical significance: intensity of IPV training ($\chi^2 = 8.708$, p = 0.069) and patient income level ($\chi^2 = 5.796$, p = 0.055). Gender was the only demographic characteristic that had a statistically significant association

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with quality of screening question. Among female providers, 49.5% of respondents asked an acceptable screening question, 45.3% asked an unacceptable one (χ^2 = 15.359, p = 0.000); by contrast, 22.6% of male providers asked an acceptable screening question while 17.9% did not. Recent training and type of training were also associated with the quality of the screening question asked (χ^2 = 16.377, p = 0.000). Specifically, of providers who received at least one hour of training in the past five years, 52.2% asked an acceptable screening question as compared to 21.1% of those who had not received training. Among those who had received IPV training specific to LGBTQ populations, 58.5% asked an acceptable screening question as compared to 33.0% who had not received this specific type of training (χ^2 = 12.173, p = 0.002).

Lastly, there was a statistically significant association between the quality of a screening question and the categorized number of correct responses on the knowledge index: 58.1% of individuals who got 6 or more true/false questions correct asked an acceptable screening question, as compared to 37.9% who got 3-5 questions correct, and 14.3% who got 0-2 questions correct (χ^2 = 11.743, p = 0.019).

Number of Patients Identified as IPV Victims

Table 8 shows that there were no significant associations between the number of patients identified as IPV victims and sex of provider (χ^2 = 1.087, p = 0.196), age of provider (χ^2 = 2.571, p = 0.463), type of provider (χ^2 = 0.569, p = 0.282), number of years in practice (χ^2 = 2.551, p = 0.473), or categorized number of correct responses on the knowledge index (χ^2 = 2.245, p = 0.325). There were, however, statistically significant associations between the number of patients identified as IPV victims and recent training, intensity of training, and type of training. Among those who had received at least one hour of training in the past five years, 46.2% identified one or more IPV victims in the past 30 days as compared to 12.3% who had received no training in the past five years (χ^2 = 17.617, p = 0.000). Additionally, among those

who received training in both medical school and CME 53.8% identified at least one victim of IPV as compared to those who received training at medical school, CME, or via their own independent research (30.5%) and those who received no training (20.0%) (x^2 = 8.466, p = 0.015). Among those who received some IPV training specific to LGBTQ populations, 48.8% identified at least one victim of IPV in the past 30 days as compared to 25.5% who have not received this specific training (x^2 = 7.385, p = 0.006).

Furthermore, significantly more providers serving low-income patients as compared to those who do not serve low-income patients (15.6%) identified at least one victim of IPV (50.7%) (x^2 = 20.586, p = 0.000). One or more victims of IPV were identified 35.2% of the time by providers practicing in a primary care/OBGYN/pediatric/mental health setting as compared to 15.4% in "other settings" (x^2 = 3.901, p = 0.036).

Lastly, there were statistically significant associations between the numbers of patients identified as IPV victims and the two other predictor variables. Specifically, among those who screen always or most of the time 55.0% identified at least one victim of IPV in the past 30 days as compared to 23.1% who rarely screen (x^2 = 13.665, p = 0.000). Among those who asked an acceptable screening question, 40.7% identified at least one victim of IPV in the past 30 days as compared to 39.0% who asked an unacceptable screening question, and 14.6% of those who do not screen generally (x^2 = 9.698, p = 0.008).

Multivariable Findings

For each outcome variable, a logistic regression model was run. The first included provider characteristics (age, sex, type of provider, number of years in practice) previous training (training in past five years, intensity of training, and IPV training specific to LGBTQ populations), and knowledge score predicted the outcome and patient characteristics (patient income level and practice setting).

Frequency of Provider Screening

As evident in Table 9, none of the measured provider characteristics were associated with odds of reported screening all or some of the time in a full model controlling for provider characteristics, IPV training and knowledge, and patient characteristics. In the same model, the intensity of IPV training was associated with more than double the odds of reporting screening all or some of the time (AOR = 2.298, p = 0.049). In terms of patient characteristics, serving low-income patients (AOR = 3.576, p = 0.006) and practice setting (AOR = 13.792, p = 0.023) were both associated with higher odds of frequency of provider screening.

Quality of Screening Question

The chi-square test examining associations between quality of screening question and frequency of provider screening indicated that among providers who did not have a screening question, only 8% had screened. For this reason, respondents who did not provide a screening question were excluded from the bivariate logistic regression and only those who provided a screening question were included (Table 4).

As Table 10 shows, among individuals with a screening question, female sex (AOR = 5.982, p = 0.003) and younger age (AOR = 0.419, p = 0.046) were both associated with higher odds of asking a quality (i.e. acceptable) screening question. In the same model, serving low-income patients was associated with 0.224 times the odds (AOR = 0.224, p = 0.012) of asking a quality screening question.

Number of Patients Identified as IPV Victims

As Table 11 shows, no specific provider characteristics were associated with higher odds of identifying IPV victims in a full model controlling for provider characteristics, previous

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training and knowledge, and patient characteristics. In the same model, serving low-income patients was associated with 4.720 the odds of identifying IPV victims (AOR = 4.720, p = 0.001). Additionally, having at least one hour of IPV training in the past five years was associated with 3.720 the odds of identifying IPV victims (AOR = 3.720, p = 0.013).

DISCUSSION

In the following section, I discuss the study findings relative to the existing literature. I also discuss the limitations of this study, future directions for research, and the implications for policy and practice.

First, this study demonstrates that healthcare providers are well positioned to screen women for IPV victimization [8-9, 18-19, 68, 73]. Of the 148 providers in this analysis, if the upper range is used for the question about the number of patients identified as an IPV or human trafficking victim (e.g. 36 providers indicated they identified 1-2 IPV victims, a range from 36-72 women positively identified) up to 138 women were reported as identified IPV victims and up to 6 women were reported as identified human trafficking victims. Although this number is an approximation and would need to be substantiated and triangulated by medical records and other reliable measures, it still suggests that healthcare providers can play an important role in the identification of IPV and human trafficking victims. If these numbers were a true indication of how many IPV and human trafficking victims were identified in the past month, in a single year 1,656 victims of IPV and 36 human trafficking victims could potentially be identified and helped.

The literature indicates that healthcare settings focused on women, such as OBGYN, exhibit more awareness of IPV, the need to screen for it, and also perceive fewer barriers as compared to those who practice among more general populations (e.g. primary care) [73]. The findings in this thesis support the literature and map onto the conceptual model accurately (Figure 3): practice settings geared toward women and children, such as OBGYN, pediatrics, and mental health, screened more frequently than primary care settings. A provider's location in which they are practicing (i.e. norms) may have affected their attitudes, which affected their actions (e.g. outcome variable measures). However, both practice settings focused on women and primary care settings screened more frequently than specialized settings, such as orthopedics, oral surgery, and occupational medicine. Yet, IPV is not a problem that only exists

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among women who visit the OBGYN, pediatrics, or utilize mental health services; this study suggests that many primary care physicians may be missing excellent opportunities to identify and potentially assist IPV victims.

Unlike some studies, which indicate that older and more experienced clinicians are more likely to screen for IPV [80], this thesis found that provider characteristics predicted neither the frequency of screening for IPV nor the number of individuals who were identified as an IPV victim. However, when respondents who did not screen were taken out of the analysis, the data supported our hypothesis and indicated that younger female providers ask better quality screening questions.

Although this is an interesting finding, it is important to note that ultimately the quality of a screening question appeared to have had no bearing on the number of patients who were identified as an IPV victim. As supported by the conceptual model (Figure 3), this has important implications for both policy and practice as it affects provider attitudes and actions: no elaborate or perfect screening question may be needed for a woman to reveal she is an IPV victim to her provider (e.g. asking "Are you in a relationship with a person who threatens or physically hurts you?" works just as well as "Do you feel safe?"). This should potentially alleviate the fear of not knowing what to ask, a reason providers specify for not screening their patients. No intricate list of questions or memorization is required; just creating the space through routine enquiry can potentially change a woman's life.

For both frequency of screening and number of patients identified as IPV victims, whether or not the respondent worked primarily with low-income patients was a significant predictor. As discussed by the CDC, being low-income is a risk factor for IPV [55] indicating that providers are adhering to the CDC's recommendations to be aware of individuals who fall into this risk category when screening for IPV. Although this questionnaire did not ask providers about whether or not they believed IPV is an important issue among the population they serve, it

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appears that this may be the case if providers serve mostly low-income patients. It is unclear if this finding is due to the provider's perception of their patients (e.g. the patients are more vulnerable or are at a greater risk for IPV victimization); if they have institutional pressure to screen more frequently because they work with a low-income clientele (e.g. clinic policy is to regularly screen because of patient demographics); or if low-income individuals are truly more likely to be victims of IPV and that is why more are identified. This represents an important area for future research.

   In support of our hypothesis and the conceptual model, training in the past five years was a predictive factor for both the frequency of screening and the number of IPV victims identified. This finding corroborates prior research [115]. Although knowledge was associated with asking an acceptable screening question, it did not increase a provider's frequency of screening or the number of IPV victims identified, which is the ultimate goal of screening. Similarly, although specific IPV training among LGBTQ populations had statistically significant associations with frequency of screening, acceptability of screening questions, and number of IPV victims identified, it was not predictive. Regardless of being trained on IPV in medical school, CME, or doing independent research, receiving as little as one hour of training on IPV in the past five years apparently can significantly increase both frequency of screening and the number of IPV victims identified. This finding, that as little as one hour of training in five years can make a difference in frequency of screening and number of IPV victims identified, could potentially de-bunk and eliminate a popular reason providers indicate they do not screen: lack of training [13, 16, 107].

   It was surprising that in the final predictive model, the frequency of screening did not predict the number of patients identified as IPV victims. There was a high correlation between frequency of screening and whether a provider had received training in the past five years, which suggests training in the past five years may be a proxy for how frequently a provider

screens. To explore this further, an additional multivariable analysis was run (not included in the tables), which eliminated training in the past five years. After training in the past five years was eliminated, frequency of screening was included in the final parsimonious model, which indicated that there may be significant multi-collinearity between receiving training and the frequency of screening.

Limitations

There are several limitations that should be addressed in regards to this thesis. The sample was obtained through snowball and convenience sampling techniques, and not randomly selected. These techniques may have introduced bias into the sample, thereby limiting the generalizability of the findings. Because some participants (n = 13) were recruited either from the UCLA's Women's Health Center, UCLA CHIME, or the Westside Domestic Violence Network, groups of physicians who are dedicated and actively working for the betterment of women, they may be more familiar and interested in women's reproductive health, IPV, and human trafficking than other providers are in California. Because we did not have access to a denominator, we cannot create a response rate for the sample.

Though there is a bias in the sample, it suggests that while levels of training and screening were low in this sample, they likely are even lower among providers who do not focus on women's health. Additionally, providers completed the questionnaire in one of four ways: in-person, in-person self-administered, online, or over the phone. This potentially creates continuity issues within the study: although the same questions were asked in the same order, there could be a difference about how a question or material is processed when someone is participating using different methods.

Although the sample size (n = 148) is appropriate for the analyses completed in this thesis, it is still a relatively small sample to represent California. More specific conclusions could

have been made if, for example, there had been a greater variety of healthcare professionals other than physicians included within the study (e.g. more than nine nurses). This would have allowed for provider-specific conclusions about frequency of screening, quality of screening questions, and the number of patients identified as IPV or human trafficking victims. Having a larger sample size also would have increased the possibility of conducting analyses beyond frequencies on human trafficking data, an important and increasingly pertinent issue in Southern California.

There were some limitations in the way the questions were asked, which limited the power and scope of the statistical tests appropriate for analysis. For example, the questionnaire originally included a question on a patient's race / ethnicity, but the way in which the question was asked (what race/ethnicities are most of your patients – please check all that apply) led many providers to select all race / ethnicities listed instead of indicating who they serve most in their practice. Additionally, it would have been beneficial to ask certain questions (In the last 30 days, about how many patients revealed to you that they were current IPV victims?) in a way that required an exact response (e.g. five IPV victims), instead of a range (e.g. 1-2 victims, 3-5 victims, etc.). We did not ask other periphery questions (e.g. patient load, number of individuals served in a certain time frame per practice) that may also influence how many victims are identified. For example, a healthcare provider who sees 10 patients a day is statistically less likely to identify a victim as compared to a healthcare provider who sees 30 patients a day.

As discussed in the methods section, the original questionnaire content was created through formative research and focus groups by a research team, in conjunction with an advisory board committee of community-based organizations in Los Angeles, who specialize in issues of IPV and human trafficking [139]. Although extensive formative and collaborative research went into its creation, it has not been tested for validity or reliability, especially important for certain components of the questionnaire (e.g. the true/false questions). This could

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explain why the mean score on the knowledge index was so low (mean = 4.31, s.d. = 1.761) and why no one answered all 10 questions correctly. However, these scores could also be a true indication that the surveyed healthcare providers did not have high knowledge about IPV.

It is unclear from the findings how IPV training influences the outcome variables. Although receiving training in the past five years was a significant predictor of frequency of screening and the number of IPV victims identified, it is ambiguous as to whether providers who frequently screen and identify IPV victims have received training on IPV because 1) it was mandatory, 2) the clinic in which they work suggested or actively support these types of training, or 3) the provider was already interested in these issues so they attended the training voluntarily. This limits our ability to conclude if training had an effect on increasing the levels of screening, of it those who went for training were already interested in or willing to screen their patients. This issue should be further examined in future research by asking questions about personal interests in IPV and human trafficking, whether any training a provider has received was voluntarily or mandatory, and what stance the clinic or institution they work for has on these issues. It could then be made clear if more women are identified as IPV victims by providers because training truly makes a difference or because providers who are already interested screen more frequently.

Finally, although we collected some data on screening for human trafficking, the numbers were too small for multivariable analysis of these data.

Future Directions for Research

For future studies, it is recommended that certain additions or modifications should be made to the instrument. To better understand and differentiate between who is required to receive training and who is interested in IPV and human trafficking issues, questions that better capture a provider's attitude about screening should be included (e.g. Do you think screening is

important? Do you think it helps women?). In addition, questions about hidden provider characteristics (e.g. inner motivation to screen and/or receive training because they themselves came from a violent home or are a victim of IPV) would be valuable.

Additionally, it was not possible to make a true conclusion about whether "more training" is actually "better" because questions were not asked about length, depth, and quality of training a healthcare provider had undergone. Future studies could address this issue in a number of ways. For example, training sessions could be provided for a group of healthcare providers of interest. This would allow for true baselines and denominators to be obtained, and control via standardization of type of training (e.g. via a pamphlet, online course, class session, etc.). Healthcare providers could also rate the quality of the training in order for an assessment of quantity and quality. The fact that we did not collect data on whether training a healthcare provider received was mandatory or voluntary is another limitation that future studies should address. Lastly, validation of the future instrument is also necessary.

This questionnaire only asked healthcare providers to report on the female victims of IPV and human trafficking they screened and identified. As indicated in the literature review, although women are the majority of IPV victims, it is also important to ask providers about their attitudes and practices specifically for male patients and other populations that are at-risk for IPV or human trafficking victimization (e.g. the elderly and LGBTQ populations). Further research should be pursued among these populations.

Overall, the study suggests that more public health professionals should screen women for IPV and human trafficking. Screening is an effective way to identify victims, assist those in distress and connect victims to the resources they need. This study focused solely on how providers screen women and did not adequately capture or address what happens after providers identify an IPV or human trafficking victim, and what steps they would potentially take after identification (e.g. referral processes). Further research should be conducted on the issues

of referral, as it may be an important component in stopping the recidivism that so often occurs in victims of IPV and human trafficking.

APPENDICES

Appendix A: Table 1 – Table 11

Appendix B: Figure 1 – Figure 4

Appendix C: Study Instrument

Table 1. Comparison of terms and definitions about violence between romantic partners

Term	Definition 1	Whom it Affects	Specifically
Domestic Violence	"pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner […] [it] can be physical, sexual, emotional, economic, or psychological" [140].	"…anyone regardless of race, age, sexual orientation, religion, or gender. [It] affects people of all socioeconomic backgrounds and education levels … occurs in both opposite-sex and same-sex relationships and can happen to intimate partners who are married, living together, or dating" [140].	• Those who are abused • Those not abused o Family members o Friends o Co-workers o Community o Children [140].
Intimate Partner Violence	"behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, psychological abuse and controlling behavior" [141]. "a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation and intimidation" [46]	A person in a current or past partner or spousal relationship. Can occur among heterosexual or same-sex couples. It does not require sexual intimacy [1].	• Current partners • Ex-partners [1].
Gender-based Violence or Violence Against Women	"Violence that is directing against a person on the basis of gender. It constitutes a breach of the fundamental right to life, liberty, security, dignity, equality between women and men, non-discrimination and physical and mental integrity" [142]. "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" [141].	Usually girls and women. Sometimes boys [143].	• Domestic violence • Rape • Sexual violence during conflict • Sex trafficking • Domestic work • Harmful customary/traditional practices (i.e. genital mutilation, forced marriage) • Forced prostitution • Forced abortion [142].

Table 1 (continued). Comparison of terms and definitions about violence between romantic partners

Term	Definition 1	Who it Affects	Specifically
Human Trafficking	"The recruitment, transportation, transfer, harbouring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" [27].	Anyone	• Prostitution of others • Sexual exploitation • Forced labor • Slavery or similar practices • Removal of organs [27].

Table 2. IPV screening questions used by selected organizations

Organization	IPV Screening Question(s)
Family Violence Prevention Fund 2004	*Framing Questions:* • "Because violence is so common in many people's lives, I've begun to ask all my patients about it" • "I am concerned that your symptoms may have been caused by someone hurting you." *Direct Verbal Questions:* • "Are you in a relationship with a person who physically hurts or threatens you?" • "Did someone cause these injuries? Was it your partner/husband?" • "Is it safe for you to go home?" • "Has your partner ever forced you to have sex when you didn't want to?"
American College of Obstetricians and Gynecologists 1999	*Framing Questions:* • "Because violence is so common in many women's lives and because there is help available for women being abused, I now ask every patient about domestic violence" *Direct Verbal Questions:* • "Are you in a relationship with a person who threatens or physically hurts you?" • "Has anyone forced you to participate in sexual activities that make you feel uncomfortable?" • "Within the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?"
American College of Obstetricians and Gynecologists 2012	*Framing Question:* • "We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health." *Insuring Confidentiality:* • "Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me that… (insert law by state) *Sample Questions:* • "Has your current partner ever threatened you or made you feel afraid?" • "Has your partner ever hit, choked, or physically hurt you?" • "Has your partner every forced you to do something sexually that you did not want to do, or refused your request to use condoms?"
Center for Relationship Abuse Awareness 2013	*Indirect Questions:* • "Have you been under any stress lately?" • "Are you ever afraid?" • "Have you ever gotten hurt?" • "How are things going in your relationship? All couple fight/argue. What happens when you disagree?"

Table 3. Sample characteristics, N=148

Variable	n (%)
Sex	
Female	95 (64.2)
Male	53 (35.8)
Age	
30 or less	6 (4.1)
31-40	25 (16.9)
41-50	37 (25.0)
51-60	40 (27.0)
61 or more	40 (27.0)
Provider Type	
Physician	72 (48.6)
Nurse Practitioner (NP)	39 (26.4)
Physician Assistant (PA)	26 (17.6)
Nurse	9 (6.1)
NP and PA	2 (1.4)
Years in Practice	
5 years or less	17 (11.5)
6-10 years	22 (14.9)
11-20 years	41 (27.7)
21 or more years	68 (45.9)
IPV training in past five years	
None	57 (38.5)
1 hour	35 (23.6)
2-3 hours	27 (18.2)
4-5 hours	11 (7.4)
6 hours or more	7 (4.7)
Can't remember	2 (1.4)
Missing	9 (6.1)
Ever received training in IPV	
Yes, in medical school	25 (16.9)
Yes, in CME	40 (27.0)
Medical school and CME	26 (17.6)
Yes, other	3 (2.0)
No	40 (27.0)
No, but done own research	10 (6.8)

Table 3 (continued). Sample characteristics, N=148

Variable	*n*, (%)
IPV training for LGBTQ populations	
Yes, in medical school	7 (4.7)
Yes, in CME	23 (15.5)
Both medical school and CME	6 (4.1)
Yes, other	3 (2.0)
No	106 (71.6)
No, but done own research	2 (1.4)
Missing	1 (0.7)
Training in human trafficking	
Yes, in medical school	4 (2.7)
Yes, in CME	15 (10.1)
Both medical school and CME	5 (3.4)
Yes, other	3 (2.0)
No	114 (77)
No, but done own research	6 (4.1)
Missing	1 (0.7)
Knowledge Index (10 items)	Mean = 4.31, s.d. = 1.761
0-2 questions correct	14 (9.5)
3-5 questions correct	103 (69.6)
6-10 questions correct	31 (20.9)
Serve Low-Income Patients	
Yes	69 (46.6)
No	67 (45.3)
Maybe	7 (4.7)
Don't Know	3 (2.0)
Missing	2 (1.4)
Practice Setting	
Primary Care	101 (68.2)
Pediatrics	13 (8.8)
OBGYN	4 (2.7)
Orthopedics	1 (0.7)
Emergency Room	0 (0.0)
Mental Health	4 (2.7)
Other	25 (16.9)

Table 4. Provider screening practices, N=148

Variable	n, (%)
Acceptability of Screening Question	
Acceptable	**59 (39.9)**
Highly Acceptable	41 (27.7)
Moderately Acceptable	18 (12.2)
Unacceptable	**41 (27.7)**
Too general	27 (18.2)
Too narrow	9 (6.1)
Too technical	5 (3.4)
Other – Those Who Do Not Screen Generally	**48 (32.4)**
Symptom-Based Question	14 (9.5)
Question related to child	4 (2.7)
Do not screen	30 (20.3)
How often screen IPV	
Always	14 (9.5)
Most of the time	26 (17.6)
Some of the time	40 (27.0)
Rarely	41 (27.7)
Only if showing symptoms	19 (12.8)
Other	7 (4.7)
Missing	1 (0.7)
How often screen Human Trafficking	
Always	3 (2.0)
Most of the time	3 (2.0)
Some of the time	5 (3.4)
Rarely	69 (46.6)
Only if patient is distressed	25 (16.9)
Other – Never	34 (23)
Other	8 (5.6)
Missing	2 (1.4)
Last 30 days patient revealed IPV	
None	97 (65.5)
1-2	36 (24.3)
3-5	9 (6.1)
6-10	1 (0.7)
More than 10	1 (0.7)
Missing	4 (2.7)
Last 30 days patient revealed human trafficking	
None	138 (93.2)
1-2	3 (2.0)
Missing	7 (4.7)

Table 5. Selected answers to open-ended items with responses of 'other'

How often screen for IPV
- Never (x3)
- When "gut tells me there is more to the story"
- On annual as new intake
- At initial appointment, and then only if showing symptoms
- During well women exams
- Do not see abused patients
- I have a child abuse practice – the people I always see are children"

How often screen for trafficking
- During immigration physicals
- Never heard of it, only have seen in the news
- I use the same questions as above, but do not add questions specifically for trafficking
- If answers do not fit clinical picture
- If something about the patient alerts me to ask
- Indirectly
- Doesn't apply to me (x2)
- Never occurred to me
- Not much
- Not pertinent in my office setting
- Not relevant to kids
- Patient usually tells me

'Other' training for IPV
- In PA school
- During residency
- "Work"
- Not specified (x2)
- Police

'Other' training for IPV among LGBTQ
- Not specified (x2)
- Conference on DV
- During PA school

'Other' training for human trafficking
- Not specified (x4)
- Investigative documentary
- Training at church
- International Study

How often screen for IPV
- Never (x3)
- When "gut tells me there is more to the story"
- On annual as new intake
- At initial appointment, and then only if showing symptoms
- During well women exams
- Do not see abused patients
- "I have a child abuse practice – the people I always see are children"

How often screen for trafficking
- During immigration physicals
- Never heard of it, only have seen in the news

Table 6. Frequency of screening by provider's characteristics

Variable	Frequency of IPV Screening		χ², p-value
	Always, n=40	Rarely or Symptom Only, n=108	
	n (%)	n (%)	
Sex			2.787, 0.68
Female	30 (31.6)	65 (68.4)	
Male	10 (18.9)	43 (81.1)	
Age			1.184, 0.76
40 or less	8 (25.8)	23 (74.2)	
41-50	8 (21.6)	29 (78.4)	
51-60	13 (32.5)	27 (67.5)	
61 or more	11 (27.5)	29 (72.5)	
Provider Type			0.099, 0.07
Physician	15 (20.8)	57 (79.2)	
Other (Nurse, NP, PA)	25 (32.9)	51 (67.1)	
Years in Practice			4.835, 0.18
5 years or less	5 (29.4)	12 (70.6)	
6-10 years	6 (27.3)	16 (72.7)	
11-20 years	6 (14.6)	35 (85.4)	
21 or more years	23 (33.8)	45 (66.2)	
IPV Training, Past five years			13.450, 0.00
No training	6 (10.5)	51 (89.5)	
1 or more hours	31 (38.8)	49 (61.3)	
Intensity of Training			10.912, 0.00
No Education	4 (10.0)	36 (90.0)	
Medical School, CME, OR Self-Education	24 (29.3)	58 (70.7)	
Medical School AND CME	12 (46.2)	14 (53.8)	
IPV training for LGBTQ populations			4.006, 0.04
No training	24 (22.6)	82 (77.4)	
Some training	16 (39.0)	25 (61.0)	
Knowledge Index (10 items)			2.764, 0.25
0-2 questions correct	3 (21.4)	11 (78.6)	
3-5 questions correct	25 (24.3)	78 (75.7)	
6+ questions correct	12 (38.7)	19 (61.3)	
Serve Low-Income*			12.852, 0.00
Yes	28 (40.6)	41 (59.4)	
No	11 (14.3)	66 (85.7)	
Practice Setting			8.594, 0.00
Primary, OBGYN, peds, and mental health	39 (32.0)	83 (68.0)	
Other	1 (3.8)	25 (96.2)	

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* For Serve Low-Income, a few respondents indicated they "maybe" or "didn't know" if they served low-income patients. A sensitivity analysis was computed by including the "maybe" and "don't know" responses into "no," (a conservative measure indicating that more healthcare providers do not serve low-income patients), and also into "yes" (indicating that more healthcare providers do serve low-income patients). The reported numbers in Tables 4-10 are of the conservative measure. The p-value was significant when "maybe" and "don't know" responses were in either "no" or "yes" categories; therefore, only the conservative measure is provided in the tables.

Table 7. Acceptability of screening questions by provider's characteristics

Variable	Acceptability of Screening Question			X^2, p-value
	Acceptable (n=59)	Unacceptable (n=41)	No general question (n=48)	
	n (%)	n (%)	n (%)	
Sex				15.359, 0.00
Female	47 (49.5)	17 (17.9)	31 (32.6)	
Male	12 (22.6)	24 (45.3)	17 (32.1)	
Age				8.183, 0.23
40 years or less	17 (54.8)	4 (12.9)	10 (32.3)	
41-50	14 (37.8)	10 (27.0)	13 (35.1)	
51-60	17 (42.5)	11 (27.5)	12 (30.0)	
61 or more	11 (27.5)	16 (40.0)	13 (32.5)	
Provider Type				2.667, 0.26
Physician	26 (36.1)	18 (25.0)	28 (38.9)	
Other (Nurse, NP, PA)	33 (43.4)	23 (30.3)	20 (26.3)	
Years in Practice				3.221, 0.78
5 years or less	8 (47.1)	5 (29.4)	4 (23.5)	
6-10 years	8 (36.4)	5 (22.7)	9 (40.9)	
11-20 years	19 (46.3)	9 (22.0)	13 (31.7)	
21 or more years	24 (35.3)	22 (32.4)	22 (32.4)	
IPV Training, Past five years				16.377, 0.00
No training	21 (21.1)	17 (29.8)	28 (49.1)	
1 or more hours	42 (52.5)	21 (26.2)	17 (21.2)	
Intensity of Training				8.708, 0.07
No Education	10 (25.0)	10 (25.0)	20 (50.0)	
Med School, CME, OR Self-Education	36 (43.9)	24 (29.3)	22 (26.8)	
Med School AND CME	13 (50.0)	7 (26.9)	6 (23.1)	
IPV training for LGBTQ populations				12,173, 0.00
No training	35 (33.0)	28 (26.4)	43 (40.6)	
Some training	24 (58.5)	12 (29.3)	5 (12.2)	
Knowledge Index (10 items)				11.743, 0.02
0-2 questions correct	2 (14.3)	3 (21.4)	9 (64.3)	
3-5 questions correct	39 (37.9)	32 (31.1)	32 (31.1)	
6+ questions correct	18 (58.1)	6 (19.4)	7 (22.6)	
Serve Low-Income				5.796, 0.06
Yes	27 (39.1)	25 (36.2)	17 (24.6)	
No	30 (39.0)	16 (20.8)	31 (40.3)	
Practice Setting				3.901, 0.14
primary, OBGYN, peds, mental heath	53 (43.4)	31 (25.4)	38 (31.1)	
Other	6 (23.1)	10 (38.5)	10 (38.5)	

Table 8. Number of IPV victims through screening by provider's characteristics

Variable	None n=101	One or More n=47	χ^2, *p-value*
	n (%)	*n* (%)	
Sex			1.087, 0.20
Female	62 (65.3)	33 (34.7)	
Male	39 (73.6)	14 (26.4)	
Age			2.571, 0.46
40 or less	20 (64.5)	11 (35.5)	
41-50	29 (78.4)	8 (21.6)	
51-60	25 (62.5)	15 (37.5)	
61 or more	27 (67.5)	13 (32.5)	
Provider Type			0.569, 0.28
Physician	47 (65.3)	25 (34.7)	
Other (Nurse, NP, PA)	54 (71.1)	22 (28.9)	
Years in Practice			2.511, 0.47
5 years or less	9 (52.9)	8 (47.1)	
6-10 years	16 (72.7)	6 (27.3)	
11-20 years	30 (73.2)	11 (26.8)	
21 or more years	46 (67.6)	22 (32.4)	
IPV Training, Past five years			17.617, 0.00
No training	50 (87.7)	7 (12.3)	
1 or more hours	43 (53.8)	37 (46.2)	
Intensity of Training			8.466, 0.02
No Education	32 (80.0)	8 (20.0)	
Med School, CME, Self-Education	57 (69.5)	25 (30.5)	
Med School AND CME	12 (46.2)	14 (53.8)	
IPV training for LGBTQ			7.385, 0.01
No training	79 (74.5)	27 (25.5)	
Some training	21 (51.2)	20 (48.8)	
How Often Screen IPV			13.665, 0.00
Always/Most of Time	18 (45.0)	22 (55.0)	
Sometimes, Rarely or if Symptoms only	83 (76.9)	25 (23.1)	
Screening Question Acceptability			9.698, 0.01
Acceptable	35 (59.3)	24 (40.7)	
Unacceptable	25 (61.0)	16 (39.0)	
No General Screening Question	41 (85.5)	7 (14.6)	
Knowledge Index (10 items)			2.245, 0.33
0-2 questions correct	12 (85.7)	2 (14.3)	
3-5 questions correct	69 (67.0)	34 (33.0)	
6+ questions correct	20 (64.5)	11 (35.5)	
Serve Low-Income			20.586, 0.00
Yes	34 (49.3)	35 (50.7)	
No	65 (84.4)	12 (15.6)	
Practice Setting			3.901, 0.04
primary, OBGYN, peds, mental heath	79 (64.6)	43 (35.2)	
Other	22 (84.6)	4 (15.4)	

Table 9. Logistic regression results predicting IPV Screening all or most of the time, N=145

Variable	Full Model	
	AOR	**p-value**
Provider Characteristics		
Sex	1.494	0.44
Age category	1.569	0.18
Provider Type	1.898	0.170
Years in Practice	0.996	0.99
Provider IPV Training and Knowledge		
At least one hour of IPV training in past five years	2.727	0.06
Intensity of IPV training	2.298	0.050
Trained on LGBTQ IPV	0.921	0.87
IPV knowledge Score (10 items)	1.012	0.93
Patient Characteristics		
Low-Income	3.576	0.01
Practice Setting: primary, peds, OBGYN or mental health	13.792	0.02

Table 10. Logistic regression results regarding acceptability of IPV screening question (N=97)

Variable	Full Model	
	AOR	**p-value**
Provider Characteristics		
Sex	5.982	0.003
Age	0.419	0.046
Provider Type	0.561	0.329
Years in Practice	1.520	0.225
Provider IPV Training and Knowledge		
At least one hour of IPV training in past five years	1.754	0.374
Intensity of IPV training	0.911	0.850
Trained on LGBTQ IPV	1.513	0.491
IPV knowledge Score (10 items)	1.345	0.082
Patient Characteristics		
Low-Income	0.224	0.012
Practice Setting: primary, peds, OBGYN or mental health	2.492	0.255

Table 11. Logistic regression results regarding number of female patients identified

Variable	Full Model	
	AOR	**p-value**
Provider Characteristics		
Sex	1.346	0.55
Age	1.914	0.05
Provider Type	0.457	0.09
Years in Practice	0.641	0.01
Provider IPV Training and Knowledge		
At least one hour of IPV training in past five years	3.720	0.01
Intensity of IPV training	1.101	0.81
Trained on LGBTQ IPV	1.564	0.36
IPV knowledge Score (10 items)	1.065	0.64
Patient Characteristics		
Low-Income	4.720	0.00
Practice Setting: primary, peds, OBGYN or mental health	1.556	0.53
How Often Provider Screens	1.984	0.17

Figure 1. IPV Power and Control Wheel

Figure 2. Human Trafficking Power and Control Wheel
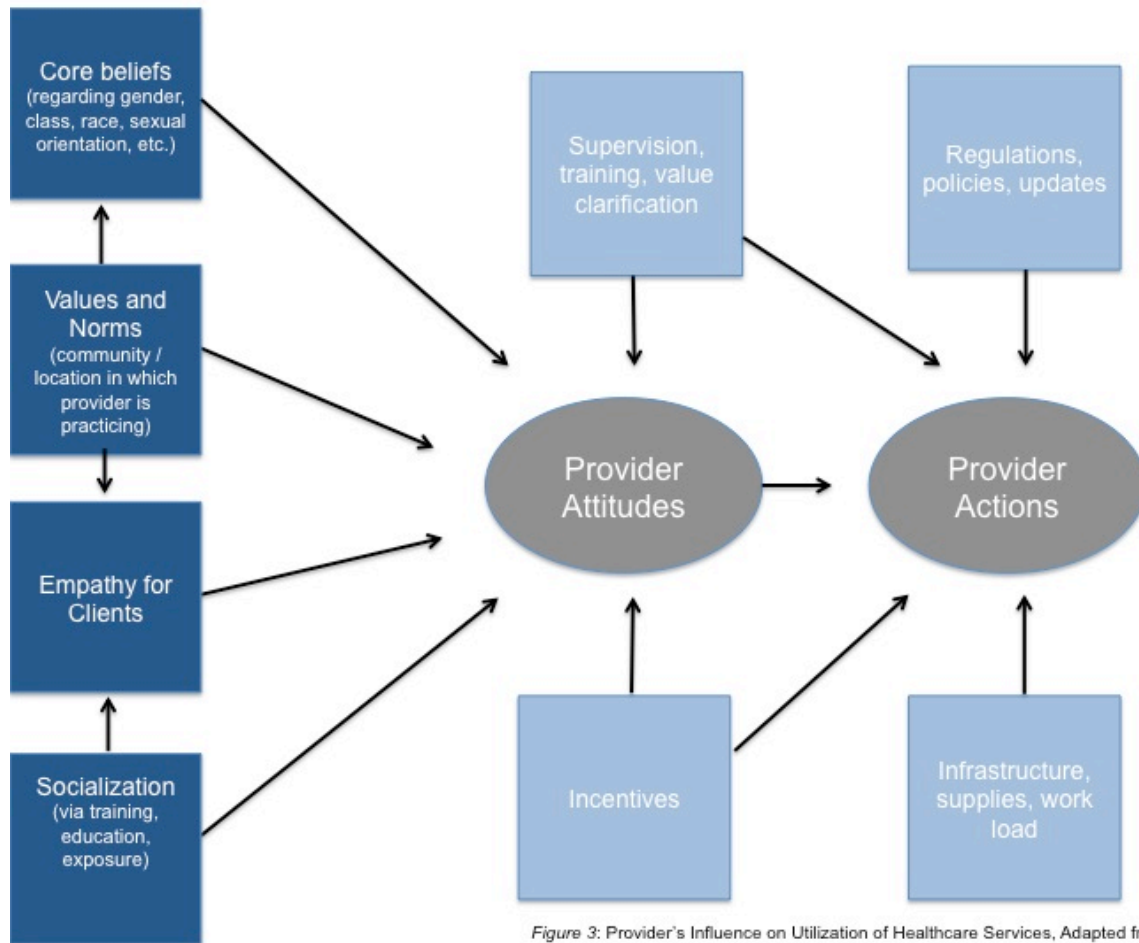
Figure 3. Conceptual Model

Figure 3: Provider's Influence on Utilization of Healthcare Services, Adapted from Tavrow 2010.

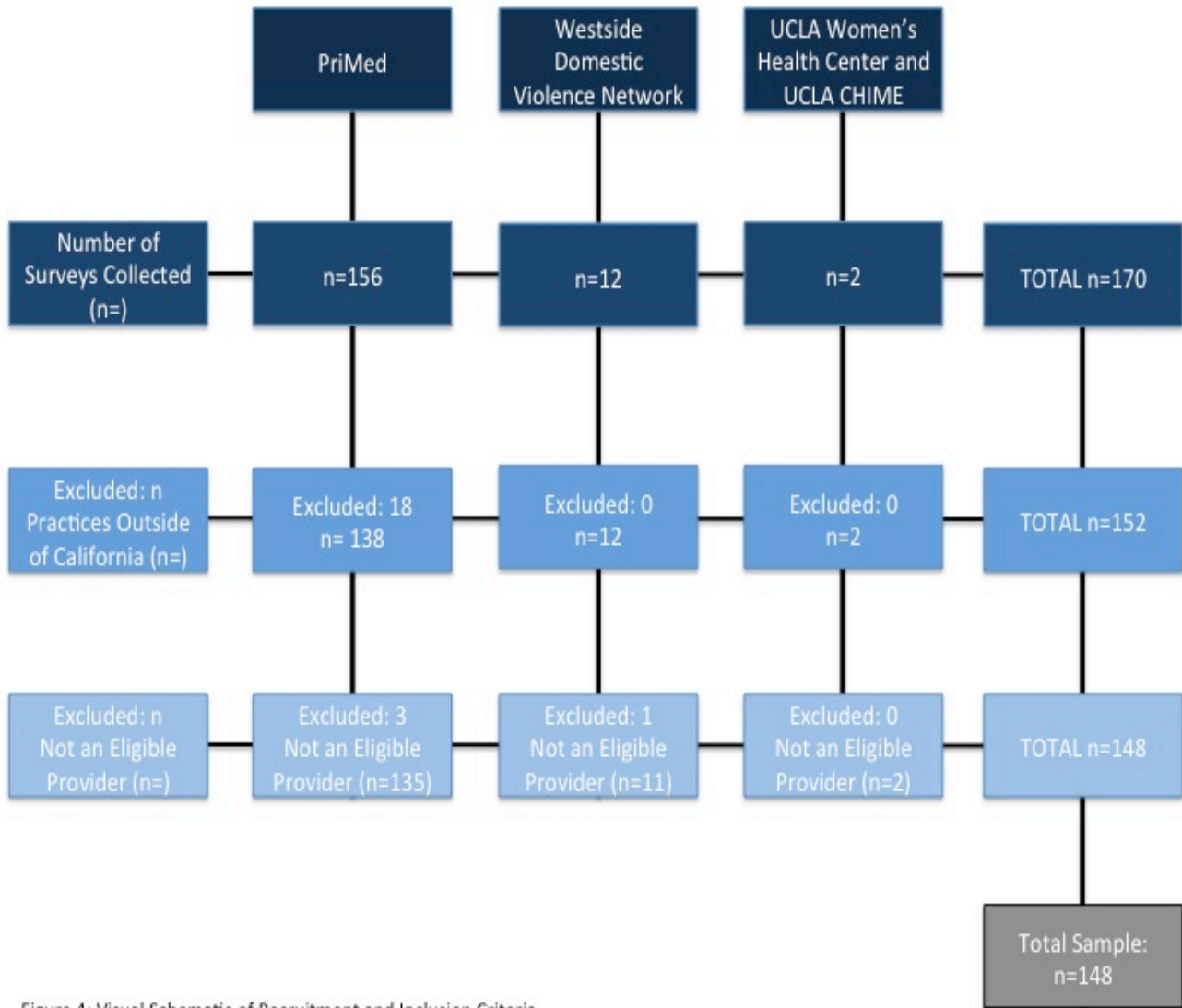Figure 4. Visual Schematic of Recruitment and Inclusion Criteria

Figure 4: Visual Schematic of Recruitment and Inclusion Criteria

PROVIDER SURVEY – DOMESTIC VIOLENCE (DV) AND HUMAN TRAFFICKING

Thank you for your interest in this study! The survey should take no more than a few minutes of your time. The findings of this study will be used to inform researchers and healthcare providers in Southern California about issues related to domestic violence and human trafficking.

Please answer all of the questions as completely as possible. All of your responses are anonymous.

SECTION 1: Background Characteristics

1.1   Age (in years)
- 30 or less
- 31-40
- 41-50
- 51-60
- 61 or more

1.2   Sex
- Male
- Female
- Transgender

1.3   Total years in practice
- 2 or less
- 3-5
- 6-10
- 11-20
- 21 or more

1.4   In what city and state do you primarily provide services?

_____

1.5   What type of clinic do you provide services in? (Please check **[✓]** all that apply)
⭘ Primary Care
⭘ Pediatrics
⭘ Obstetrics/Gynecology
⭘ Orthopedics
⭘ ER
⭘ Mental health
⭘ Other (Please specify) _____

1.6   Occupation
⭘ Physician
⭘ NP
⭘ PA
⭘ Nurse
⭘ LCSW
⭘ Other (Please specify) _____

SECTION 2: About Your Patients

2.1   What race/ethnicities are most of your patients? (Please check **[✓]** all that apply)
⭘ White
⭘ Black / African American
⭘ Hispanic / Latino
⭘ Asian / Pacific Islander
⭘ Native American
⭘ Other (Please specify) _____

2.2   Does your clinic mainly serve low-income patients?
⭘ Yes
⭘ Maybe
⭘ No
⭘ Don't Know

SECTION 3: Screening Procedures

Note: All of the following questions are about the **female** patients you see.

3.1   How often do you screen patients for domestic violence in your clinic?
   ❍ Always
   ❍ Most of the time
   ❍ Some of the time
   ❍ Rarely
   ❍ Only if showing symptoms
   ❍ Other (Please specify) _____

3.2   If you do screen, at what age do you start screening patients for domestic violence?

   _____

3.3   When screening patients for domestic violence, what is the first question you typically ask? _____

   _____

3.4   If a patient's answer indicates she is experiencing domestic violence, what do you normally do? (Please check **[✓]** all that apply)
   ❍ Record her answers in her chart
   ❍ Refer her to outside resources or help
   ❍ Refer her to internal resources at your clinic (i.e. warm hand-off)
   ❍ Help her make an appointment for victim-services
   ❍ Nothing
   ❍ This has never happened to me
   ❍ Other (Please specify) _____

3.5   In the last 30 days, about how many patients revealed to you that they were current domestic violence victims?
   ❍ None
   ❍ 1-2
   ❍ 3-5
   ❍ 6-10
   ❍ More than 10
   ❍ Don't recall or not applicable

3.6   Is there a specific code or codes you put into the emergency medical records when you have a patient who screens positive for domestic violence?
   ❍ Yes, and this is what I use: _____
   ❍ Yes, but I cannot remember it

○ No

3.7 Do you use the notes section of the patient record when you have a patient who screens positive for domestic violence?
○ Yes, and this is what I write: _____
○ Yes, but I write it differently every time
○ No

3.8 If you can, please list three agencies or organizations close to your work where you could refer victims of domestic violence:

1. _____

2. _____

3. _____

3.9 How often do you screen patients for human trafficking in your clinic?
○ Always
○ Most of the time
○ Some of the time
○ Rarely
○ Only if patient seems distressed
○ Other (Please specify) _____

3.10 In the past 30 days, about how many patients revealed to you that they were human trafficking victims?
○ None
○ 1-2
○ 3-5
○ 6-10
○ More than 10
○ Don't recall or not applicable

3.11 If a patient's answer indicates she is being trafficked, what would you do? (Please check **[✓]** all that apply)
○ Record her answers in her chart
○ Refer her to outside resources or help
○ Refer her to internal resources at your clinic (i.e. warm hand-off)
○ Help her make an appointment for victim-services
○ Nothing
○ This has never happened to me

❍ Other (Please specify) _____

SECTION 4: Previous Training

4.1   Have you ever received specific training regarding domestic violence?
(Please check **[✓]** all that apply)
- ❍ Yes, during pre-service training in medical school, nursing school, etc.
- ❍ Yes, during in-service training or continuing education
- ❍ Yes, other (Please specify)
- ❍ No
- ❍ No, but I have done my own research on how to identify victims of domestic violence

4.2   In the past five years, about how much training have you received in domestic violence?
- ❍ None
- ❍ 1 hour
- ❍ 2-3 hours
- ❍ 4-5 hours
- ❍ 6 hours or more
- ❍ Can't remember

4.3   Have you ever received training specifically regarding domestic violence among lesbian, gay, bisexual, transgender, queer (LGBTQ) patients?
- ❍ Yes, during pre-service training in medical school, nursing school, etc.
- ❍ Yes, during in-service training or continuing education
- ❍ Yes, other (Please specify)
- ❍ No
- ❍ No, but I have done my own research on how to identify LGBTQ victims of domestic violence

4.4   Have you ever received specific training regarding human trafficking?
- ❍ Yes, during pre-service training in medical school, nursing school, etc.
- ❍ Yes, during in-service training or continuing education
- ❍ Yes, other (Please specify)
- ❍ No
- ❍ No, but I have done my own research on how to identify victims of human trafficking

SECTION 5: Confidence

How confident are you in your ability to do the following for patients who are victims of DOMESTIC VIOLENCE (DV): (please check [✓] only one box per question)

	Not at all confident	Somewhat confident	Confident	Very confident
5a-DV. Recognize the signs and symptoms of domestic violence?				
5b-DV. Know services available for victims in Southern California?				
5c-DV. Communicate effectively with domestic violence victims?				
5d-DV. Overall ability to assist domestic violence victims?				

How confident are you in your ability to do the following for patients who are victims of TRAFFICKING: (please check [✓] only one box per question)

	Not at all confident	Somewhat confident	Confident	Very confident
5e-T. Recognize the signs and symptoms of trafficking?				
5f-T. Know services available for victims in Southern California?				
5g-T. Communicate effectively with trafficking victims?				
5h-T. Overall ability to assist trafficking victims?				

SECTION 6: True/False (Please check **[✓]** one box per statement]

6.1   A provider is mandated to report to police any revelation of domestic violence, even if the woman shows no physical signs.
   ❍ True
   ❍ False
   ❍ Don't know

6.2   Generally, women leave an abusive relationship up to three times before separating permanently.
   ❍ True
   ❍ False
   ❍ Don't know

6.3   According to studies, most violence escalates quickly from verbal arguments to physical abuse.
   ❍ True
   ❍ False
   ❍ Don't Know

6.4   Domestic violence among lesbians is rare.
   ❍ True
   ❍ False
   ❍ Don't know

6.5   Women are less likely than men to abuse their partner.
   ❍ True
   ❍ False
   ❍ Don't know

6.6   Making threats without physical violence is still considered abuse.
   ❍ True
   ❍ False
   ❍ Don't know

6.7   The more abuse a woman experiences, the more likely she will appear anxious and fearful.
   ❍ True
   ❍ False
   ❍ Don't know

6.8   Being pregnant heightens a woman's risk for domestic violence.
       ❍ True
       ❍ False
       ❍ Don't know

6.9   People abuse their partners because they can't control their anger.
       ❍ True
       ❍ False
       ❍ Don't know

6.10   Relationship abuse happens most often among African-Americans and Hispanics, regardless of income levels.
       ❍ True
       ❍ False
       ❍ Don't know

[END OF QUESTIONNAIRE]

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