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Jane W. Segebrecht Date

Identifying and Addressing the Healthcare Needs of Women Survivors of Sex Trafficking: A Qualitative Analysis of the Barriers and Facilitators to Self-Efficacy for Primary Care Providers

By
Jane W. Segebrecht
Degree to be awarded:
Master of Public Health
Rollins School of Public Health
Emory University

Rita K. Noonan, PhD — Date
Thesis Chair

Lisa M. Carlson, MPH, MCHES — Date
Thesis Field Advisor

Laurie Gaydos, PhD, Associate Chair for Academic Affairs — Date

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A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
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By
Jane W. Segebrecht
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Thesis Chair: Rita K. Noonan, PhD

Thesis Field Advisor: Lisa M. Carlson, MPH, MCHES

Executive Summary

Title: Identifying and Addressing the Healthcare Needs of Women Survivors of Sex Trafficking: A Qualitative Analysis of the Barriers and Facilitators to Self-Efficacy for Primary Care Providers

Background: Sex trafficking is a complex public health challenge with unique ramifications for health conditions. Trafficked individuals utilize a variety of healthcare settings, including primary care, but may encounter providers for whom readiness to identify trafficking and respond to healthcare needs is varied. Increasing primary care providers' self-efficacy to address sex trafficking can strengthen primary care settings as key public health points of intervention to address sex trafficking.

Objectives: The primary aim of this qualitative study is to identify barriers and facilitators to self-efficacy for primary care providers to respond to the healthcare needs of women survivors of sex trafficking. Additionally, this study seeks to inform policy or program development to strengthen approaches for primary care providers to respond to sex trafficking.

Methods: After conducting a review of the literature, 11 providers in seven states, representing distinct healthcare settings, were recruited to participate in semi-structured interviews. Providers interviewed for this study included physicians and nurse practitioners currently addressing the primary care needs of survivors of sex trafficking in practice. Survivors were defined in this study as women currently or formerly in sex trafficking and older than 18 years of age. Purposive chain-referral sampling of provider networks was employed as a recruitment technique until data saturation was achieved. The Braun and Clarke (2006) six-phase approach to thematic analysis was used to generate themes; an adaptation of the Gist and Mitchell (1992) Self-Efficacy–Performance Relationship Model served as the theoretical framework to organize themes.

Results: Multiple barriers and facilitators to self-efficacy were identified for providers to respond to sex trafficking. Opportunities identified in this study to support self-efficacy include: building upon an existing primary care culture which addresses social determinants of health and intersectionality; ensuring role clarity for providers; employing team-based and trauma-informed care approaches; learning experientially in practice and through discourse with social service providers, peers, professional networks, and mentors; addressing vicarious trauma through resiliency-supportive techniques; establishing practice-based safety planning; and utilizing protocols. The primary barriers to self-efficacy were challenges in addressing the mental health needs of survivors, visit length, and navigating coverage for care. Connections beyond the practice also were key to support self-efficacy and include engaging a multi-disciplinary network of referral providers and forming partnerships with social service providers and legal services.

Conclusion: Study findings suggest there are multiple barriers and facilitators to self-efficacy for primary care providers to identify and respond to the unique healthcare needs of survivors of sex trafficking. Respondents generally expressed a high self-estimation of confidence to address sex trafficking; however, their noted barriers demonstrate opportunities to strengthen approaches in primary care and the healthcare delivery system to support providers to address sex trafficking. The methods designed to encourage facilitators and reduce barriers identified in this study can be integrated into public health interventions to support primary care provider responses for survivors of sex trafficking.

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Chapter 1: Introduction and Context of the Problem

1.1 Introduction to the Issue

Human trafficking, which includes forced labor and sexual exploitation, is a complex issue with implications for both public health and healthcare delivery. This exploitation, comparable to "modern-day slavery" includes, "at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs" and does not discriminate by age, gender, language ability or citizenship status (United Nations Office on Drugs and Crime (UNDOC), 2004; Chisolm-Straker, Baldwin, Gaïgbé-Togbé, Ndukwe, Johnson, Richardson, 2016). Human trafficking affects an estimated 20.9 million people globally, of whom more than half are women and girls (11.4 million or 55% of the total) (International Labor Organization (ILO) Global Estimate of Forced Labour, 2012).

With significant impact on health outcomes and societal costs, sex trafficking, which comprises one specific facet of trafficking, is an important public health concern. Sexual exploitation is present in 79% of trafficking cases and women and girls represent 98% of individuals trafficked for the purposes of forced commercial sexual exploitation (UNDOC, 2009; Besler, de Cock, and Mehran for ILO, 2005). Sex trafficking is a risk factor for severe health issues, such as sexual and physical violence, underscoring the value of a public health-based response to combat the issue (Ellsberg & Heise, 2005). Health problems resulting from gender-based violence may compromise mental or physical wellbeing in the form of, but not limited to, "injuries, gynecological disorders, mental health disorders, adverse pregnancy outcomes, and sexually transmitted infections" (Ellsberg & Heise, 2005). Additionally, violence can operate as a mediator to health outcomes; Ellsberg & Heise (2005) conceptualized "victimization, like

tobacco or alcohol use … as a risk factor for a variety of diseases and conditions, rather than primarily as a health problem in and of itself." The estimated global annual net profit of this criminal activity is $150 billion (ILO Standards on Forced Labor, 2016). In addition to the high prevalence and complex social ecology associated with the issue, a multifaceted web of financial rewards associated with trafficking (both labor and sex) make it a particularly challenging public health issue.

Despite the significant public health burden, trafficking is preventable. Within the Social Ecological Model (SEM), comprehensive public health prevention is conducted through interventions spanning individual, relationship, community, and societal factors (Dahlberg and Krug, 2002). Multiple interventions to address trafficking are underway across these four levels; however, multiple opportunities to strengthen public health response remain. A public health response in this space is designed to reduce risk for populations most "vulnerable to human trafficking due to experience of prior violence, stigma, and disconnection" and positions responses "along a spectrum of inter-related violence, understands the ripple effects of trauma, and encourages cultural-specific prevention and intervention efforts" (Chon, 2015). Such a systems-based response warrants a social determinants approach and takes interventions beyond criminal justice and social service interventions to incorporate prevention strategies (Chon, 2015). Dismantling "deep rooted cultural norms around power, equity, gender, and consumer behavior [that] shape the social and economic dynamics that have enabled human trafficking" is challenging but "a public health framework is more likely [than other approaches] to confront entrenched interests and highlight barriers to reducing slavery" (Chon, 2015). A public health approach is appropriate to address trafficking because the complexity of the issue requires

employing interventions across multiple levels of the social ecology and recognizes the issue as connected to other inequities and violence (Chon, 2015).

The five-tier *Health Impact Pyramid* was proposed by Frieden (2010) as a conceptual framework to organize approaches to address public health challenges. Within this model, at the base of the pyramid are social determinants of health which engender the greatest impact to public health. Beyond this, "in ascending order are interventions that change the context to make individuals' default decisions healthy, clinical interventions that require limited contact but confer long-term protection, ongoing direct clinical care, and health education and counseling" (Frieden, 2010). According to this framework, direct clinical care is an important point of intervention to impact public health.

In using the *Health Impact Pyramid* as a model, the healthcare setting is one key approach, among several, to address trafficking. A study by Lederer and Wetzel (2014) found "[d]espite their abusive situations, most survivors did receive medical treatment at some point during their trafficking. Of those who answered the questions about their contact with healthcare (n=98), 87.8% had contact with a healthcare provider while they were being trafficked." Primary care, the focus of this thesis, presents an important point of intervention in trafficking as it is the second most visited care setting by survivors (Chisolm-Straker et al., 2016). In one study of trafficked individuals, "[t]he majority (68%, n=117) of participants were seen by a healthcare provider while being trafficked" with "[r]espondents most frequently report[ing] visiting emergency/urgent care practitioners [56%], followed by primary care providers [44.4%], dentists [26.5%], and obstetricians/gynecologists [25.6%] (Chisolm-Straker et al., 2016). For this sometimes hidden and vulnerable population, primary care, and healthcare in general, are key points of public health intervention as they are generally recognized as "safe spaces for patients

to speak freely with providers, creating a unique opportunity for victims to be identified, treated, and offered intervention" (Chisolm-Straker et al., 2016). Survivors often seek medical attention, but providers have varying experiences, comfort levels, and readiness to identify and treat the unique needs of trafficked patients. Providers' experiences suggest opportunities for strengthening healthcare encounters as an important point of intervention to address trafficking.

Self-Efficacy for Providers to Address Trafficking

One avenue for strengthening provider response in public health interventions is to apply self-efficacy as an approach to modify provider behavior. Self-efficacy is an essential element in understanding and promoting clinical behavior. For providers to enact new behavior, they are supported by both knowhow (skill acquisition) and their confidence to engage in behaviors (self-efficacy). Exploring self-efficacy for providers to care for survivors of trafficking is a relevant inquiry to the current healthcare landscape as "[r]ecent research suggests that 28–88% of trafficking victims in the United States who come into contact with [healthcare] professionals while in captivity are not recognized as experiencing [human trafficking] victimization by those providers" (Family Violence Prevention Fund, 2005; Grace et al., 2014; International Organization for Migration, UN Global Initiative to Fight Human Trafficking & London School of Hygiene and Tropical Medicine, 2009; Lederer & Wetzel, 2014; as cited by Stoklosa, Dawson, Williams-Oni, & Rothman, 2016). However, while "HCPs [healthcare providers] have the potential to play a critical role in human trafficking victim prevention, identification, and care … most HCPs are unfamiliar with how to care for trafficking survivors" (Powell, Dickins, & Stoklosa, 2017).

Study Overview

The primary aim of this qualitative study is to identify the barriers and facilitators to self-efficacy for primary care providers as they address the healthcare needs of women survivors of sex trafficking. Furthermore, this study seeks to share findings and offer recommendations which may contribute to policy or program development to strengthen primary care response to sex trafficking. This study interviewed providers (N=11) who offer primary care services in 11 distinct care healthcare settings across seven U.S. states. Responses from semi-structured interviews were analyzed for common themes that indicate barriers and facilitators to self-efficacy for providers to identify and treat women survivors of sex trafficking. The providers engaged in this study *currently* address in practice the healthcare needs of adult women who are survivors of sex trafficking. Providers who are experienced in this area were interviewed because their experiences can provide insight that may be applicable to the broader population of primary care providers.

To frame the language throughout this thesis, the term *survivor* refers to currently and formerly trafficked individuals; this term was selected to represent more empowering language when referring to those currently or formerly in trafficking and also is a more inclusive term given the patient mix primary care providers may encounter (Stoklosa, H., MacGibbon, & Stoklosa, J., 2017).

1.2 Problem and Purpose Statement

As identified in the upcoming literature review chapter, multiple studies indicate sex trafficking is a significant public health issue with complex social and clinical dimensions that can be addressed by primary care providers in appropriately equipped healthcare settings. However, to date, there has not been a formal study of factors (including, motivation,

engagement, and interaction with the social environment beyond the healthcare setting) which contribute to self-efficacy for primary care providers who currently provide care for sex trafficked survivors. Studies have assessed medical providers' understanding of a variety of dimensions of trafficking, including training and tools to support providers. Yet, from a self-efficacy framework, studies have not solely analyzed the factors which support primary care providers who are currently to addressing sex trafficking of women.

The purpose of this study is to elucidate factors contributing to or limiting self-efficacy for primary care providers to identify and address sex trafficking. This was done through a qualitative study which captured themes from content shared directly by providers who are currently addressing sex trafficking. By analyzing primary care providers' responses to what supports and challenges their ability to address sex trafficking, this study highlights themes which can lend to policy or program development to increase primary care provider self-efficacy to respond to healthcare needs for women who are sex trafficked. There is an increasing appreciation for the role of primary care providers to address health inequities and social determinants of health (Rasanathan, Montesinos, Matheson, Etienne & Evans, 2010). Because primary care providers are key actors in addressing the social dimensions at play for patients from within healthcare, they may be able to play a role in ameliorating health inequities connected to sex trafficking. Provider self-efficacy is integral to support engagement in this area of care.

1.3 Research Questions

According to the American Psychological Association, "[s]elf-efficacy reflects confidence in the ability to exert control over one's **own motivation, behavior, and social environment**" (Forsyth & Carey, 2017). Using these components, this qualitative research study seeks to specifically answer the following questions:

(1) Which factors, including both barriers and facilitators, contribute to primary care providers' ***motivation*** to address the needs of patients who are survivors of sex trafficking?
(2) Which factors, including both barriers and facilitators, contribute to primary care providers' ***active engagement*** to address the needs of patients who are survivors of sex trafficking?
(3) Which factors, including both barriers and facilitators, contribute to primary care providers' sense of ***interaction with the social environment beyond the healthcare setting*** to address the needs of patients who are survivors of sex trafficking?

The preceding questions are organized according to "triadic reciprocal causation" as defined by the Social Cognitive Theory (Bandura, 1998). This triad, displayed in Figure 1, is the interplay of behavioral, cognitive or personal factors, and environmental events which impact psychosocial functioning and organizational approaches (Bandura, 1998).

In analyzing themes related to self-efficacy, this thesis study seeks to highlight aspects of primary care practice which can be further targeted through policy or program development so as to strengthen opportunities to respond in primary care settings to the needs of sex trafficked women.

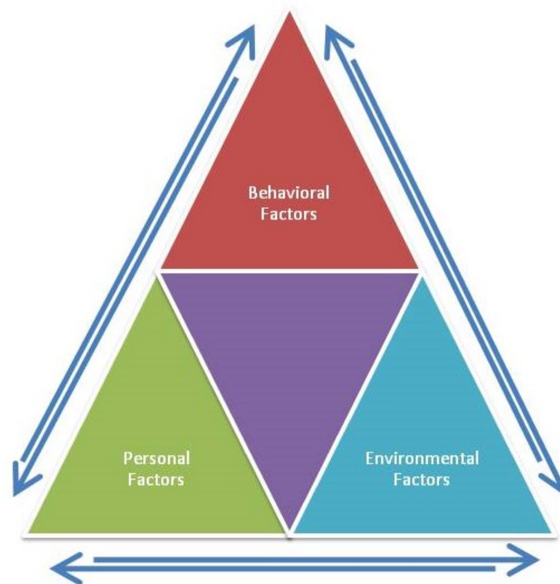
1.4 Theoretical Framework

As providers are increasingly called to address social determinants of health and psychosocial dimensions of health, including sex trafficking, an understanding of methods to foster provider self-efficacy to address sex trafficking can be helpful to design interventions to support providers. Self-efficacy is a motivational construct which influences decisions, reactions, level of

effort, coping and persistence on the part of individuals when approaching a behavior (Gist & Mitchell, 1992). Self-efficacy was selected as the theoretical framework for this study as it can be modified through interventions which support learning, engagement in behavior, self-reflection, and input from others (Gist & Mitchell, 1992).

The aspects, or levers, which influence provider self-efficacy when addressing trafficking, rooted in Social Cognitive Theory (SCT), serve as a guide for this study. SCT views psychosocial functioning and organizational approaches as outcomes of the interplay of behavioral, cognitive or personal factors, and environmental events, known as "triadic reciprocal causation" (Bandura, 1998) (Figure 1).

Figure 1: Bandura's Triadic Reciprocal Determinism
(from Wood & Bandura, 1989; as cited by Redmond, 2016).



A key driver of behavior under the SCT is self-efficacy, defined as: "people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives" (Bandura, 1994). Self-efficacy beliefs determine how people feel, think, motivate themselves and behave" (Bandura, 1994). For this study, self-efficacy of primary care providers is concerned with providers' ability to learn new behaviors and "beliefs in their

capabilities to exercise control over their own functioning" including, "choices, level of motivation, quality of functioning, resilience to adversity and vulnerability to stress…" (Bandura, 1994).

Two models of self-efficacy were used as the scaffold from which to develop semi-structured interview questions (interview guide included in Chapter 3) and arrange responses to interviews according to how providers acquire the confidence and competencies necessary to address sex trafficking. The first model, Bandura's four drivers of influence on self-efficacy (Figure 2), contains the most commonly cited methods to support self-efficacy. Gist and Mitchell (1992) expanded this theoretical construct, beyond the four drivers, to include elements which help individuals—in this study, healthcare providers—interpret or make sense of their learning and identify personal and situational resources or constraints to their attainment of self-efficacy. The second model (Figure 3) incorporates the components of the first model (Figure 2) and uses the four drivers as a base from which to add additional levers to support self-efficacy development (Figure 3).

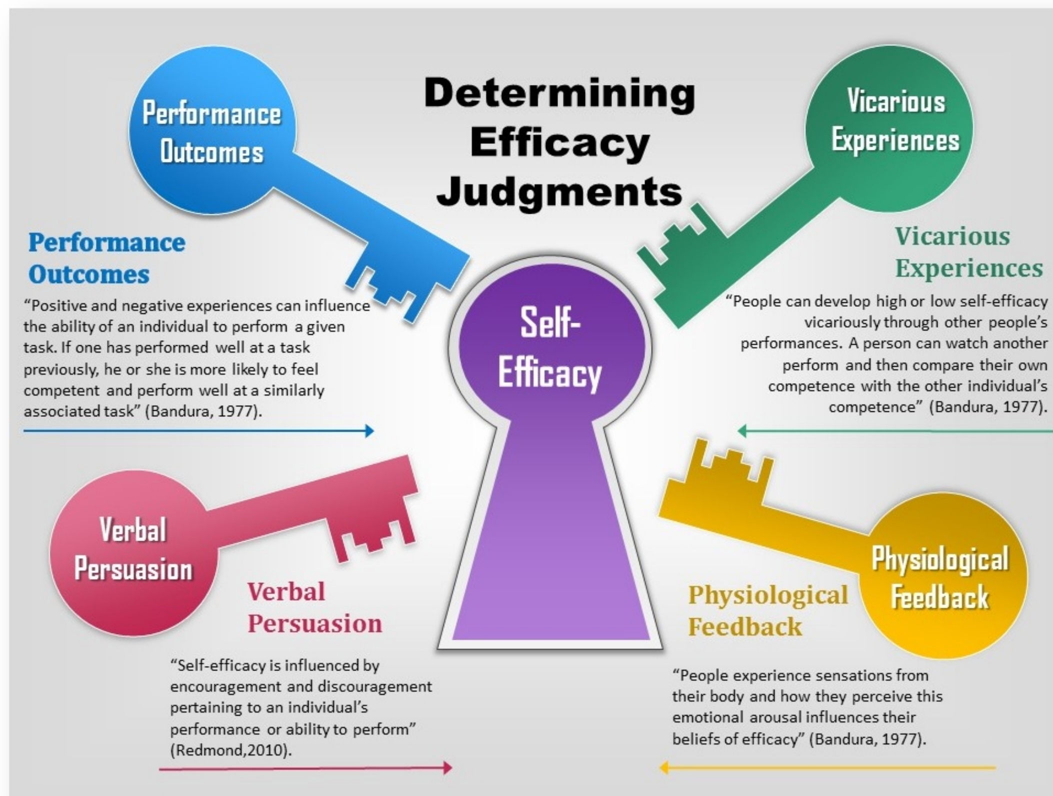
In the first model (Figure 2) Bandura positions the generation of a sense of self-efficacy in four main drivers of influence:

(1) mastery experiences;
(2) seeing people similar to oneself manage task demands successfully [vicarious experience];
(3) social persuasion that one has the capabilities to succeed in given activities [including verbal persuasion]; and
(4) inferences from somatic and emotional states indicative of personal strengths and vulnerabilities (Bandura, 1994).

An example of the above four drivers in practice is as follows: (1) the skill could be developed over time in engagement with patients; (2) providers may learn from peers or engage in a network of experts; (3) providers may be encouraged verbally to implement concrete changes in

support of the work; and (4) providers may develop coping mechanisms to sustain continued engagement in this space. To this last factor, Bandura notes that "[p]eople with high assurance in their capabilities approach difficult tasks as challenges to be mastered rather than as threats to be avoided." This "efficacious outlook [i.e., *do I affect change as a provider?*] fosters intrinsic interest and deep engrossment in activities" (Bandura, 1994).

Figure 2: Bandura's Four Drivers of Influence to Achieve Self-Efficacy
(from Bandura, 1998 and Redmond, 2016)

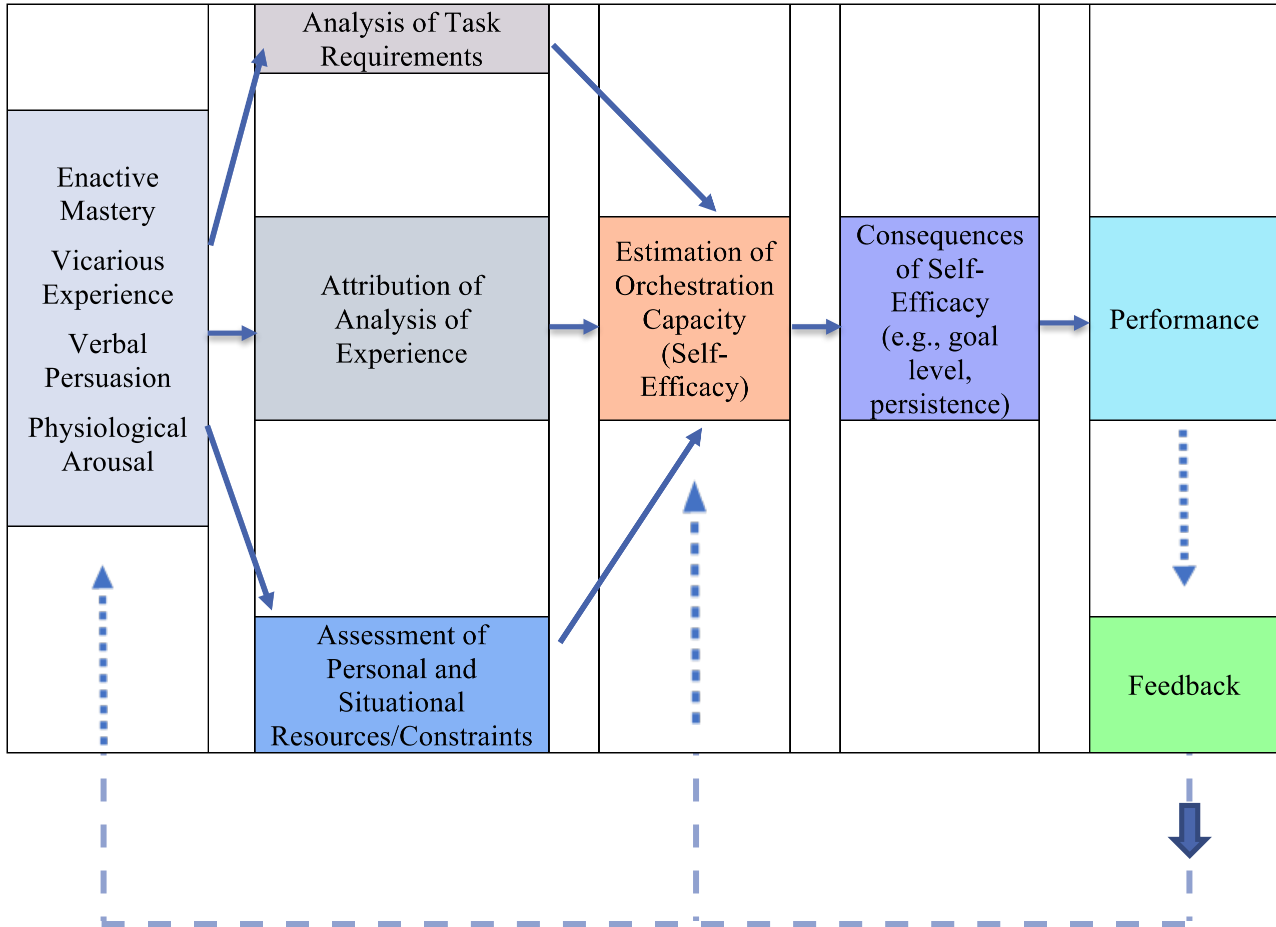


In the second model, Bandura's original factors are listed on the left-hand side of the model, followed by the expanded elements to support interpretation or cognitive synthesizing of self-efficacy, followed by consequences, or outcomes, of addressing trafficking in primary care settings, including provider goals (Figure 3). This expanded version was used to frame providers' interpretation of their personal and situational resources and constraints which impact

their confidence to work in this space. The components of the expanded model are defined in detail in Chapter 4.

Figure 3: Self-Efficacy–Performance Relationship Model

(Adapted from Gist and Mitchell, 1992)



1.5 Key Terms

The following key terms and definitions are used throughout the study:

I. Human Trafficking

According to the UN,

> Trafficking in Persons [is defined] as 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 (UN Office on Drugs and Crime, 2004).

According to the U.S. Department of State (2007), persons in trafficking do not need to be physically transported across geographic boundaries to be considered trafficked.The overarching definition of human trafficking is further clarified by the "Act-Means-Purpose" model where an event is designated as trafficking if it includes the following three elements as illustrated in Table 1 (National Human Trafficking Resource Center, 2012).

A. Act: includes one of the following: "[r]ecruitment, transportation, transfer, harbouring or receipt of persons" (National Human Trafficking Resource Center, 2012).

B. Means: includes one of the following: "[t]hreat or use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or giving payments or benefits to a person in control of the victim" (National Human Trafficking Resource Center, 2012).

C. Purpose: if it is done "[f]or the purpose of exploitation, which includes exploiting the prostitution of others, sexual exploitation, forced labour, slavery or similar practices and the removal of organs (National Human Trafficking Resource Center, 2012).

Table 1: Act-Means-Purpose Model
(Adapted from the National Human Trafficking Resource Center, 2012)

ACT		MEANS		PURPOSE		
Recruitment Transport Transfer Harboring Receipt of persons	+	Threat or use of force Coercion Abduction Fraud Deception Abuse of power or vulnerability Giving payments or benefits	+	Exploitation*, including:* Prostitution of others Sexual exploitation Forced labor Slavery or similar practices Removal of organs Other forms of exploitation	=	**Trafficking**

II. Sex Trafficking

In U.S. Code, Title 22, Chapter 78, § 7102 (2010), the term *sex trafficking* is defined as:

> the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age.

Additionally, the term, *commercial sex act* means any sex act on account of which anything of value is given to or received by any person (22 U.S. Code § 7102, 2010).

According to the National Human Trafficking Hotline (2017), "[s]ex trafficking has been found in a wide variety of venues within the sex industry, including residential brothels, escort services, fake massage businesses, strip clubs, and street prostitution." However, a commercial sex act is not automatically defined as trafficking unless it meets the criteria in the Act-Means-Purpose with the inclusion of an element from each column listed in the image in Table 1.

III. Survivor/Victim

The term *victim* describes a person subjected to an act or practice described in the definition given for sex trafficking above (22 U.S. Code § 7102, 2010). The term *victim* may be used in this paper when included in a cited reference. The terms *survivor* and *victim* are often used interchangeably in trafficking literature and trafficking-related policy.

In alignment with the language of choice by some current anti-trafficking organizations and feminist literature, this thesis defaults to the use of the term *survivor* in lieu of the term *victim* to serve as a more empowering term to "capture the strength it takes to face extensive trauma" and reflects women who are currently or formerly trafficked (Stoklosa, et al., 2017). The term *survivor* was also included as providers may encounter women in practice who are currently or formerly trafficked.

IV. Primary Care Practice and Primary Care Provider

According to the American Academy of Family Physicians,

> Primary care is that care provided by … [providers] specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis (AAFP, 2017).

For the purposes of this thesis, "[a] primary care practice [often] serves as the patient's first point of entry into the [healthcare] system and as the continuing focal point for all needed services" (AAFP, 2017).

For the purposes of this thesis, primary care providers include: physicians, physician assistants, and advance practice nurses, including nurse practitioners. Care provided by these disciplines, in primary care "includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of [healthcare] settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.)" (AAFP, 2017).

V. Patient Centered Medical Home

According to the Agency for Healthcare Research and Quality,

> The primary care medical home, [a model for structuring practice] also referred to as the patient centered medical home (PCMH) … and the healthcare home, is a promising model for transforming the organization and delivery of primary care (AHRQ, 2017).

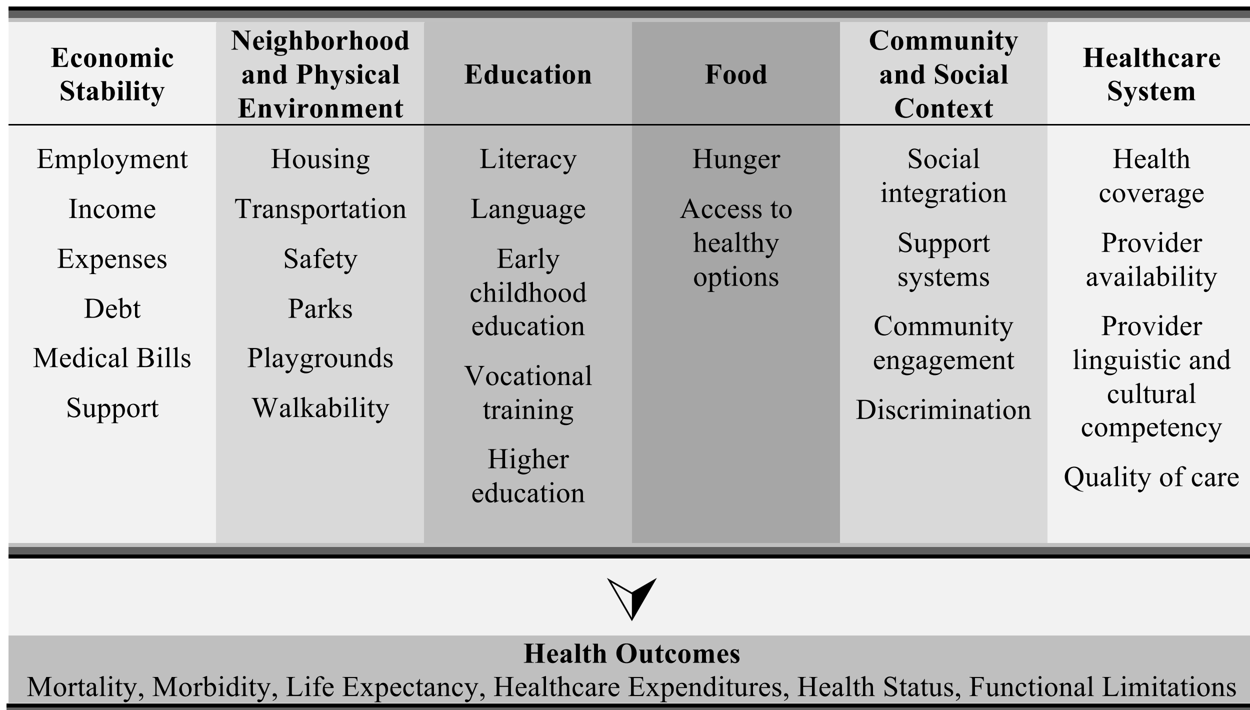
While there are different PMCH models, "the primary care medical home is accountable for meeting the large majority of each patient's physical and mental [healthcare] needs, including prevention and wellness, acute care, and chronic care" via a team of providers (AHRQ, 2017).

The unique aspects of the PCMH model is an emphasis on: "[healthcare] that is relationship-based with an orientation toward the whole person" and includes coordinated care across "all elements of the broader [healthcare] system, including specialty care, hospitals, home [healthcare], and community services and supports" (AHRQ, 2017). Additionally, the PCMH model places value on delivering accessible services alongside quality care through use of evidence-based medicine, clinical decision-support tools, performance measurement and improvement, measurement of patient experiences and patient satisfaction, and population health management (AHRQ, 2017).

VI. Social Determinants of Health

Social Determinants of Health (SDH) are defined as "the structural determinants and conditions in which people are born, grow, live, work and age" (Marmot, Friel, Bell, Houweling, & Taylor, 2008; WHO, 2017). SDH include factors such as socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to healthcare (Heiman & Artiga, 2015) (Table 2).

Table 2: Social Determinants of Health
(Adapted from Heiman & Artiga, 2015)



Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Healthcare System
Employment Income Expenses Debt Medical Bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes
Mortality, Morbidity, Life Expectancy, Healthcare Expenditures, Health Status, Functional Limitations

VII. Self-efficacy

Albert Bandura's definition of perceived self-efficacy "as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives" is used throughout this thesis (Bandura, 1994). Self-efficacy "determine[s] how people feel, think, motivate themselves and behave" and "reflects confidence in the ability to exert control over one's own motivation, behavior, and social environment" (Bandura, 1994; Forsyth, Carey, 2017). When the term "self-efficacy" is used in this thesis, it is referring to self-efficacy on the part of the primary care provider.

VIII. Facilitators and Barriers

Facilitators (to address sex trafficking): include the personal, structural, organizational, professional, social and environmental aspects or elements which may equip, support, or enable a provider to practice.

Barriers (to address sex trafficking): include the personal, structural, organizational, professional, social, and environmental aspects or elements which may challenge, delay, or impede a provider to practice.

Chapter 2: Background Research and Review of the Literature

This chapter includes the background research and literature that informed the development of study questions, a semi-structured interview guide, and sensitizing concepts to develop themes and guide analysis. The goal of this literature review was to provide contemporary context for the significance of the issue of sex trafficking and the current landscape of provider response. The research included a search of public health databases with broad search terms, including combinations of search terms related to sex trafficking and health, healthcare, primary care, and self-efficacy. Literature at the intersection of health, sex trafficking, and primary care were analyzed in the development of this review.

2.1 Overview of the Sex Trafficking Landscape

Sex trafficking is a criminal act and form of violence associated with both physical and psychological harm, which relies on exploiting an individual's desire to improve his or her future (UNGIFT, International Organization on Migration, & London School of Hygiene and Tropical Medicine, 2009). The UN Special Rapporteur on Violence Against Women elevates this sexual exploitation (e.g., forced prostitution and sexual slavery), from simply "general community and economic violence" to "a critical aspect of human rights violations related to violence against women worldwide" (Miller, Decker, Silverman, & Raj, 2007). Trafficking operates as a form of gender-based violence and violence against women. According to the UN (1993), "[g]ender-based violence assumes many forms" and "violence against women constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms, and [is] concerned about the long-standing failure to protect and promote those rights and freedoms" (UN General Assembly, 1993).

Sexual exploitation takes place during commercial or transactional sex where anything can be traded for a sexual act, from money to tangible goods (Logan, Walker, & Hunt, 2009; as cited by Richards, 2014). These transactions entail actions such as "solicitation of mail-order brides, stripping, pornography, prostitution and sex tourism" (Richards, 2014). When referencing sex trafficking, a distinction should be made between those who engage in trafficking and those who engage in commercial sex acts of their own volition. It is the "engagement that links a person to an 'employer' which determines forced labour, not the type of activity that a worker is actually performing" (Belser, 2005). In this respect, "[a] woman trafficked and forced into prostitution is in forced labour because of the menace under which she is working [which indicates sex trafficking], not because of the sexual duties that her job demands or the legality or illegality of that particular occupation" (Belser, 2005). Sex trafficking takes a variety of forms to limit freedoms such as violence, threats, fraud, lies, debt bondage, and coercion to exploit or force individuals to engage in commercial sex acts (Polaris, 2015). Becoming romantically involved with an individual in order to later manipulate them by dangling the hope of a brighter future is an example of one method traffickers may use to initiate coercion (Polaris, 2015). According to an article by Richards (2014), "[s]imilar to forced labor, individuals may be sold or forced into sex work or tricked into thinking they are taking a legitimate job; others may enter into prostitution voluntarily but become victims when they are held under force or threats." Trafficking can take place across all ages and involves an array of relationships established by strangers to romantic partners to family members. The length of time spent in trafficking can range from a few days to years (Polaris, 2105). Sex trafficking is initiated or conducted in locations as diverse as online ads, escort services, brothels, truck stops, motels, hotels, and fronts for fake businesses such as in massage parlors (Polaris, 2015).

Domestic and Global Public Health Burden

Trafficking is both a domestic and global challenge. The ILO estimates 4.5 million people experience forced sexual exploitation (ILO, 2012). According to a U.S. Department of Justice report, between 2008 and 2010, 83% of confirmed sex trafficking cases in the U.S. were classified as U.S. citizens (Banks & Kyckelhahn, 2011). While precise prevalence is challenging to determine, every year it is estimated that roughly 700,000 to 2 million women and girls are trafficked across borders internationally (Ellsberg & Heise, 2005). From the domestic perspective, Muftic and Finn (2013) cite a study by O'Neill (1999) where "[e]arly estimates from the federal government reported nearly 50,000 women and children are trafficked into the United States annually." The same authors also reference more conservative numbers from Clawson, Dutch, Solomon, & Goldblatt Grace (2009) which estimate between 14,500 to 17,000 individuals are trafficked each year (Muftic & Finn, 2013). Of this estimate, "80% of these international victims are female and 70% are trafficked into the sex industry" (Clawson, et al., 2009, as cited in Muftic & Finn, 2013). For women who are being trafficked across borders, the decision to move is often made not of her own volition but in response to false pretenses, such as the promise of a better life and opportunities (Miller et al., 2007).

The commodification of women in sex trafficking is an alarmingly lucrative criminal endeavor. The underground nature of the sex trafficking economy makes it challenging to measure revenues from forced commercial sexual exploitation, resulting in broad ranges of estimates, with one study estimating $27.8 billion in 2005 to another estimating $51.13 billion in 2007 (Belser, 2005; Dank et al., 2014).

Risk Factors for Entry into Trafficking

Push-pull factors for entering trafficking and continued entrapment are complex and differ broadly across instances of sex trafficking (Dank et al., 2014; Anh et al., 2013). Across all types of trafficking, a healthcare provider guide developed by Ahn et al. (2013) contains an assemblage of risk factors to entry into trafficking such as: a history of experiencing or witnessing abuse; false promises for career or better life; to please a so-called boyfriend; deception/bait-and-switch; poverty; lack of employment options; gender inequality; political or social conflict; environmental degradation (impact on economic opportunities); and societal demand for transactional sex. Sex trafficking affects women across populations. However, due to the intersection of trafficking and social determinants, select factors may heighten vulnerability and disproportionately affect some populations (Rollins, Gribble, Barrett, & Powell, 2017). Select characteristics, which may make certain populations particularly vulnerable to trafficking, include: racial or ethnic minority status; a background of childhood abuse and neglect; exposure to foster care or time in juvenile justice; homelessness; low socioeconomic status and poverty; LGBTQ+ status; gender; age; disability; experience of intimate partner violence and sexual assault; isolation and social discrimination; undocumented immigrant status; war and displacement; and hope for a different life circumstance (Polaris, 2015; Logan et al., 2009; Rollins et al., 2017).

Citing data from a U.S. Department of Justice special report (2011), an article by Rollins et al. (2017) categorized trafficking, for survivors whose race was known as: 40.4% black; 25.6% white; 23.9% Hispanic; 4.3% Asian; and 5.8% classified as other. With grounding in this data, the authors note “[t]he high rates of human trafficking within communities of color present an excellent opportunity for professionals, researchers, and policymakers who are knowledgeable

about minority health disparities to contribute their expertise to human trafficking prevention and intervention strategies" (Rollins et al., 2017).

Specific Risk Factors for Special Populations

The focus of this study is on adults, but the commercial sexual exploitation of children, youth, and young adults also is a major challenge for those working to address trafficking (Fogel, Martin, Nelson, Thomas, & Porta, 2016). Multiple studies focusing on youth and young adults have found that those experiencing homelessness face a greater risk of commercial sexual exploitation (Greene et al., 1999; Holger-Ambrose et al., 2013; Saewyc et al., 2008; Tyler and Johnson, 2006 as cited in Fogel et al., 2016). At the intersection of homelessness and trafficking are LGBTQ+ youth and young adults who may have been rejected by family members and then, in turn, engage in a survival-sex economy to meet basic needs (U.S. State Department, 2014; Dank et al., 2015). The U.S. State Department (2014) notes, "[t]he cumulative effects of homophobia and discrimination make LGBT persons particularly vulnerable to traffickers who prey on the desperation of those who wish to escape social alienation and maltreatment." Martinez and Kelle (2013) reference a U.S. National Coalition for the Homeless article which describes homeless LGBT youth as far more vulnerable to sexual exploitation and trafficking than homeless youths in other populations. While only 20% of U.S. homeless youth are LGBT, 58.7% of LGBT homeless youth are exploited through transactional sex (Martinez & Kelle, 2013). An article calling for increased service provision, by Martinez and Kelle (2013), recommended that "[m]ore research, health promotion, and awareness are needed to address the wide range of health disparities affecting LGBT victims of sex trafficking" because "LGBT victims face unique and distinct health challenges."

Another population with unique risks and vulnerabilities for trafficking are women who have immigrated to another country, according to a case study by Miller et al. (2007). A case report by Miller et al. (2007) demonstrates the complexities and realities of interpersonal violence in the context of migration and trafficking for one such survivor of trafficking. The authors present many of the complex dimensions at play, including potential vulnerabilities for some migrant populations (Miller et al., 2007). The study notes:

> Added to the experience of being an undocumented migrant are the complexities associated with gender inequality in education and work trajectories, the gendered dimensions of trafficking (where more girls and women are caught in webs of sexual exploitation), and the limited work options available to women constrained by limited resources … enslavement in the sex industry may be the direct goal of some trafficking networks, whereas other migrant workers may be coerced into sex work as part of paying back their debts to their traffickers … and others may find that sex work is one of the few options available to them as undocumented workers (Miller et al., 2007).

Additionally, "[t]rafficked women engaging in sex work tend to have far fewer resources, limited options, and increased vulnerability to violence and abuse compared to women who have not been trafficked" (Miller et al., 2007). A variety of social determinants to health, including "[l]inguistic barriers and cultural expectations, limited education, low literacy and limited health literacy, lack of knowledge about symptoms … lack of financial resources, uninsured or underinsured status, and social isolation all contribute to limited access to care, care seeking, and poor adherence to medical care" (Betancourt, 2003; Carrillo, Green, & Betancourt, 1999; Green, Betancourt, & Carrillo, 2002; Liebschutz, Frayne, & Saxon, 2003; Smedley, Stith, & Nelson, 2003, as cited in Miller et al., 2007). Lastly, this study cites capitalizing on fear of authorities as a method to manipulate undocumented migrants in trafficking (Liebschutz et al., 2003 as cited in Miller et al., 2007).

Isolation and Entrapment

Once in trafficking, fear may be further exploited by traffickers through “lack of knowledge about alternatives, isolation, and physical and psychological confinement” (Logan et al., 2009). Another challenge to isolation and entrapment is the covert nature of trafficking where women may be forced to engage in criminal acts they may otherwise never commit. Women may be fearful to leave or seek justice for trafficking due a threat of disclosure, on the part of the trafficker, for involvement in prostitution, drug use, and documentation status, and in turn may become shielded from society, social networks, friends, and family (Logan et al., 2009). In some situations, however, given the possible criminalization of prostitution, law enforcement may “not look past the criminal activity to see whether it is part of a larger problem such as human trafficking, leaving some victims of human trafficking identified only as criminals” (Logan et al., 2009). Beyond legal concerns, some of the more pernicious aspects of the sex industry itself may promote social isolation by either keeping women in seclusion or regularly moving them to new locations as an intentional act to dissuade survivors from seeking help (Miller et al., 2007; O’Neill Richard, 1999; Raymond et al., 2001; as cited by Miller et al., 2007). Moreover, O’Neill and Raymond (1999), as cited by Miller et al. (2007), highlight the threat of violence which may be used to deter their escape. Many survivors who may attempt to leave are deterred by violence or threats of violence (O’Neill Richard, 1999; Raymond et al., 2001; as cited by Miller et al., 2007).

Breaking the Cycle of Trafficking

Despite the myriad of factors which foster continued entrapment, multiple policies and services support survivors of trafficking. First, the landmark legislation, *Victims of Trafficking and Violence Protection Act*, is a key lever for the legal system to provide support to survivors

and bring justice to bear in combating trafficking (U.S. Citizenship and Immigration Services, 2017; The Protection Project, 2015). This law provides:

> prosecution of perpetrators of trafficking in persons by establishing the crimes of trafficking in persons and listing the punishments, protection of victims of trafficking by creating a bill of rights for victims, including the right to medical care, shelter, restitution, civil remedy, residency status, work permit, access to information, and prevention of trafficking by allowing for programs and grants to increase awareness on human trafficking (The Protection Project, 2015).

Another legal lever available to support those affected by trafficking is the T-visa designation. The visa allows foreign survivors who meet certain criteria indicating trafficking, and survivors' family members, to remain in the U.S. (The Protection Project, 2015). The T-visa applies when the individual

> would suffer extreme hardship involving unusual and severe harm upon removal from the United States, is physically present in the United States, and has complied with any reasonable request for assistance in the investigation or prosecution of acts of trafficking or is under the age of 18 (The Protection Project, 2015).

A significant not-for-profit, community-based, state, and federal service infrastructure support survivors of trafficking. With engagement across these levels, anti-human trafficking task forces in multiple states align disparate services and sectors to combat trafficking and provide assistance to those in need. These also offer services such as training law enforcement and supporting T-visa applications (Bureau of Justice Assistance, 2017). The Bureau of Justice Assistance (a component of the U.S. Office of Justice Programs (OJP)), and the Office for Victims of Crime jointly support an Enhanced Collaborative Model (ECM) to Combat Human Trafficking Task Force initiative to fund task forces throughout states and local levels of government (Bureau of Justice Assistance, 2017). Other select federal efforts include trainings, campaigns, and programs administered by the Department of Health and Human Services and the Administration for Children and Families (ACF). The ACF, through the Polaris Project,

administers the National Human Trafficking Resource Center (NHTRC), which maintains a 24-hour support line to report tips and connect survivors to services (Bureau of Justice Assistance, 2017).

2.2 Health Outcomes and Sex Trafficking

A study by Muftic and Finn (2013) examined the relationship between identified risk factors and health outcomes for women in sex trafficking in the U.S. Within this study, a larger proportion of domestic trafficking survivors displayed poorer health outcomes than international trafficking survivors (Muftic and Finn, 2013). The study also concludes, "when compared to nontrafficked sex workers, a larger proportion of domestic trafficking victims reported problems with physical health, mental health, co-occurring illnesses, [and] suicidal ideation" (Muftic & Finn, 2013). While the small sample size of this study limits its application to the broader experiences and health outcomes across survivors, the study underscores that sex trafficking takes multiple forms, and suggests different avenues for entry, with the potential for distinct impact on health.

To further illustrate health consequences, Lederer and Wetzel (2014), completed one of the most expansive patient-level domestic studies to date by cataloging more than 200 health issues experienced by survivors of sex trafficking. Secondarily, the study analyzed data on healthcare access, interactions with healthcare, and symptoms experienced during and after trafficking (Lederer & Wetzel, 2014). The study triangulated qualitative data, informed by focus groups and structured interviews, alongside quantitative analysis with survivors across a broad geographic representation of cities across the U.S. (Lederer & Wetzel, 2014). Respondents "reported being used for sex by approximately 13 buyers per day" buyers and "some respondents reported typical days of as many as thirty to fifty buyers (Lederer & Wetzel, 2014). Key results found that

“[s]urvivors suffered tremendously, virtually without exception” and 99.1% of survivors in the study reported one or more physical health problems while in trafficking (Lederer & Wetzel, 2014). Key health problems for providers to look for include: neurological challenges (91.5% of respondents), such as memory issues, lack of concentration and inability to sleep; nutrition and diet related issues (71.4%); physical injury (70%); cardiovascular or respiratory challenges (67.9%); gastrointestinal issues (61.3%); STI/STD (67.3%); painful intercourse (46.2%); UTIs (43.8%) and tooth loss (42.9%) (Lederer & Wetzel, 2014). Despite inconsistencies in responses which limited precise results, the surveys concluded “with confidence that pregnancy, miscarriage, and abortion were all common experiences for survivors in the study” with some survivors reporting experiences of forced abortions (Lederer & Wetzel, 2014).

In Lederer and Wetzel’s study (2014), new or exacerbated psychological conditions were attributed to exploitation. Survivors noted an average 12.11 psychological issues, including conditions such as depression (88.7%), nightmares (73.6%), anxiety (76.4%), guilt (82.1%) bipolar disorder (30.2%), suicide attempts (41.5%), and Post Traumatic Stress Disorder (54.7%) (Lederer & Wetzel, 2014). A total of 98.1% of survivors noted at least one psychological challenge while being trafficked or post-trafficked (Lederer & Wetzel, 2014). This psychological toll intersects with high rates of abuse endured. A total of 95.1% reported violence or abuse, such as being: forced to have sex (81.6%); punched (73.8%); beaten (68.9%); kicked (68.0%); threatened with a weapon (66.0%); or strangled (54.4%) (Lederer & Wetzel, 2014).

Risk Factor for Substance Use and Misuse

Lederer and Wetzel (2014) also reported substance use often served as a coping mechanism to address trauma and abuse associated with trafficking: 84.3% of survivors in the study reported use of alcohol, drugs, or both; and 27.9% reported substance use by force. In a commentary by

Stoklosa et al. (2017), opioids are highlighted in particular as "an effective coercion tool for traffickers because they numb both emotional and physical pain" with clinicians noting "clear links between the current U.S. opioid epidemic and trafficking" (Stoklosa et al., 2017). Taylor, a survivor, as quoted in the Lederer & Wetzel study said,

> *I am telling you that you have to not be in your sober mind to run these tricks—you just can't do it straight so everyone on the street is hooked on some drug. I've done drugs so long I have really hurt my body.*

Miller et al. (2007) emphasizes that while examples of substance use and addiction in trafficking may be common among sex trafficked women, "the nexus of substance use and sex work is complex" and includes transactional exchanges of substances for sex, and use of substances to numb the experience of violence (Zimmerman et al., 2003; El-Bassel et al., 2001; Farley et al., 2001; Raymond et al., 2001; Romero-Daza et al., 2003; Silbert & Pines, 1982; as cited by Miller et al., 2007).

Mental Health Impacts of Trafficking

A systematic review of literature by Oram et al. (2012) found that consistent with high rates of exposure to physical violence, studies reflect a high prevalence of physical, sexual, and mental health challenges for women in trafficking (Oram, Stöckl, Busza, Howard, & Zimmerman, 2012). The health consequences of trafficking are multifaceted, potentially impacting physical health and mental health, sexual and reproductive health, substance abuse and misuse, and occupational and environmental health (Zimmerman, Yun, Shvab, Watts, … et al., 2003). Trafficking also may limit a woman's social wellbeing, economic viability, and utilization or access to healthcare or social services (Zimmerman et al., 2003). A two-year qualitative study in the European Union by Zimmerman et al. (2003) underscored the relationship between trafficking and health in this way:

> The risks and abuses faced by trafficked women are rarely singular in nature. They are often combined in a calculated manner to instill fear and ensure compliance with the demands of the traffickers, pimps and employers … In addition to health complications caused directly by violence and intimidation, trafficked women also face health risks associated with their social, legal, and gender marginalization …

In *A Survey of Women Entering Posttrafficking Services in Europe* by Zimmerman, et al. (2008), 63% of survivors reported at least 10 or more physical symptoms experienced between zero to 10 days of leaving trafficking. This study, one of the first to quantitatively assess the health condition of women and girls after exiting trafficking, concluded the most common and severely felt symptoms include: "[h]eadaches (82%), feeling easily tired (81%), dizzy spells (70%), back pain (69%), memory difficulty (62%), stomach pain (61%), pelvic pain (59%), and gynecological infections (58%)" (Zimmerman, et al., 20018). However, in an article by Richards (2014) it is noted that, "[t]he health effects of human trafficking may be vague and not necessarily related to the trafficking experience."

Additionally, the Zimmerman et al. (2008) study raises the possibility that health impacts could be underreported due to survivors "suffering, pain and distress, especially memory problems that may affect their ability to engage in criminal investigations and asylum petitions" when they encounter police and immigration personnel" (Zimmerman et al., 2008). The study notes "[t]rafficking survivors are often quickly deported or obliged to cooperate in criminal investigations as a condition of assistance" but "[t]he multiplicity and severity of symptoms indicate that trafficked women may not be capable of making rapid decisions about their safety" warranting supportive services for a period of recovery and reflection (Zimmerman et al., 2008).

Trauma and Trafficking

There is a complex nexus between trauma and trafficking. Demonstrating the impact of trauma, Amanda, a survivor, as quoted in the Lederer and Wetzel (2014) study said,

> The mental health problems are the worst and most long lasting. I was diagnosed with chronic depression, have anxiety, post-traumatic stress syndrome, nightmares, flashbacks, disorientation … I don't think anyone is out on the street without having these long-lasting effects.

One study by Hossain, Zimmerman, Abas, Light, and Watts et al. (2010) aimed to fill an evidence gap by going beyond qualitative reports and case studies. The study, which used the Brief Symptom Inventory and Harvard Trauma Questionnaire to analyze experiences of 204 post-trafficked girls and women in seven social service sites, focused on three common mental health disorders (PTSD, depression, and anxiety) and adjusted for trauma experienced prior to trafficking (Hossain et al., 2010). The findings suggest that longer periods of post trafficking care to address concomitant mental health issues may be commensurate with the length of time a girl or woman has been trafficked. The authors noted that violence which preceded the experience of trafficking may have less of an effect on mental health than the trafficking itself; this could be attributed to a temporal effect of time of assessment (Hossain, et al., 2010). However, this conclusion may not fully account for the significance of potential exposure to violence that occur before trafficking, including adverse childhood events, as a contributing risk factor for entry into trafficking (Alpert et al., 2014). Overall the Hossain et al. (2014) study mirrors the Lederer and Wetzel (2014) findings of common mental health comorbidities (i.e., PTSD, depression, anxiety) for women and girls in trafficking and suggests the need for post-trafficking mental healthcare.

A briefing developed by Clawson, Salomon, and Goldblatt Grace (2007) for the U.S. Department of Health and Human Services presented trauma along a continuum of experience

ranging from less to more complex; survivors often experience the most complex form of trauma, which is invasive and "frequently of an interpersonal nature, often involving a significant amount of stigma or shame" (Briere & Spinazzola, 2005; as cited by Clawson et al., 2008). Beyond stigma, the trauma associated with trafficking entails physical and sexual violence in addition to "psychological damage from captivity and fear of reprisals if escape is contemplated, brainwashing, and for some, a long history of family, community, or national violence (Stark & Hodgson, 2003; Ugarte, Zarate, & Farley, 2003; as cited by Clawson et al., 2008). Such trauma may manifest in a variety of conditions such as mental health challenges, substance abuse, mistrust of motives, hyperarousal, and avoidance of triggering stimuli (Clawson et al., 2008). However, the impact of trauma may not be permanent or static, as observed in a study by Cecchet and Thoburn (2014).

2.3 Healthcare Utilization by Survivors of Sex Trafficking

A limited number of studies have investigated the intersection of trafficking and healthcare utilization defining characteristics of encounters in healthcare during and after trafficking. In one key study, Lederer and Wetzel (2014) found that while trafficked, 87.8% of survivors had some form of contact with a healthcare provider. While this degree of contact varies across studies, multiple studies note that providers may be the sole contact encountered by the survivor who can offer assistance (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Ernewein & Nieves, 2015; Sabella, 2011; as cited by Stoklosa, Showalter, Melnick, & Rothman, 2016a). Due to the controlling forces enacted by traffickers, encounters with [healthcare] providers represent a rare opportunity to identify trafficking and provide intervention for survivors (Lederer & Wetzel, 2014). This section describes literature on healthcare utilization as a foundation for a more thorough discussion on role of the provider provided in section 2.4.

Zimmerman, Hossain, and Watts (2011) present a conceptual framework which presents trafficking as a multi-stage process. In their continuum, survivors have different need for healthcare utilization depending on the stage of trafficking. If a survivor encounters healthcare along this multi-stage process, varying needs necessitate different provider expertise. Zimmerman et al. (2011) present the following possible stages: recruitment, travel-transit, exploitation, integration, reintegration, detention, and re-trafficking. These stages are an important consideration for this thesis because different interventions may be appropriate based on stage of trafficking and change may not be linear and are driven according to the readiness of the survivor (Zimmerman et al., 2011).

Research by Lederer and Wetzel (2014) note survivors encounter all types of care settings, such as Planned Parenthood clinics, neighborhood clinics, women's health clinics, or urgent care, and hospital/emergency rooms. The most common settings identified were hospital/emergency rooms and Planned Parenthood clinics. Survivors presented to care for a broad array of reasons, as reflected in the variety of health issues noted in section 2.2. Lederer and Wetzel (2014) found, 80.9% of survivors (who answered a question on birth control) used some form of birth control while trafficked. Of those specifying how birth control was obtained, 51.7% reported acquiring it from a provider or clinic (Lederer & Wetzel, 2014). Of those who obtained birth control from a doctor or clinic, 65.2% noted they were not accompanied to the clinic (Lederer & Wetzel, 2014). The lack of accompaniment may provide an opportunity for providers to communicate with patients in trafficking.

Challenges to Healthcare Utilization

A study by Chisolm-Straker et al. (2016), aimed to understand the dynamics of healthcare utilization by survivors. Their research findings were consistent with Lederer and Wetzel (2014) by demonstrating that while care encounters are taking place with survivors currently in trafficking situations, identification of trafficking status is not consistently conducted by providers, suggesting the need for improved provider training in this area (Chisolm-Straker et al., 2016). Healthcare settings are often seen as safe spaces for open dialogue with providers, which may provide unique opportunities to care for patients in trafficking (Chisolm-Straker et al., 2016). However, using such settings to encourage survivors to disclose their situation may not be an appropriate or safe goal for every encounter. A provider guide developed by Alpert et al. (2014) notes reluctance to disclose trafficking may arise from a variety of factors: not being seen alone with a provider; fear of return to trafficker or abusive situation; lack of leaving in the past; being overwhelmed; language/lack of trusted interpreter; deferential cultural beliefs; mental illness; unfamiliarity with healthcare; and past negative experiences (Polaris, 2013; as cited by Alpert et al., 2014).

Beyond the myriad barriers to disclosure, other research has been conducted to determine barriers preventing survivors from engaging healthcare in the first place. In a qualitative study of justice-involved women, Ravi, Pfeiffer, Rosner, & Shea, (2017) presented the experiences of domestically sex trafficked women in seeking healthcare while trafficked. In this study, respondents most commonly described seeking healthcare for "STI and HIV testing[;] unintended pregnancies[;] acute, violence-related issues (such as rape, traumatic injury, and suicide attempts)[;] and chronic disease management (such as hypothyroidism or asthma)" (Ravi et al., 2017). Despite some degree of care utilization, survivors noted traffickers' role in limiting

access to care due to concerns of impinging upon time with a buyer or concerns that a survivor might leave or report the situation (Ravi et al., 2017).

The study also describes an array of obstacles to trafficked survivors who might seek care. For example, the study notes instances when survivors may prioritize substance use over healthcare, fear criminal justice may be encountered in healthcare, and fear of trafficker retaliation for certain diagnoses including pregnancy and infection (Ravi et al., 2017).

Adding to care challenges, healthcare encounters may be controlled by the trafficker. For example, the study illustrates how traffickers may arrange to independently treat or privately treat a survivor outside of healthcare or ensure survivor visits to healthcare are not conducted alone (Ravi et al., 2017). After the encounter, there may be logistical challenges to obtaining further care or follow-up visits for survivors. These range from lack of access to a phone to lacking a permanent address (Ravi et al., 2017). The research found survivors may encounter challenges in standards of care—such as "being prescribed a vaginal antibiotic suppository for nightly use or being counseled to not have sex for 7 days following STI treatment"—as well as adherence to medication, and cost of medication. The study's findings raise important considerations for this thesis, especially opportunities for healthcare providers to consider their role in caring for this population.

2.4 Provider Role in Identifying and Treating Survivors of Sex Trafficking

The American Medical Association policy titled *Preventing, Identifying and Treating Violence and Abuse* stresses that "physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse" (Chaet, 2017). It is only ethical to prevent, identify, and treat a survivor of trafficking if a provider is trained and equipped to do so and able to connect survivors to corresponding services. Also prescribed in this AMA policy is the

"physician's obligation to familiarize him or herself with strategies for violence and abuse detection, resources available to the patient, and legal requirements for reporting" (Chaet, 2017). Accordingly, approaches to the patient-provider relationships are supported by the ethical tenants in the healthcare profession: "*beneficence* (the obligation to prevent harm and promote good), *nonmaleficence* (the obligation to do no harm) [or inflict the lease harm possible], *justice* (the obligation to provide others with whatever they are owed or deserve), and *autonomy* (the obligation to respect the self-determination of other persons)" (Beauchamp & Childress, 1983; as cited by Rollins et al., 2017). While there is no consensus on the exact role of the providers in confronting trafficking, "[t]hese principles are important directives for healthcare professionals faced with a potential victim of human trafficking in a healthcare setting, and they guide and form the foundation for any effective response" (Rollins et al., 2017).

Hemmings, Jakobowitz, Abas, Bick, Howard, Stanley, Zimmerman, and Oram (2016), note that in this "criminal form of extreme exploitation and abuse, from which individuals suffer multiple physical, psychological, and sexual and reproductive health problems … healthcare professionals must be at the centre of responses for survivors." The range of literature on provider response to trafficking largely positions the provider to: (1) provide trauma-informed care; (2) assess for red flags and provide inquiry; and (3) conduct safety planning and connect the survivor to resources. These themes, along with an assessment of the current state of provider training, are discussed to provide a grounding context for the interview results section of this thesis (Chapter 4).

A systematic review, with qualitative analysis of peer reviewed and grey literature, by Hemmings et al. (2016), was conducted in response to limited evidence-based guidelines to aid providers in addressing the broad range of health needs of trafficked individuals.

This was the "first review to synthesize information on identifying and responding to human trafficking in healthcare settings" and was conducted through analyzing 44 records, from a variety of formats, including databases and expert recommendations (Hemmings et al., 2016). Their review found that "[e]vidence to inform the identification, referral and care of trafficked people is extremely limited" (Hemmings et al., 2016). Of the findings, "key indicators [to identify survivors] included signs of physical and sexual abuse, absence of documentation, and being accompanied by a controlling companion" and underscore the need for providers to see patients alone, establish trust, and use professional interpreters (Hemmings et al., 2016). Records reviewed in this study highlighted care provision themes noting "the importance of comprehensive needs assessments, adhering to principles of trauma-informed care, and cultural sensitivity" multi-agency working strategies, and well-defined referral pathways (Hemmings et al., 2016). The authors recommended additional research to determine the effectiveness of and strengthen materials, and determine generalizability of guidelines throughout care settings to treat those impacted by trafficking (Hemmings et al., 2016).

Trauma-Informed Care

A key theme across the literature, including the Hemmings et al. (2016) review, is the need for a framework for providing care known as trauma-informed care. According to the Substance Abuse and Mental Health Services Administration, trauma-informed care:

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- seeks to actively resist re-traumatization (SAMHSA, 2017).

SAMHSA (2017) specifies that a trauma-informed approach include six principles of: "trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; [and] cultural, historical, and gender issues." In a commentary by Rollins (2017), "care ethics approaches to trauma-informed care require a clinician's attention to respond to the needs, wishes, goals, priorities, risks, and vulnerabilities of the patient and incorporate them into the care plan" (Rollins, 2017). Coupled with Rollins' assertion, Johns and Macy (2011) add that although "trauma-informed services were not specifically developed for use with survivors of sex trafficking, and have not been evaluated with this population, consensus exists in the literature that trauma-informed services have promising potential." However, they emphasize:

> Providers designing trauma-informed services specific to sex trafficking survivors should ensure that they (a) give priority to survivor's physical and emotional safety; (b) concurrently address co-occurring problems; (c) use an empowerment philosophy to guide service delivery; (d) maximize survivors' choice and control of services; (e) emphasize survivors' resilience; and (f) minimize the potential of the survivor experiencing additional trauma (Elliott et al., 2005; Harris & Fallot, 2001 as cited in Johns & Macy, 2011).

A trauma-informed approach strengthens care for survivors of trafficking by providing compassionate and intentional approaches to care, thus helping to avoid triggering fear, shame, or distress for patients (Macias-Konstantopoulos, 2017). This approach can be integrated by the entire care team and practice staff—from front office to security—to ensure that the practice as a whole "prioritizes a safe environment for the clinical encounter, helping the patient to regain a sense of agency and autonomy during the clinical encounter" (Stoklosa et al., 2017). A commentary by Stoklosa et al. (2017) notes the potential for daily, or even hourly, violence and psychological attacks endured by survivors of trafficking which can contribute to extreme trauma and stigma. Recognizing that past and current trauma in trafficking can play a role in care

encounters may allow providers to embrace trauma-informed care interventions. Such interventions may include: alternative approaches in the practice space (i.e., seeing the patient alone and providing interpreters); offering care without judgement; being mindful of body language and power dynamics; and conferring dignity to the patient—"by asking permission before examining patients and reassuring them that they are in control of the exam" (Stoklosa et al., 2017).

Red Flags, Identification, and Inquiry

Commentary by Bohnert, Calhoun, and Mittel (2017), describes the greatest challenge for providers in caring for trafficked individuals as the: "[1] lack of awareness of the prevalence of trafficking, [2] an inability to identify victims of human trafficking, and [3] a lack of appropriate communication techniques." When a patient's trafficking status is not known at the outset of a visit, multiple articles suggest the role of the provider is to employ observation and inquiry techniques to identify cases by observing red flags that may indicate trafficking.

While there is not a precise profile of a patient involved in trafficking, outside of disclosure, red flags—cues arising from both conversation and visual assessment—may signal trafficking. Although red flags offer important possible indicators of trafficking, disclosure by the survivor may not be a primary goal for providers; in taking a trauma-informed approach, "[t]he overarching goal of the clinical encounter is not rescue but rather [to] improve[e] health and safety" (Stoklosa et al., 2017).

A study by Logan et al. (2009), presents a possible range of red flags which may require a series of sensitive and nuanced questions on the part of the provider to reveal whether someone is being trafficked. For example, a provider may ask "questions about their freedom to leave their current employment, what happens if they make a mistake at work, whether they owe their

employer money … what their work hours and conditions are like … if they are forced to have sex as part of their job" (Logan et al., 2009). Other questions assess for wellbeing and deprivation such as asking about safety and access to basic necessities (Logan et al., 2009). This interaction is delicate and the generation of trust requires time, patience, rapport, cultural sensitivity, and awareness of trauma (Logan et al., 2009). An individual's demeanor, be it nervous, fearful, or evasive, may also suggest a provider to consider further investigation. Beyond what is learned in conversation, other cues may be visual or based on presenting health needs.

Select physical red flags, defined by Lederer and Wetzel (2014) and The National Human Trafficking Resource Center (NHTRC), excerpted from a table by Bohnert et al. (2017), include: "malnutrition or dehydration; delayed healthcare; signs of physical trauma, including being beaten, punched, kicked, burned, stabbed, strangled, or shot; signs of sexual abuse; head or facial injuries; signs of self-harm; serial cases of STIs; signs of substance abuse." A multitude of red flags are outlined in trafficking literature, none of which are exhaustive but provide possible cues. The NHTRC provides a list of red flags which may present across all types of trafficking:

- *Shares a scripted or inconsistent history*
- *Is unwilling or hesitant to answer questions about the injury or illness*
- *Is accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them*
- *Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer)*
- *Demonstrates fearful or nervous behavior or avoids eye contact*
- *Is resistant to assistance or demonstrates hostile behavior*
- *Is unable to provide his/her address*
- *Is not aware of his/her location, the current date, or time*
- *Is not in possession of his/her identification documents*
- *Is not in control of his or her own money*
- *Is not being paid or wages are withheld* (NHTRC, 2016)

Beyond the list above, the NHTRC defines a list of indicators specific to sex trafficking:

- *Patient is under the age of 18 and is involved in the commercial sex industry*
- *Has tattoos or other forms of branding, such as tattoos that say, 'Daddy,' 'Property of…,' 'For sale,' etc.*
- *Reports an unusually high number of sexual partners*
- *Does not have appropriate clothing for the weather or venue*
- *Uses language common in the commercial sex industry* (NHTRC, 2016)

Cole (2009) notes additional red flags specific to sex trafficking:

- *Exhibit emotional distress such as depression, anxiety, manifestations of trauma, self-inflicted injuries, or suicide attempts*
- *Engage in prostitution or live in a brothel*
- *Are sexually exploited in strip clubs, massage parlors, or pornography* (Cole, 2009)

In tandem with assessment and identification needs, once a trafficking encounter is identified, healthcare settings can serve as a bridge to social and other services. Prior to connecting a survivor to services, a provider must first adequately navigate consent. A breach of privacy, or undesired reporting, can compromise survivors' trust of the healthcare system, diminish a sense of autonomy, and produce effects of mistrust that may ripple beyond healthcare to compromise other avenues of support (Alpert et al., 2014). A provider guidebook by Alpert et al. (2014) presents consent as a straightforward approach:

> Healthcare providers are not required to—*and in fact may not*—report suspected instances of human trafficking that involve a competent adult victim, without the patient's express consent. Accordingly, healthcare providers must refrain from involving law enforcement and/or social service providers (e.g., housing/shelter services, legal services, and case management) without first obtaining the explicit informed consent of the patient, or unless otherwise required under relevant law (e.g., mandatory reporting laws for disabled adults; elders; … injuries resulting from burns, firearms, or knives; or threats of imminent harm to oneself or another).

The literature suggests it is to a providers' benefit to have a plan in place detailing established connections to social service partners, as well as law enforcement (Lederer & Wetzel, 2014; Macias-Konstantopoulos, 2016). Lederer and Wetzel (2014) caution that "[w]ithout established policies and protocols to guide the response, providers may not know how to proceed or may

hesitate to act for fear of not being able to help, giving false hope, or triggering a reactionary response that spins out of control and causes the patient more harm than good." Macias-Konstantopoulos (2016) notes that "[p]olicies and protocols should be survivor centered, be designed to allow patient participation, and be respectful of patients' decisions about how much and what type of assistance to accept."

Connections to Social Service Partners

Johns and Macy (2011) prepared a systematic review of the literature on aftercare and social service needs of international survivors who are trafficked into the U.S. While the review is focused on international survivors, aftercare services for survivors of domestic trafficking were also reviewed. Overall, the study "revealed a consensus that survivors have numerous, significant needs that are best addressed through comprehensive services (Aron et al., 2006; Caliber, 2007; Clawson & Dutch, 2008; International Organization for Migration, 2009; TAHR, 2008; VSSLS, 2010; as cited in Johns & Macy, 2011). Parallel to the aforementioned Zimmerman et al. (2011) conceptual framework which presents trafficking as a multi-stage process, the review found survivors' needs are not static and change over time (Armstrong, 2008; Clawson et al., 2009; as cited in Johns & Macy, 2011). Most pertinent to this thesis, a review by Johns and Macy (2011) outlines various survivor needs, including for healthcare, based on a stage of trafficking and defines opportunities for healthcare providers to serve as a bridge to the services continuum. While services deemed most immediate and critical will vary depending upon each survivor's individual needs, intentions, and circumstance, the review determined:

- "Survivors' most immediate need at emancipation from sex trafficking is for (a) immediate safety, (b) emergency shelter, (c) basic necessities, (d) language interpretation, (e) emergency medical care, and (f) crisis legal advocacy" (Johns & Macy, 2011).

- In the next stage, “survivors then need help in recovery from trauma to establish stability in their lives, including services to address their (a) physical health, (b) mental health, (c) substance abuse problems, (d) safety, (e) transitional housing, (f) immigration, (g) legal issues, and (h) language needs (e.g., interpretation and translation)” (Johns & Macy, 2011).
- Lastly, “survivors enter a recovery phase in which they begin to establish independence and require services to address long-term needs” including “(a) life skills, (b) language skills, (c) education and job training, (d) permanent housing, and, depending on their decisions whether to remain in the United States, (e) family reunification, and (f) repatriation.” (Johns & Macy, 2011).

The review outlines crucial practices to attend to survivors’ aftercare needs, including for practitioners to:

> (a) begin service delivery with a comprehensive needs assessment; (b) ensure survivors’ safety and confidentiality; (c) engage in trauma-informed care; and (d) provide comprehensive case management for survivors to coordinate health, human, and legal services (Johns & Macy, 2011).

Enhancing connection to social services is not unidirectional from healthcare providers to social services; social services providers have underscored the need for them to connect survivors to health services (98% of social service providers reported this need in an assessment by the National Institute of Justice) (Clawson, Small, Go, & Myles, 2003). Thus, provider formation of collaborative partnerships can support their own work in addition to supporting social service partners (Clawson, Small, Go, & Myles, 2003). Additionally, this bidirectional endeavor is important because “[w]ithout a robust network of acute and long-term resources including housing, mental-health service provision, substance-abuse treatment, and legal services, survivors may quickly return to their exploitation” (Stoklosa et al., 2016a). Unless social service connections are in place to support a survivor after identification, “it could endanger or harm a victim to be identified but then receive inadequate follow-up help” presenting an ethical challenge for those providers who address trafficking (Stoklosa et al., 2016a). To mitigate this ethical quandary, healthcare settings can establish formal networks and

agreements with social services organizations similar to the *coordinated community response* intervention strategy which has brought together an array of services to the domestic violence field (Shepard, Falk, & Elliott, 2002; Shorey, Tirone, & Stuart, 2014; as cited by Stoklosa et al., 2016a).

Ensuring Care for Providers

To ensure providers sustain their role in caring for survivors, the literature suggests providers in this field also must take care of themselves. The Office of Justice Programs, Office for Victims of Crime, states that "[g]iven the emotional drain and intensive nature of human trafficking cases, everyone involved should take extra care in defining clear boundaries in assisting victims and take sufficient time to maintain personal health" through "proper sleep, exercise, nutrition, and occasionally time off" (Human Trafficking Task Force e-Guide, 2011). A qualitative study by Kliner and Stroud (2012) assessed the mental and physical toll for health and social care professionals in the United Kingdom working with survivors of sex trafficking. Their primary finding was that providing care to vulnerable populations may be rewarding, but is also often extraordinarily stressful and puts providers at risk of burnout and secondary traumatic stress (Kliner & Stroud, 2012). The participants "generally described the experiences of the victims of trafficking to be more overwhelming and difficult to deal with emotionally than other vulnerable populations" (Kliner & Stroud, 2012). The study recommended individuals providing services to survivors of sex trafficking receive occupational support and training from their employer to minimize adverse effects on physical and psychological wellbeing (Kliner & Stroud, 2012).

2.5 Training and Preparing Providers to Address Sex Trafficking

Expanding provider response will likely require a systems-based approach with an emphasis on formal training to ensure a broad public health response. According to Rollins et al. (2017), "[w]ith training, a public health focus, and practice [to] policy feedback loops, healthcare professionals will be able to see, understand, and respond appropriately to victims of human trafficking…" To that end, this section discusses an array of training needs and provides examples of existing opportunities to train a broad universe of providers. Proposed methods to promote provider engagement offered in the literature include protocols, formal training, educational resources, professional networks, and advocacy to elevate the issue throughout healthcare.

The literature suggests significant variability in the ability of providers to identify and navigate care for survivors of sex trafficking. Underscoring a need for increased provider awareness, one survey demonstrated the potential for providers to inadvertently harm survivors (Miller, 2004; as cited in Stoklosa, Grace, & Littenberg, 2015). A *Needs Assessment for Service Providers and Trafficking Victims*, prepared for the National Institute for Justice, found training often happens through experiential on-the-job learning (Clawson et al., 2003). This needs assessment also described a lack of awareness of the crime of sex trafficking and the risk of "misidentifying trafficking victims or inadvertently denying services to a victim who may otherwise be eligible by definition…" (Clawson, et al., 2003). A survey by Beck, Linner, Melzer-Lange, Simpson, Nugent and Rabbitt (2015) found gaps in provider awareness correlate to experience and exposure to training. Providers and social service professionals who reported having received prior trafficking-related training considered sex trafficking a "major problem

locally, were more likely to have encountered a victim in their practice, and reported more confidence in their ability to identify victims" (Beck et al., 2015).

A study of survivors in Los Angeles, across three types of trafficking, by Baldwin et al. (2011), found that "[c]oercion and control by traffickers, language barriers, social and cultural alienation, and pervasive fear and shame all impede victim identification in clinical settings." The authors recommended that "greater awareness of human trafficking among physicians and other healthcare professionals, should enable providers to more effectively assess risk among vulnerable patients in the U.S. and could improve victim identification" (Baldwin et al., 2011).

Developing awareness of the issue and skills to assess for red flags and appropriate follow-up care can be learned. In a study by Chisolm-Straker, Richardson, and Cossio (2012), emergency department (ED) healthcare providers filled out a survey that sought to determine their knowledge level of trafficking and relationship to care. Providers then participated in a training intervention which used an authentic narrative of a trafficked individual to convey the significance of appropriately identifying red flags, intervening, and providing care (Chisolm-Straker et al., 2012). After the intervention, respondents were asked to rate their confidence level to define trafficking and identify and treat those in trafficking. Self-reported levels of confidence increased from 19.2% before training to 90.3% after training (Chisolm-Straker et al., 2012). While this study suggests training can be effective for ED settings, the literature on primary care generally has been limited to case studies.

Another ED-based study, conducted in the 20 largest EDs in San Francisco, similarly assessed whether an educational presentation would raise ED providers' identification of trafficking cases and awareness of the resources available to manage trafficking (Grace et al., 2014). The study found the intervention group showed increased awareness of who should be

contacted when a potential survivor is identified, from 7.2% to 59%, with no change in the comparison group (Grace et al., 2014). Also, success in detecting suspected trafficking increased from 17% to 38% for providers in the intervention group (Grace et al., 2014).

Both ED studies (Chisolm-Straker et al., 2012; Grace et al., 2014) demonstrate the opportunity for providers to make post-training gains to recognize trafficking. However, there is a need for additional research to demonstrate retention of increased confidence over time and impact on health outcomes. The Bohnert et al. (2017) commentary cautions that there is "a distinct lack of [rigorously] validated curricula on trafficking for physicians and other allied [healthcare] professionals" referencing a review of educational materials by Ahn et al. (2013). It should be noted that a variety of resources have been developed since this review. A review of 27 sources by Ahn et al. (2013) found the majority of educational materials lacked any rigorous evaluation and could not demonstrate outcomes of behavior change. Multiple educational models incorporate pre-and post-test surveys to assess change in confidence and awareness, mirroring the model used in the ED-based studies referenced above (Ahn et al., 2013). However, beyond generating changes in confidence and awareness on the part of providers, it is unclear whether these approaches suggest long-term changes in behavior or impact health outcomes (Ahn et al., 2013).

In light of this gap in the literature, protocols provide one method to support healthcare settings to implement structural changes which may influence long-term measurable provider behavior. In a review of 30 existing protocols, Stoklosa, Dawson, Williams-Oni and Rothman (2016b) found that many healthcare organizations have developed human trafficking protocols for use in healthcare settings. However, the researchers concluded more study is needed to discern best practices for protocol content. Some steps commonly outlined on protocols include

history of physical or sexual abuse, reporting laws, provider scripts, and contacts for local organizations or the NHTRC Hotline (Dawson et al., 2015). While this is a promising approach, the use of such protocols has been limited, with less than 2% of hospitals adopting this approach, as well as a limited number of health systems and practices (Barrows, 2015; as cited by Dawson et al., 2015; Via Christi, 2016; Dignity Health, 2017). Additional data collection can help determine if the most commonly used protocol indicators are useful in detecting trafficking while avoiding overscreening (Dawson et al., 2015). A study by Stoklosa et al., (2016a) captured reactions of providers and administrators involved in one of the first healthcare system-wide protocol deployments to support the identification, treatment, and referral of those in trafficking. The interviews yielded common themes including: (1) that protocol development is difficult, in the absence of an existing example; (2) protocols are easy to use and support survivor identification; and (3) identifying and serving survivors is difficult due to the limited number of providers trained on the issue and a shortage of resources for survivors (Stoklosa et al., 2016a). Overall, it was found that this field needs further research on the role of protocols in improving provider skills and knowledge. The study demonstrated that in using simple, visually attractive, pocket-sized consultation protocols, "clinicians reported feeling more confident about their capacity to assess patients for victimization after receiving protocol-related training and were generally more mindful about the possibility that they were treating trafficking victims" (Stoklosa et al., 2016a). This literature suggests protocols may offer an important intervention that may improve provider self-efficacy and downstream public health outcomes.

Beyond structural changes, there are a variety of promising initiatives—from formal trainings to toolkits to professional networks—which may increase provider awareness and offer support to providers. Given there are too many initiatives and training modalities deployed across local,

state, and federal levels to list in this thesis, a few select examples are provided. On the federal level, as part of the *Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States, 2013-2017*, the U.S. Department of Health and Human Services, through its Office on Trafficking in Persons in the Administration for Children and Families, has released a nationwide rollout of the *Stop, Observe, Ask, and Respond to Health and Wellness* (SOAR) training (Office on Trafficking in Persons, 2017). This web-based or in-person provider training was developed with input from a working group of subject matter experts, including survivors and healthcare professionals (Office on Trafficking in Persons, 2017). Beyond these examples of formal training, providers may access a variety of toolkits and guides to address trafficking in practice. Additionally, providers can engage in professional networks for support and learning in this space. For example, one such network:

> Health Professional Education, Advocacy, and Linkage (HEAL) Trafficking unifies and mobilizes interdisciplinary professionals in combating human trafficking and serves as a centralized resource on [healthcare] for the broader anti-trafficking community. HEAL Trafficking convenes multiple working groups that address various aspects of health and trafficking, including protocol development, education and training, direct services, prevention, and media and technology (Stoklosa, Baldwin, Chang, Chisolm-Straker, Grace, Littenberg, 2014; as cited by Stoklosa et al., 2015).

Additionally, various professional associations reference the role of providers in addressing trafficking:

> The American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), the American Medical Women's Association (AMWA), the American Nurses Association (ANA), the American Psychological Association (APA), the American College of Emergency Physicians (ACEP), and other medical, nursing, and social welfare organizations have encouraged their members to receive training in and increase their awareness of human trafficking (Stoklosa et al., 2014; as cited by Stoklosa et al., 2015).

2.6 Addressing Sex Trafficking in Primary Care

Primary healthcare was selected, for this thesis, as an important point of intervention to address trafficking. Primary care, as noted earlier, is the second most utilized healthcare setting for trafficking survivors (Chisolm-Straker et al., 2016). Beyond utilization, the vision for primary care, as described in the World Health Organization Declaration of Alma-Ata in 1978, presents a care paradigm which is aligned to provider response to trafficking because it places emphasis on a "health for all" orientation of "health equity, community participation, solidarity and intersectoral action" (Rasanathan et al., 2010). As seen in the previously presented literature, addressing trafficking often requires an awareness and appreciation for social determinants of health (SDH) on the part of the provider. In addition to the Alma-Ata "health for all" approach, primary care is increasingly shifting to engage providers to address SDH (Rasanathan et al., 2010). Primary care providers' close connection to communities through established long-term relationships with patients support opportunities to address SDH in practice. Consistent with this approach, this thesis considers supportive factors for primary care providers to address SDH as part of addressing trafficking.

Primary care may be among optimal care settings to address trafficking in that it is often a first entry point into the healthcare system for survivors. However, limitations of time during visits can be a hurdle to provide comprehensive care and coordinate social needs, thus making primary care a potentially demanding setting for providers to address trafficking (Chesluk & Holmboe, 2010). In a field study of three primary care practice types, Chesluk and Holmboe (2010) note, "[f]or primary care practices to fulfill a range of growing demands—from simply examining patients who call for appointments, to facing the increasing demands to comprehensively manage and coordinate patients' care—the scarcest resources are time and

teamwork." Common challenges to the detriment of both providers and patients may include: hectic routines; division between disparate staff roles; and the need to facilitate schedules around the demands of the physician or practice rather than accommodating the needs of patients (Chesluk & Holmboe, 2010). If sufficient time is already an issue across patient visits, it may complicate the challenge of addressing complex health or trauma experiences of survivors. Based on common themes gleaned from their interviews, the authors recommend that "[f]or practices to succeed in managing diverse patients and in helping them understand and manage their own health, it will be critical to break down the silos and organize teams with shared roles and responsibilities" (Chesluk & Holmboe, 2010).

Supporting Provider Satisfaction

In an empiric model, Ruben (2007), presents multiple factors important to providers' professional satisfaction, which intersect with self-efficacy:

- Intellectual stimulation ("Is my work interesting and challenging"),
- Meaning ("Am I contributing to the greater good of individuals and society?");
- Resources and support ("Do I like my work environment?" "Do I have the support I need to do my work?");
- Independence ("Do I have decision-making ability to benefit my patients?");
- Respect ("Do my patients and peers hold me in high regard?");
- Collegiality ("Do I feel like I am part of a community of professionals with similar goals and needs?");
- Potential for professional growth ("Can I advance in the coming years?");
- Lifestyle ("Are my work and work hours circumscribed and predictable?"); and
- Compensation ("Can I support myself and my family?") (Reuben, 2007)

A primary care practitioner's decision to address trafficking could impact these elements of professional satisfaction. When healthcare systems deploy new trainings, protocols, or policies to address trafficking, it may be beneficial for those efforts reinforce Ruben's (2007) aforementioned factors of satisfaction. Emphasizing the Chesluk and Holmboe (2010)

recommendation for team-based care, Ruben (2007) noted the importance of shedding an "artisan model" of medicine where a single physician must be all things to every patient.

The Patient-Centered Medical Home Model

To meet these challenges, primary care settings are increasingly shifting to patient-centered medical home models, some with a focus on trafficking. The medical home model is structured to be "patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety" (Patient Centered Primary Care Collaborative, 2017). There is an emerging consensus that the medical home model has advantages for delivering primary care across the healthcare system (Patient Centered Primary Care Collaborative, 2017). More than "90 health plans, dozens of employers, 43 state Medicaid programs, numerous federal agencies, hundreds of safety net clinics, and thousands of small and large clinical practices nationwide have adopted this innovative model" (Patient Centered Primary Care Collaborative, 2017).

To respond to the challenge of fragmented, inconsistent, and rushed care for survivors in Texas, the state's human trafficking task force embarked on the development of a medical home for trafficking. As a response, [t]he University of Texas Southwestern Obstetrics and Gynecology Department in Austin, University of Texas School of Social Work, CommUnityCare, Seton Healthcare Family, Refugee Services of Texas, and University of Texas School of Nursing collaborated to determine best practices for providing care to survivors of trafficking and formed the Hope Through Health Clinic with the health center CommUnityCare (McNiel, Held, & Busch-Armendariz, 2014). Elements which distinguish this Texas-based medical home from more traditional primary care settings include the adoption of a trauma-informed care philosophy, in-house social workers and therapists, group and individual psychotherapy, encouragement for patients to ask questions, communal meals designed to

convey community for patients, and access to specialty services through established referral relationships. The medical home also treats survivors' children and partners and encourages returns to the clinic, with 24% of survivors returning there four or more times (McNiel et al., 2014). This model illustrates the role of partnerships and dedicated planning to address trafficking and offers an example of one approach to address this issue in primary care.

Federally Qualified Health Centers and Trafficking

A key aspect of the U.S. primary care infrastructure, salient to addressing trafficking, are federally qualified community health centers (FQHCs), such as CommUnityCare referenced in the example above. FQHCs serve as critical locations of care for individuals in trafficking because they provide a range of services, often using a medical home model, to "underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality, primary [healthcare] services" in "areas where economic, geographic, or cultural barriers limit access to primary healthcare for a substantial portion of the population" (Bureau of Primary Health Care, 2016). The footprint of these centers is pervasive with nearly 1,400 health centers administering more than 10,400 service delivery sites to provide care in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin, impacting over 24 million patients, about 24% of whom are uninsured and 71% are at or below the 100% federal poverty level (Oral Health Fact Sheet, 2016). When patients visit a health center, care is administered on a sliding scale, in conjunction with enabling services such as transportation, education, interpretation services, and ancillary services which may be important for trafficking survivors (Bureau of Primary Health Care, 2016). A written testimony submitted to Commission on Security and Cooperation in Europe/U.S. Helsinki Commission by Chang (2015) noted that multiple community health centers are already engaged in addressing

trafficking and developing new models of care. The testimony named community health centers "the best healthcare response to human trafficking" and underscored the fact that "health centers are key components of the healthcare system serving people at risk for being trafficked" (Chang, 2016).

2.7 Summary of Current Problem and Study Relevance

The review of the literature provided an overview of sex trafficking including risk factors. Following this foundational review, the literature demonstrates the challenging health needs for survivors of sex trafficking and suggests healthcare providers play an important part of the public health response to address trafficking. The literature points to the crucial role providers can play in addressing trafficking while highlighting challenges they may face. However, much of the literature is not specifically focused on the experience of primary care providers. The literature places an emphasis on trauma-informed care, an understanding of risk factors and red flags, and healthcare provider partnerships with social services as critical aspects to address trafficking within healthcare settings.

Although the literature conveys the need and significance of the provider in addressing trafficking in healthcare, it is only suggestive of the impact such an approach plays on trafficking prevalence and population-level health outcomes. Most research reviewed as a part of this study, defined aspects of the utility of specific tools, such as protocols or trainings, which may engender support for providers across healthcare settings. However, the literature suggests there is ample opportunity to assess the short and long-term impact these tools have on health outcomes.

Even though literature positions primary care as a key setting from which to address trafficking, the research on how primary care providers should approach addressing trafficking is

scarce. The literature touched on multiple barriers and facilitators to address trafficking but rarely in the context of primary care provider's self-efficacy in addressing trafficking. There were only limited references to factors including motivation, active engagement, and interaction with the social environment beyond the healthcare setting specifically for primary care providers to address trafficking. The literature contains only a limited number of articles on primary care, primarily as qualitative patient perspectives or narrow case studies. Moreover, this review could not identify an existing study which defines barriers and facilitators to address self-efficacy for primary care providers to address sex trafficking. The following section will describe the methodology used in this study to define barriers and facilitators to self-efficacy for primary providers to address sex trafficking.

Chapter 3: Methodology

This chapter describes the research methodology used to guide this qualitative study including research design, population and sample, instrument design, and thematic analysis. Braun and Clarke's 6-phase approach to thematic analysis, described in section 3.4, was used to organize data and generate themes from providers' self-identified barriers and facilitators to identify and address the healthcare needs of women survivors of sex trafficking (Braun & Clarke, 2006).

3.1 Research Design

Interviews took place until data saturation was achieved; interviews were conducted with 11 total providers, across 7 U.S. states, in 11 distinct healthcare settings. To generate insight to the key research questions, this study was initiated through purposive sampling of professional provider networks known to address trafficking in practice. Recruitment was initiated via emails to providers within such networks to solicit potential involvement from interested providers who met inclusion criteria. In some instances, the emails were forwarded by the original recipient to other providers to share the study in the event there was interest in participation. Inclusion criteria required participants to: (1) provide primary care; (2) be physicians, nurse practitioners or physician assistants; and (3) treat women older than age 18 who were either currently or formerly sex trafficked.

Dates and times for phone interviews were arranged by email. Prior to the interview, the participants received Emory's Institutional Review Board oral consent form for sociobehavioral consent tailored to the purposes of this study (see appendix I) as an attachment to an email. At the beginning of the interview, the author of this study asked the participant to open the consent form and read the document. Oral approval for the interview to be recorded for transcription purposes was obtained before proceeding with reviewing the oral consent form with the

participant. After the participant provided consent to participate in the study, the researcher provided a brief background by stating:

> *The purpose of this study is to learn from providers who address sex trafficking in primary healthcare. For the purposes of this interview, when I refer to sex trafficking, I am speaking about sex trafficking of adult women older than age 18. When sharing your experiences as a provider, to the extent that you can, please consider your experiences with this adult patient population in mind.*

The author of this study then guided the participant through a semi-structured interview, detailed in the semi-structured guide in section 3.3. The general scope of question topic areas were motivations to address trafficking, aspects which are helpful to address trafficking in care, and aspects which make addressing trafficking in care a challenge. The interviews were conducted one time per participant, over 1 to 1.5 hours, recorded with a digital recorder, and transcribed verbatim for subsequent analysis.

At the end of the interview, chain-referral sampling or snowball sampling was initiated. This sampling method was employed to ensure providers who were currently addressing trafficking in practice were engaged in the study and could speak in detail to their experiences, thus avoiding providers who are unfamiliar or new to the subject of trafficking. According to Atkinson and Flint (2001), the snowball sampling technique is beneficial for studies which seek to access difficult-to-reach populations who may be "obscured from the view of social researchers and policymakers who are keen to obtain evidence of the experiences." They note, "[i]n its simplest formulation snowball sampling consists of identifying respondents who are then used to refer researchers on to other respondents" (Atkinson & Flint, 2001). When inquiring about other possible respondents, the participants were assured their names would not be disclosed to the referred respondent. The referred respondents were then reached by email with a recruitment email similar to the original recruitment email. If the referred respondent declined or was

deemed to not meet inclusion criteria, the author of this study then inquired if there were others to whom the author of this study should speak, and those respondents, in turn, were also assured their identities would not be shared.

Data confidentiality was assured by using a secure email network, maintaining passwords on computers, and omitting names of providers, locations, and healthcare practices in transcription. Each interview respondent was assigned a code that was used solely by the author of this study to conduct analysis without the use of identifiers. Protected health information and medical records were not accessed during the study, therefore no HIPAA waiver was necessary. The final written thesis and all drafts submitted for review did not include any identifiers to participants.

3.2 Population and Sample

The population studied included a purposive sample of primary care providers who were actively working to address the healthcare needs of women survivors of trafficking in the primary care setting. There were no risks to respondents other than inconvenience of time for the interview. Not all suggested names were engaged for interviews as a maximum variation sample was sought to support broad geographic representation. Only two provider types (medical doctors and nurse practitioners) were engaged through snowball sampling.

Selection criteria was designed to reflect a diverse primary care landscape accessed by women survivors of sex trafficking who are over the age of 18. Largely, providers engaged in this study defined their role as primary care providers. In one instance, an interview was initiated and it was determined the provider only provided care to a pediatric population. In this case, the interview was not conducted and no data was included in the results. In limited instances, participants who identified as either obstetrician-gynecologists or women's health nurse practitioners who provided primary care were included in the study. In these instances, the

definition provided by the American Academy of Family Physicians of *non-physician primary care providers* was applied to this thesis which states: "[t]here are providers of [healthcare] other than physicians who render some primary care services. Such providers may include nurse practitioners, physician assistants and some other healthcare providers" (Primary Care, 2016). The inclusion of these professions in the study was also justified in that they provide primary care services, according to an American Congress of Obstetricians and Gynecologists policy statement titled: "Obstetrician-Gynecologists Are Primary Care Providers" (ACOG Statement, 2015). This statement describes the profession as having a tradition of practicing primary care for women. The ACOG statement notes "[o]b-gyns deliver primary and preventive care services to women; an ob-gyn is often the only doctor a woman sees on a regular basis" (ACOG Statement, 2015). A few providers included in the study identified as adolescent health providers who delivered primary care to women over the age of 18. They were included in the inclusion criteria per the *Healthy People 2020* definition of adolescent health which includes young adults (ages 20 to 24) (Healthy People 2020, 2017). In these limited instances, at the start of the interview, adolescent health providers were prompted to only speak to experiences of treating women who are greater than 18 years of age.

3.3 Instrument

A semi-structured interview guide, developed specifically for this thesis, was the sole instrument used in this study. Overarching questions were provided, including prompts to support response when respondents were reserved in their response. Questions were designed to be open-ended, flow from least sensitive to most sensitive, and were shifted in order, as necessary, to parallel the flow of the conversation. The order of questions was sometimes modified or omitted to avoid redundancy based on responses given. The concept of self-efficacy,

grounded in Social Cognitive Theory, provided the initial scaffold for development of the semi-structured interview guide. Question development was refined based on the literature review and Albert Bandura's revised and expanded self-efficacy framework (Gist & Mitchell, 1992). After the interview, providers were thanked for their time by email. Results were then transcribed to conduct thematic analysis.

Semi-Structured Interview Guide

Thank you for taking the time to speak with me today. For later transcription, which will allow me to accurately understand and represent your comments, I will be recording today's call, are you comfortable with me recording? If so, we will start with the consent form for this study.
[Proceed if receive verbal consent]

My name is Jane Segebrecht, and I am a Master of Public Health Student at Emory University. Today's interview is for a qualitative research study for my student thesis. I am using an oral consent process, so I am going to start by reading an oral consent form.
[Read form. Proceed if receive verbal consent]

The purpose of this study is to learn from providers who address sex trafficking in healthcare. For the purposes of this interview, when I refer to sex trafficking, I am speaking about sex trafficking of adult women age 18 and older. When sharing your experiences as a provider, to the extent that you can, please consider your experiences with an adult patient population in mind.

Do you have any questions before I proceed?

Question 1:
To start with some general context, how do you describe the healthcare setting in which you work?
Example prompts: How would you further the describe care setting: primary care or other type of care setting; type of provider and care you provide; patient mix or demographics.

Question 2:
How did treating women who are currently or formerly in sex trafficking originally become a focus area of your work?
Example prompts: What originally motivated you to work in this space? What continues to motivate you? How does your practice delegate this work to you?

Question 3:
What are the most common interventions you engage in as you treat women currently or formerly in sex trafficking in your practice?

Example prompts: What are the most common health problems that you encounter among survivors of sex trafficking; what is the focus of your interventions? When you suspect or know that you are in a care encounter with a survivor of trafficking, how does this change your approach as a provider?

Question 4:
What do you see as your own role as a provider in addressing the challenge of sex trafficking?
Example prompts: What particular area of trafficking do you see as your role to address? How confident do you consider yourself to treat this patient population?

Question 5:
What factors have helped you feel equipped to treat this population with unique needs?
Example prompts: What aspects of the practice itself that have helped (e.g., length of visit time, connection to social service organizations, team structure); aspects of your own training; self-education; practice and gaining experience over time? How does your level of experience in this space impact your patient's health outcomes or access to services? What gives you control over the interventions? How do you consider yourself to be impacting health outcomes? What simplifies your work in this space?

Question 6:
In what way do you feel you are not equipped to treat this population with unique needs?
Example prompts: What makes your work most difficult? For what reasons do you ever avoid this work? What aspects of addressing trafficking in healthcare do you see as beyond your current capabilities? What concerns you about working in this space?

Question 7:
What could help you to overcome these challenges?
[Note if there is a specific challenge mentioned in prior questions]
Example prompts: What changes to your practice could help you do your work? What changes to the healthcare system could help you do your work?

Question 8:
What helps you master your work in this space?
Example prompts: What helps you be the most proficient you can be as a provider? What helps you learn in this space? How do peers or a network help you in this work? In what way has a mentor helped you navigate this work? Are you continuing to learn? What helps you learn? How do you actively continue to learn new approaches in this space?

Question 9:
With work as challenging as addressing sex trafficking, how do you handle any setbacks?
Example prompts: How do you cope with stress? Where does your resiliency come from?

Question 10:
In what ways do you play a role in teaching fellow providers?
Example prompts: What are the main gaps that you see in the landscape amongst your peer providers to addressing trafficking in healthcare? Mentoring? Teaching classes? Teaching new staff?

Question 11:
We talked about how you originally started working in the sex trafficking field, what continues to inspire you?
Example prompts: What motivates you? From own experience? Role expectation? What are your goals for yourself in this work?

Question 12:
What else you would you like to share that I have not asked?

Question 13: (to support snowball sampling)
Do you have any colleagues that are primary care providers who you consider an expert on addressing sex trafficking or regularly treat survivors of sex trafficking that you would recommend me speak to for another interview? What is your relationship to them? I will not provide your name to them and will simply note a colleague recommended they be contacted.

3.4 Thematic Analysis

Thematic data analysis was conducted using Braun and Clarke's 6-phase approach to thematic analysis. This was selected as the preferred "method for identifying, analysing, and reporting patterns (themes) within data" because "[t]hrough its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data" (Braun & Clarke, 2006). Braun and Clarke (2006) "argue thematic analysis should be considered a method in its own right." This thematic analysis was conducted primarily at a direct surface level, but in some instances latent conclusions were drawn "beyond the semantic content of the data, [to start] to identify or examine the underlying ideas, assumptions, and conceptualisations—and ideologies—that are theorised as shaping or informing the semantic content of the data" (Braun and Clarke, 2006). According to Braun and Clarke (2006), the 6-phase approach to thematic analysis includes:

- phase 1: familiarizing yourself with your data;
- phase 2: generating initial codes;
- phase 3: searching for themes;
- phase 4: reviewing themes;
- phase 5: defining and naming themes;
- phase 6: producing the report

Each phase was followed to arrive at themes situated within the selected self-efficacy framework.

Phase 1: Familiarizing Yourself with Your Data

After the interviews were transcribed verbatim in Microsoft Word; each line of the document was numbered (generally between 300 and 500 lines) for ease of revisiting lines in the context of the interview during coding and thematic analysis. A rigorous transcription, which maintained all verbal utterances—excluding some speaking patterns which paused with "um"—was conducted in its entirety for all 11 interviews (Braun & Clarke, 2006). This was "a key phase of data analysis within interpretative qualitative methodology" where initial codes shared across interviews started to become apparent (Bird, 2005; as cited by Braun & Clarke, 2006).

Phase 2: Generating Initial Codes

After each transcribed document was read from start to finish, each line of substantive commentary was cut and pasted into Microsoft Excel. The data were organized in rows according to initial codes. Selected text from each author was kept in single columns. The rows of initial codes and columns of comments organized by respondents become the foundation for a thematic map. The codes represented the "feature of the data (semantic content or latent) that appears interesting to the analyst, and refer to 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon'" (Boyatzis, 1998; as cited by Braun & Clarke, 2006). Braun and Clarke's recommendations for this phase were utilized including:

- code for as many potential themes/patterns as possible (time permitting)
- code extracts of data inclusively
- code individual extracts of data in as many different 'themes' as they fit into—so an extract may be uncoded, coded once, or coded many times (Braun & Clarke, 2006).

Example codes include:

setbacks—personally managed coping/self-care; setbacks—practice managed coping/self-care; motivation inherent to primary care; social justice orientation; not to "fix" patient/transtheoretical view of patient's readiness for change.

Phase 3: Searching for Themes

Once initial coding was complete, the running list of codes was transferred to a single page. These were then grouped according to "broader level of themes, rather than codes, [and] involve[d] sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes" (Braun & Clarke, 2006). This step narrowed the analysis to a more focused level and allowed for additional revisiting and analyzing of selected codes, with some codes omitted or combined at this stage.

Example themes, based on codes given above, include:

setbacks—personally managed coping/self-care and *setbacks—practice managed coping/self-care* were grouped, along with others, under the theme *resiliency. Motivation inherent to primary care; social justice orientation;* and *not "fix" patient/transtheoretical view of patient's readiness for change* were grouped under the theme *culture of primary care.*

Phase 4: Reviewing Themes

Once themes were generated, the overarching themes were revisited in relation to the initial codes. This involved looking across coded extracts for a pattern and any additional or misplaced themes. Across the themes, patterns started to emerge which could be situated in the self-efficacy framework. Subsequently, the themes were reviewed on the whole (the corpus data) in relation to the full data set to make sure all "themes adequately capture the contours of the coded data and that the 'thematic map'… reflects the meanings evident in the data set as a whole" (Braun & Clarke, 2006). Overall, this phase allowed for the data to be reread to ensure the themes have meaning in relation to the full data set and to check for missing themes. (Braun & Clarke, 2006).

Phase 5: Defining and Naming Themes

Following theme review, "[o]ngoing analysis [was conducted] to refine the specifics of each theme, and the overall story the analysis tells … [by] generating clear definitions and names for each theme" (Braun & Clarke, 2006). In this phase, the author of this study positioned the themes within the Gist and Mitchell's (1992) self-efficacy theoretical framework as a method to organize the themes. In this phase, sub-themes deemed too specific to standalone were incorporated with other codes under overarching themes.

Phase 6: Producing the Report

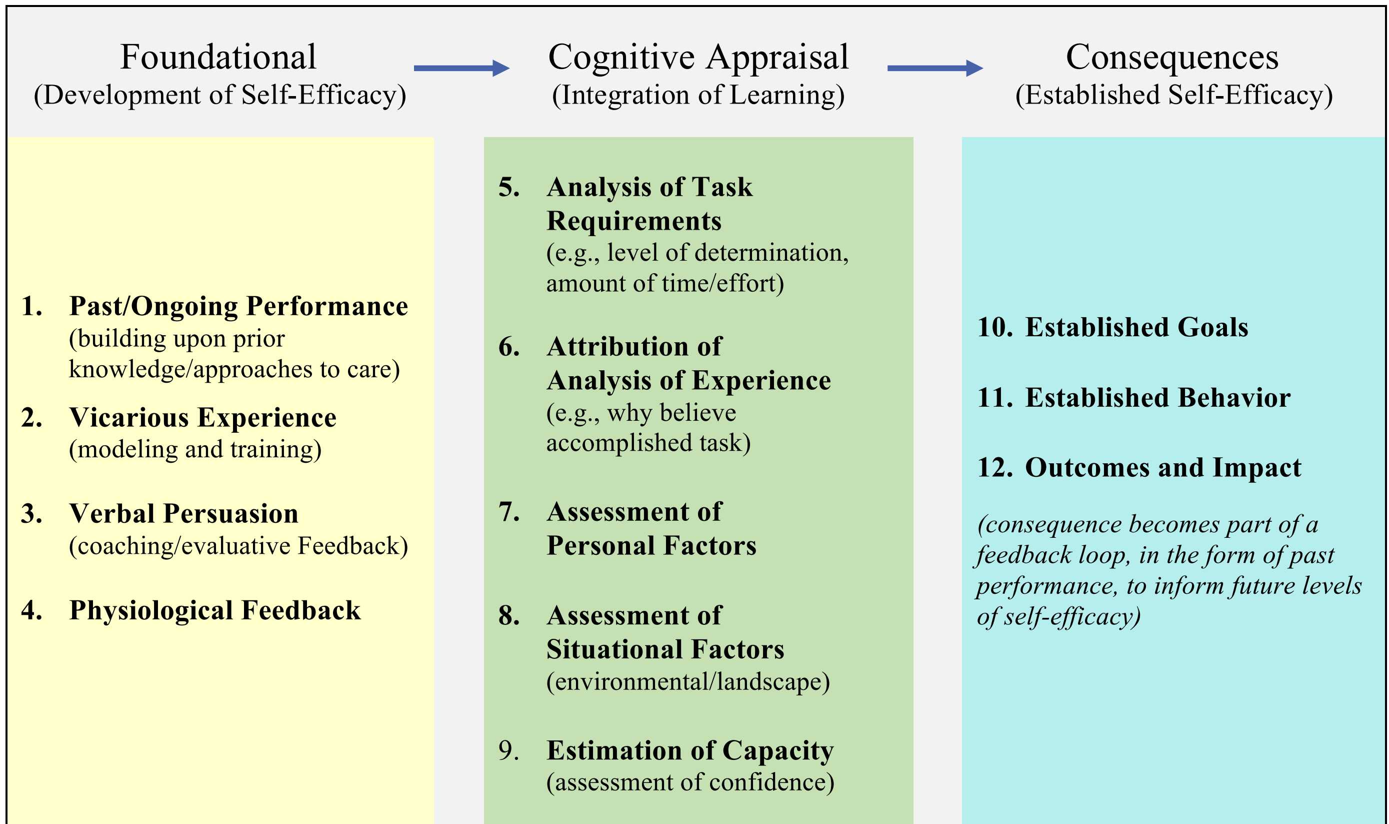
This final phase informed Chapter 4 (results) with a goal of conveying the aspects at play in provider self-efficacy in a straightforward and logical manner (Braun & Clarke, 2006). In this section, the specific themes of barriers or facilitators were organized with narrative to provide context to the self-efficacy theoretical framework. After each theme was fully analyzed, a "selection of vivid, compelling extract examples [was selected] for inclusion" in the thesis (Braun & Clarke, 2006). A "final analysis of selected extracts [was then conducted], relating back … the analysis to the research question and literature, producing a scholarly report of the analysis" (Braun & Clarke, 2006).

Chapter 4: Results

4.1 Introduction

Several thematic findings emerged across the 11 interviews related to providers' self-efficacy to address trafficking. These themes are organized, in this chapter, using a modification of Gist and Mitchell's (1992) original theoretical framework: Self-Efficacy–Performance Relationship Model (Figure 3). The components of this framework are outlined on the following page in Table 7. The framework contains (1) *foundational* aspects, which serve to lay the groundwork for self-efficacy to address trafficking, (2) *cognitive appraisal*, which include motivations and an analysis of personal and situational factors to address trafficking, and (3) the *consequence* or outcomes of addressing trafficking. In the following table, the combination of the first two columns (Foundational and Cognitive Appraisal) contribute to the third column (Consequences). This chapter first includes an overview of provider practice types and initial entries into addressing trafficking, followed by an analysis of the qualitative responses which are mapped to Gist and Mitchell's (1992) framework of levers of influence to achieve self-efficacy (Table 3). Throughout each section, key interview themes are italicized and underlined.

Table 3: Levers of Influence to Achieve Self-Efficacy
(Modified from Gist & Mitchell, 1992)



Foundational (Development of Self-Efficacy) →	Cognitive Appraisal (Integration of Learning) →	Consequences (Established Self-Efficacy)
1. Past/Ongoing Performance (building upon prior knowledge/approaches to care) **2. Vicarious Experience** (modeling and training) **3. Verbal Persuasion** (coaching/evaluative Feedback) **4. Physiological Feedback**	**5. Analysis of Task Requirements** (e.g., level of determination, amount of time/effort) **6. Attribution of Analysis of Experience** (e.g., why believe accomplished task) **7. Assessment of Personal Factors** **8. Assessment of Situational Factors** (environmental/landscape) 9. **Estimation of Capacity** (assessment of confidence)	**10. Established Goals** **11. Established Behavior** **12. Outcomes and Impact** *(consequence becomes part of a feedback loop, in the form of past performance, to inform future levels of self-efficacy)*

Practice Landscape

Providers representing 11 distinct healthcare settings in 7 states were included in this study to provide multiple perspectives. A variety of healthcare settings were represented, all of which provided primary care. The practices represent a mix of entries into care for survivors. Some locations treat patients specifically referred to care by the Department of Homeland Security, social service organizations, or other healthcare settings; thus, the status of trafficking is known by the provider at point of care. However, the majority of the sites treated patients whose status of trafficking was not known; in those instances, identification of trafficking may take place during point of care.

Entry into Addressing Trafficking

Provider entries into addressing trafficking in primary care were varied and originated from both personal motivation and institutional recommendations.

Need

Awareness of an existing need was identified as a common initial engagement point. One provider noted the realization:

> that there were specialty clinics for women like this and really that the social service agencies had a hard time finding really good, continuous and sensitive and trauma-informed care for these women. And that is when I decided to try and do something.

Another provider determined they were uniquely positioned to be a voice for marginalized patients:

> These [survivors of sex trafficking] are patients who largely don't recognize that they themselves are victims. They are patients who tend to be abused, mistreated, come from already very challenging environments and socioeconomic situations and don't tend to receive the care that they need and then by the time they reach our care … many of them don't think that they deserve any better treatment or better care.

Missed Cases/Appeasing Social Justice

Multiple providers recalled how they had missed earlier cases after learning about trafficking, and were in turn motivated to continue to address trafficking. For example, when reading about trafficking, one provider remembered a former patient who was likely in trafficking; the experience:

> triggered the memory of the woman that I saw in the O.R. and made me wonder how many victims of human trafficking I was seeing, as a doctor in training, that I wasn't recognizing. That was how I became interested in this topic.

Yet another provider recalled a former patient who:

> had a bar code on her arm. I was completely unaware of what that meant when I saw her. I didn't even realize that I should have asked her more questions. I asked her about it and she said she thought it was a cool tattoo. Wrong! When I found out I still remember that lady.

A common theme among the majority of providers was a call to being a change agent due to a social justice orientation that compelled them to work in this space. As such, one provider considered:

> It is morally wrong to not do something about it. It is moral argument for me—this is just wrong and it needs to end and it isn't right for me not to do something about it. I cannot pretend not to know.

Another one defined practice in this space as a way to practice social justice:

> I really just think of it as a really concrete form of social justice. I think that in some ways it makes it easy for me to continue because I feel like I have one very specific population that I give back to and think about and feel like I am creating some good in the world … I found something that gives me a lot of satisfaction and at this point it I have developed a little bit of expertise in, and it makes me feel like I you know there's still so much of a ways to go and if in the meantime I can continue to really provide them with the dignity of standard of care, then I will.

Complex Pathology

For others, the entry into addressing trafficking was simply exposure to seeing complex pathology which pointed to a deeper root cause, for one, in residency:

> I saw a lot of women diagnosed with various mental illness and bipolar disorder who I found did not seem to fit that diagnosis. When I spoke with them about their behavioral issues, I found that almost universally they had experienced some form of sexual trauma.

Along the same lines, a provider describes seeing a patient who raised "all kinds of red flags":

> I kinda didn't know what to do or how to approach it so I basically started talking to colleagues and thinking about what we have or what we do not have in our various primary care settings to address these issues and as I was looking at how to work with labor trafficking patients, I opened my eyes to sexual trafficking issues and until then I had seen patients who were sex workers or who had been victims of intimate partner

> violence or gender-based violence and it just never occurred to me that they could be having all of these issues because they were being trafficked … Had I not been reading about trafficking in general it wouldn't have occurred to me to think about the bigger context of other lifestyle or life circumstances.

Institutional Decision and Institutional Support

For other providers, an institutional decision from the healthcare setting to address trafficking moved them into the area. For example, in speaking of a protocol recommended by a medical student who conducted a rotation in the practice:

> My boss decided we could take her protocol and put it in our clinic … I was more than happy to do it. I thought it was great. I really wanted to do it. It sort of started out unstructured and we didn't have any rooms or approval but all of the sudden when we said 'yes' Homeland Security started calling with patients, with women. I guess it came through our resident's final year project. No not even a resident, a 4th year medical school student's project.

Beyond the initial entry into providing care in this space, four providers attributed the support of practice leadership imbuing the need to provide care in this area to allow them to continue to practice in this space. For example:

> We have support of leadership to look at what are the issues facing our patients and how does their social situation impact their health. It is not a disease-based focus but a health-based focus.

Another, in a large urban metropolis, noted support came from supervisors, stakeholders in the affiliated hospital, and the general culture of the community:

> My supervisor was so supportive. I got buy-in from stakeholders from the larger clinic. I was worried when I started the clinic they would see them as prostitutes or undesirables. But that didn't happen. Everyone I talked to … has been so supportive. I wondered if I was in a different city, that was less progressive or less diverse, would I be doing this work?

Along the same lines, connection to a larger hospital was attributed to growing a survivor-focused program and supported providers in being able to connect survivors to services within the hospital:

> Last year we saw 680 women … some of that was me holding back the reins because I am growing the program. I am lucky the [institution leadership] supports me in doing the work and … If the numbers continue to go the way they are, I will grow the clinic … we aren't going to let anyone out … without feeling we can safely discharge them. We don't discharge homeless people to the street and we don't discharge people on the weekend that we don't feel they are safe because the perpetrator is out and about. We will keep them in the hospital under a Jane Doe name.

A common theme was reported that providers did not have all the tools they needed to provide care when they initially started treating trafficking survivors, but learning and confidence was gained by practicing while providing care. For example, in learning how to ask questions that move beyond the surface, one provider noted:

> It isn't rare, but in the beginning when we don't know how to recognize it, training will help … The little red flags that pop up and will invite me to explore more. For example, you said you are couch-surfing for a month. Are you trading sex for a place to sleep? Just starting to think one more layer from the surface so I am not missing an exploitation situation. The training is key. Most people are just wide-eyed the first time and they cannot even imagine having to deal with this, but the more you repeat it to people, the more comfortable they become.

Similarly, when a provider started working in this area:

> I knew I didn't know everything and that I was taking on a challenge and I was interested. I wouldn't say I lacked confidence but I understood there was a learning curve. I could handle the medical problems but how to handle someone who was flooding, or learning the signs of it was not something I had ever been trained to do and I did it by making mistakes … There wasn't anywhere for me to look it up or read about it.

When talking about first getting started, one provider lacked confidence and confided in a peer provider:

> I had nothing to go on. I had a discussion with one of my colleagues and I remember saying I really want to take care of these women but you know, how am I supposed to approach them? I should just hold back, right? They will tell me when I am ready. I should just do a complete physical and get them to trust me. We had this conversation and we decided the professionalism would be the primary thing so they know they [survivors would] have somewhere to come who knows what they are doing in taking care of them.

One provider overcame nervousness simply by getting started:

> I have always liked working with populations that have significant needs. There was no challenge for me, I wanted to do this. I was a little nervous because I didn't want to upset the patients. I wanted to provide really good care and counseling. How did I get over it? I just did it. I read a few things and then I just went and saw the patients. That was the challenge—starting it—but I want to do it.

4.2 Gist and Mitchell Lever of Influence: Foundational (Development of Self-Efficacy)

This section outlines themes according to Gist and Mitchell's first lever of influence: Foundational. This includes factors which contribute to providers' development of self-efficacy including: (1) past/ongoing performance; (2) vicarious experience; (3) verbal persuasion; and (4) physiological, emotional self-regulation and self-reflection.

Table 4: Lever of Influence: Foundational (Development of Self-Efficacy)

Foundational (Development of Self-Efficacy)
Past/Ongoing Performance (building upon prior knowledge/approaches to care) **Vicarious Experience** (modeling and training) **Verbal Persuasion** (coaching/evaluative feedback) **Physiological Feedback**

Self-Efficacy Lever of Influence 1: Past/Ongoing Performance

Gist and Mitchell (1992) credit performance outcomes, also referred to as mastery experiences, which include past experiences, as the *most important* lever of influence in the development of self-efficacy. If past experiences can be called on when performing a task, as defined within the self-efficacy framework, confidence can be gained. Such individual level determinants arise most often for participants interviewed as factors gathered under a theme of a *culture of primary care*. Providers can call on this culture—the aspects which define and make primary care unique to other specialties—when navigating their care for survivors of sex trafficking.

The Role of Primary Care

The first aspect of a *culture of primary care* is presented by providers when defining their past training as preparing them to practice in this space and having past experience to call upon. One provider said they feel equipped to treat this population with unique needs in that:

> Being a family practice physician who looks at the patient on a whole life spectrum. Having trained in an urban setting where the goal of the residency was to produce family care physicians who are experts in urban underserved setting.

Others ground their approach in what they consider to be the unique aspects of primary care to other specialties. In terms of forming relationships with patients, one provider noted:

> Because I am in primary care I am able to do that. I know that in the ER or urgent care it is different.

Others described the life course perspective as unique to the culture of primary care:

> There is a different perspective when we come from a family medical practice because we take care of babies from birth to … grandparents in the ICU who are 100 years old. There is really a family perspective and a continuity of care that focuses on the person. When you break it down to different specialties they have a lot of the same goals and compassionate desires but their scope of practice is going to be more limited to their

> scope of specialty. We can deal with 95% of whatever problems they have whether it be psychologist care, obstetric, prenatal, dermatological or general care or care for their child or their spouse. We have victims bring in their sisters or their spouses, or anyone who has been touched by trafficking. To have that all in one place [a medical home] is beneficial.

In transcending straightforward primary care, and shedding past performance, providers noted that the work was interesting, or "something new to do" contributing to engagement:

> It always feels like I am helping … that can be lost in primary care when people don't seem that sick. I found myself in my routine … like [before addressing trafficking] I was always telling people everything is fine and that doesn't feel particularly valuable. Or when you are in a high acuity setting you feel like you are saving lives. And there is constant learning. You can get bored in your practice but every patient situation is different. I am always astounded by these stories and I have heard some terrible stories and I am still like, 'oh my god.' I am always learning. I am at a unique human interaction level which is very rewarding for me. I cannot speak for everybody else but I don't come away feeling bummed. I feel energized and motivated.

Understanding Social Determinants of Health/Intersectionality

The second aspect of a culture of primary care presented by providers, when defining their engagement in addressing trafficking, is experience rooted in primary care, where the patient is treated within their life context, or with an understanding of social determinants of health. Acknowledging intersectionality and the variety of push-pull factors influencing survivors of trafficking was a common theme in provider responses, originating from past performance and central to the *culture of primary care*.

In one example, a provider recognized the social determinants impacting survivors:

> What is important is that we not look at these issues as isolated issues. The intersectionality is key and critical … I am constantly amazed when I ask new patients about violence, sex exploitation, trauma, how many positive answers I get for adults. It just astounds me and makes me very sad … I think that is very important, [I] don't see human trafficking separate from child abuse or poverty or immigration or labor and wage exploitation or occupational hazards and disregard for regulations by employers or domestic violence or misogyny or whatever. It is related, it is all related. One of the

> barriers is doctors think of things in bucket issues, we have to break that down. Things are all related.

One provider touched on multiple social determinants when speaking of a patient with a chief complaint of domestic violence:

> So sometimes a woman might not realize that this boyfriend who she is referring to is really her pimp but in her mind, he is her boyfriend. I was aghast when I started seeing these patients. It is domestic violence but it is in the context of sexual assault and human trafficking … Now we see the intersections and we are better prepared to identify the red flags, and we have better questions to ask, like, how are you paying for these drugs? We have changed how we have that conversation and instead of saying what is wrong with you … We look at their strengths—look at how you have survived this. There is quite an overlap between opioids and human trafficking. It seemed glamorous. The john doesn't pick them up the first night and make them turn 20 tricks. They will form a relationship with them and embrace her as her new boyfriend, if you really love me, you will do it with this one guy, it is really good money and the next thing you know, they are trapped. In order to deal with that they start drinking and dealing with drugs. It makes perfect sense.

In calling on a provider's role to address intersectionality, one said of their role:

> One is to help professionals be able to recognize it, offer opportunities to the survivor and choices, in a non-suspicious way, always being a safe haven for them to come to, letting them know I am their ally, and I really think suspending judgment … I actually have prostitutes that come to my clinic because they know they can get safe care and that I won't judge them … They can come and go at any point so that makes them different than trafficking … I think human trafficking is far more reaching and I think its ties to the opioid epidemic and mental health is significant. And we are totally missing it.

Another provider spoke of seeing the patient beyond the medical setting within their social context:

> So, you know, learning what is out there, the framework, and then adequately being able to address a patient's needs and understanding that help is not just doing a pap smear but it's also looking at the whole patient and what is going on with them.

When teaching other providers about seeing patients in the context of their communities, beyond the four walls of the clinic, a provider shared that other providers appreciate the approach, but this perspective is not shared across all providers:

> I do think that people appreciate that they can get better at it and that they can get better at recognizing the signs and understanding the global social picture with a patient. On the other hand, I think sometimes people feel so much, I don't know, resistance, and kind of it just depends on the provider right, but a lot of people did not go into medicine for the social issues they, you know, they really love the science, or they really love operating or whatever it is and so they're just a little bit more resistant to thinking about the social issues.

Through past experience, when considering a patient in the context of their life experience, a less judgmental attitude may be brought to patients; for example, some providers note the importance of being flexible in their approach. In doing so, one suggested there is a benefit to remaining open to the fact that a trafficker or lawyer may try to reach a patient during a visit:

> …patients are going to get a million calls during the visit, like it might be a trafficker trying to check up on them. I know that they have a million stresses like immigration lawyers, this or that, all trying to reach them so that to me is not like, oh you need to put your phone away and pay attention. I never think you are taking up my time. It is so important to understand the stresses that people are coming in with and working around those. It gives me a much better context what to ask about, like why my medical counseling needs to change, making sure that I ask the right questions like if someone needs medicine for treatment, can they even make it to the pharmacy, if I have an in-house version, even if they have insurance, I will give it to them. I know it is not realistic for them to get to a pharmacy. A lot of it is overlaps the care you might do for people who are undocumented or homeless or in shelters …

This is further elaborated on by a provider who spoke of sensitivity and cultural humility as an approach common to primary care providers:

> to screen in a nonjudgmental and emphatic way that sometimes can be developed and sometimes cannot be developed to make people feel at ease … it is how you talk and how you touch and whether you touch … My guess is that most people who go into primary care have developed empathy and particularly those people who work in [an] underserved community, that is sort of a common denominator in terms of personality. And so those

> are kind of clinic skills. Beyond that an STD is an STD and a broken bone is a broken bone. But all of this has to be looked at in the context in which they occur so we aren't just treating an STD, why is that person having an STD or why is she having multiple STDs. It is beyond the clinic skills of treating common issues.

In building upon cultural humility and cross-cultural learning, a provider noted the importance of addressing social determinants of health:

> We have to because our patients are totally underserved. So, all of this stuff like immigration and refugees and new cultural issues that your patients bring to you because you are talking to them [about] the things they are doing outside to the extent that their health is maybe harmful but it is coming with them from their country of origin. Or the things that are really great that make their community great and resilient and can be applied to different populations. These are things that I can bring to the trafficking world and makes it exciting for me.

Role Clarity

Providers expressed varying but clear perspectives on their roles. First, most respondents defined their role first as addressing health needs. Beyond this, most commented on their role in identifying red flags. For example:

> My own role is just to make sure I don't miss it. That I can recognize the signs of suspected trafficking cases and I know what to do when I encounter those and getting people help and that they understand what is happening to them and getting them medical care and all their social needs meet. It is a hands-on approach with someone sitting across from me in the office.

Beyond identification, providers expressed their role in creating a trauma-informed space for patients to be heard and tailoring care to meet a patient with their particular needs in mind. One defined their role to be a "constant presence" for patients:

> to be someone that earns their trust rather than demands it and is worthy of their trust and respect … And then I would say approaches that I use are as trauma-informed as they can be: trying to provide a sensitive interview [and] a confidential and safe space; knowing the warning signs and red flags; and knowing how to separate a young woman from her possible trafficker/abuser; and also just providing a space where she can disclose as much

> or as little as she chooses to; and offering good continuity of care; good follow-up and phone calls and so forth to let her feel that she is cared for.

Providers often saw their role as connecting patients to social service organizations or engaging with existing organizations already supporting a survivor. For example:

> So, there are two roles: one is my role as provider to the patient in that exam room … two is my seeing the patient with the social service organization because I think this is not work you do on your own, and in fact I don't accept patients directly on their own but only through social service organizations … In terms of my relationship to the patient, my responsibility is to provide care that is appropriate, facilitation that makes sense, that every patient is not the same or that every patient is traumatized or still traumatized (although most of them are).

In terms of creating a practice space conducive to trust, one provider noted the approach to all patients should be the same:

> anyone coming into the healthcare system is probably at baseline a little nervous about what you're going to find and what you're going to say, and that people are perhaps more defensive or more aggressive—that people when they're coming to a doctor they're not going to be their best selves, as they are out with their friends. So, the first approach is from that angle and making sure you are comforting and kind and sort of thoughtful about those things.

However, the same provider went on to expound that the approach may change when providing care to some survivors:

> here has to be a little bit different of an approach in understanding what their goals are out of that visit, making sure that you know really all of their questions are appropriately answered, because they may not be the person who can go home and then read up some more and email you questions, the sort of the things we expect from a lot of other patients. So just having a, you know, much more thorough assessment of you know, did they get understanding from that visit. I think a lot of trafficking survivors are sort of eager to please and eager to say 'yes' and so when you ask 'do you understand, are you sure, are you comfortable,' they will say 'yes, yes, yes,' but you really need to assess whether that's true.

A few providers defined their role in terms of primary prevention and sharing best practices with other providers so as to help advance the evidence-base for other providers and change the healthcare system, as in:

> you have to be an ambassador to undo the medical culture of things that people have experienced in the past and made them not feel comfortable engaging in medical care … Anything we can do to show that we care and that we are invested in their health. That is a huge priority. There aren't really any best practices in the care of what people are experiencing. Making sure that we document well what we are seeing and making sure that we can actually share the information so that on a broader scale … if people are interacting with survivors in different settings … they would be able to also know what to look at or for as a health perspective and potential ways to ask questions and talk about the issues.

In a context of culture change, another provider who practiced primary prevention noted:

> When I look at the issue of sex trafficking I think about it [in] terms of a prevention model, harm reduction model and of how to prevent it from occurring. When I talk to patients I talk about the risk and harms of high risk behaviors … or identifying early, reframing the issues, giving patients ideas of what the long-term consequences might be. They might not be aware of the continuum between violence, sex exploitation, trauma … So, if you look at the child abuse issues, it wasn't recognized for a long time but a pediatrician started, in the 60s, writing about it in the research and it became more in the lay media and then became more incorporated in health professional education, in medical schools, nursing schools and it follows along with many legislative based changes from all sides and social welfare. So that awareness comes from research, training, education, lay media and changing a culture …

Role clarity appeared to support providers when approaching and navigating care but was viewed differently across providers. For example, one provider conceptualized their role as establishing a therapeutic alliance and providing routine medical care and couched social needs as health needs:

> And so, whatever comes up whether a direct diagnosis or a social issue that is impacting their health, I address those things so very often there is chronic disease or acute issues or there is also food and scarcity or issues of housing or legal issues. We need to connect them with lawyers. Clothing is a problem or child care. It is really a mix of direct diagnosis and things that we can assist with …

Maintaining a Transtheoretical Model of Change Perspective

Close to one third of respondents stressed that the role of primary care is not to solve all of a patient needs, but meet a patient where they are and connect them to services if the patient wants them. This intersects with this first lever of self-efficacy, as providers can call on past performance and know that their role is to not be all things to all patients.

For example, in explaining what makes the role difficult, a provider mentioned the challenge of separating what they see as a better future for a patient and their current reality:

> To move them from contemplative to reactive state of change. It is difficult to see these different realities. You can hope and say there are so many ways they cannot be in this situation, but is this true? They may not have money, education, resources or a safety net, they may not speak English, and maybe their whole community who they love and trust is in this situation with them. That is frustrating and demoralizing. How can our whole society look away? What are we going to do? There is a pull between civil rights and human rights.

Another provider, comforted by embracing a transtheoretical model perspective, but also frustrated by not being able to always intervene, would reflect on a message given by a mentor:

> 'It's not your job to save these patients. No one thing that you can do is going to save them. Your job is to provide compassionate care and to restore their humanity.' And I've really taken that to heart, not only with trafficking patients but with any of my patients I find it very easy, to experience burnout as a physician. And to kind of bitch about patients and just simplify things you know, 'crazy mom' or 'oh she's a flake' calling people names rather than exploring more … I'm not going to change these patients but it's my job to be compassionate for them, and that may be the best medicine that I can give them. And that's frustrating sometimes, because we like to fix things as practitioners but sometimes that's more than anybody else is giving them, so that simplifies my work just because then I don't feel the pressure to get all the information out of them and figure everything out in one visit, which of course is impossible.

Lastly, this model required patience in that:

> The outcomes don't really come quickly, you have to learn to be patient … It isn't about me—it is about them. It is their journey, and they just happen to let me come along on it.

Self-Efficacy Lever of Influence 2: Vicarious Experience

According to Bandura, "[p]eople can develop high or low self-efficacy vicariously through other people's performances" and in seeing another provider succeed, self-efficacy can be increased (Bandura, 1997; as cited by Redmond, 2016). When conducting this modeling "[o]f critical importance are the credibility, expertise, trustworthiness, and prestige of the person doing the persuading" and "task familiarity and the observation of others" (Bandura, 1977; as cited by Gist & Mitchell, 1992). A key theme for providers within this self-efficacy lever of influence was the concept of *ongoing mastery.* Ongoing mastery, via modeling, took place in the form of learning through practice, learning from social service providers, engaging in professional development in the form of conferences and professional networks, and the act of teaching colleagues and the next generation of providers. To support ongoing mastery, many respondents noted major knowledge gaps, both personally and in the field. In a sense, providers were learning while building the evidence-base in practice:

> I would love to know what other people are doing, I think we are just breaking ground. I think we are flying the plane while we are building it. I know we are building it with the best of intentions. I would love to learn more. My check and balance system is always the patient.

Learning from Social Service Providers

Although providers learn from colleagues, as elucidated in the *verbal persuasion* section below, an unexpected partner in learning the trafficking landscape was often social service providers. The social service provider offered unique insight to the providers on the trafficking landscape, survivor experiences, and push-pull factors contributing to trafficking. Social service providers also helped the healthcare providers understand the social service landscape so as to more appropriately attend to the needs of survivors. One provider clarified how engagement with social service providers helps them learn:

> A lot of it is collaboration with community organizations which to me is my continuing education where I learn about new things that are popping up like resources or why people are being arrested and I know to look out for it too.

One respondent learned about emergency programs available to survivors of trafficking, noting being able to be responsive to one patient who was starving:

> She was eating once a day and she was giving almost all of her food to her daughter. But she had no way of making an income and she was too embarrassed to tell her social worker because she felt like she was asking for too much—the patient felt like she was asking too much—so she just wasn't eating so she was desperate and she was actually thinking about going back into sex work because she wanted to feed her six-year-old daughter and I was like, 'no way! I am going to help you,' and so I immediately got in touch with her case manager who said 'we had no idea. We're going to use some emergency funding, we are going to get her groceries today.' So, understanding, that that is a function of these organizations.

It was shared it was important for a provider to understand that the social service providers in the field act as advocates and engage in supportive hand-holding. One respondent exclaimed surprise at learning the extensive offerings of social services:

> I didn't realize how many social services there were. I mean, you know, the fact that these social service organizations are largely private donor and grant funded … they have a lot of employees, a lot of case managers and social workers that their job is to get these people to their—whatever they need to get to—medical care, government offices, paperwork, and that they will physically accompany them. I mean, that doesn't exist for other patients. So that this is their whole job, so understanding that, and then I reach out to them, it's like, it's not that they're doing me a favor, this is what they want, and this is the job that exists for them.

They go on to indicate lessons learned from social service in navigating the T-visa process:

> I didn't know there was a T-visa for trafficking victims until I started doing this work and learned from the lawyers what that meant, what that looked like, but also later learning how difficult it is to even start the application process for it. I had patients that were too traumatized in the opinion of the lawyers and the social workers to even start the process because they're very psychologically fragile … but that means that their status stays essentially undocumented if they haven't initiated the process of applying for a T-visa. So …if when they come into me and 'I'm not feeling that well, I'm feeling really down and it's because I can't enroll in my GED program or college'… I actually have a much more

nuanced understanding of why they can't … and what are the specific obstacles and I can also communicate back to the social service organization.

Educational resources and experiential learning

Respondents use a web of educational resources to navigate this work including articles, conferences, and lectures. However, much of their learning was informal with ongoing mastery achieved during practice. In speaking of the patients, and ways to learn, one provider stated:

> I feel that I can always learn something from them. There is not a day that goes by that I am not learning something from them. More recently it has been about the administration, the impact of what is happening in Washington [on] the patients … Being a good listener, reading literature, gong to conferences …

Similarly, the variety of the work and complexity of the patient cases supported ongoing learning:

> [As with] anything in medicine, the more exposure and experience and different varieties, you get better each time. Compared to when I first started, I feel much more prepared for the different things I am going to see. The toughest part is not the medical issues that come up, and I think that is the hardest, like being prepared for all the different scenarios and complexities and follow-up care.

One provider shared the impression that direct service is key to gaining confidence:

> For me personally, it is having had a lot of patients' experiences and patient care experiences. It is important to have direct service experience. When people think about experts they say they are researchers, but you become an expert by having experiences over time with a population. That is very key and critical for me at least. I have done some research as well but the most important thing is to have those experiences.

There was also value shared in reinforcing challenging work through practice. For example, in speaking of treating transgender patients, and discussing with colleagues:

> I see them weekly and there are all these things that are coming up. I feel like I study for clinic each week. It feels like clinic is a test that I have prepared for, and when I go in I think okay, I know it. I don't think of it that way but when I go in and I think this is a horrible scenario but it is within the realm of what is possible in the setting. I think

> constant review of those basics and interacting with colleagues who are also providing feedback about what people are facing keep you on the pulse of what people are saying.

Lastly, the integration of practice and writing supported multiple providers as in:

> practice, practice, practice. Seeing the patients over and over again … And then I would also say writing, for me writing everything down even just the active writing notes, but also writing articles for the lay press, and collaborating on research articles or case studies is helpful to me.

Professional Network Learning

A key support for addressing trafficking in practice, noted across multiple interviews were a variety of provider associations or professional networks such as HEAL Trafficking (Health, Education, Advocacy, Linkage) or Physicians Against the Trafficking of Humans (PATH) as part of the American Medical Women's Association (AMWA). Professional networks were described as opportunities to bolster learning and support in practice and in turn self-efficacy. For example, in terms of what supports mastery, a provider noted:

> being part of a group that are always thinking about this [and] always trying to come up with better protocols, you know, just knowing what's going on around the country and the challenges other people run into and how they overcome them. You know, just kind of engaging with a larger community that works on this makes me better at it.

In another nod to the importance of a professional network a provider shared:

> One of the most incredible resources has been the HEAL Trafficking listserv. Unbelievably useful and beneficial to me personally and as an extension to others because I take a lot of ideas from those discussion and work groups and articles that are being circulated. I share them … so, this network of clinicians has been—even without exchanging a word with anyone—that has been incredibly helpful. The HEAL community has just been phenomenal in teaching me, and subsequently, me teaching others based on what I learned. I think a lot of my colleagues don't know about this.

Learning Through Teaching

Beyond experiential learning, professional networks, and consuming educational materials, a common theme across respondents, reflecting high levels of self-efficacy, is teaching other providers, including peer colleagues, medical students, nursing students, medical residents. Teaching and producing a wide array of materials—from films to toolkits—to support other providers in this work supports the providers in their own learning.

Teaching occurs both in practice and in formal trainings. In terms of practice, one respondent stressed engaging residents:

> Any time we get a consult on a patient, I used to go and do it and write my notes. I don't do it that way anymore. I say 'come on we are in this together.' I use that model of do one, teach one. I use that model so there isn't a day that goes by that teaching doesn't just happen.

Another provider reflected on challenges of engagement when training other healthcare professionals including nursing students:

> I give talks and lectures to partners and colleagues and some people think meh, while most of them are good hearted people, they just don't think it needs this much attention. It is a big deal, my own personal editorial, but I think our culture sort of hasn't yet embraced the fact that trafficking is a lot bigger than what they realize it is…

While providers valued leading training, they also noted outcomes from informal interactions:

> sometimes it's the one-off comments that are more effective than these hour-long sessions. So, for example, you know where you have a grand rounds in ob-gyn a couple of weeks ago and someone was talking about a case that they had seen of a girl who had come in with STDs and it was, you know, the case was much more so about how they treated her medical issues but at the end of it I kind of said, 'well who asked her about her social issues, and what were those, and why did she wait so long to present to care?'
> So my point to the audience was … I think we did a great job of taking care of the medical issues, but you know we still don't really know whether there are bigger issues of trauma there or whether she has the support to follow through any of this care, you know, what makes you think this couldn't be trafficking. I think sometimes the comments

> about a particular case make people think a lot more than the sort of a global overview training.

Multiple providers spoke about the value of mandated universal resident training:

> For me, my goal is to create a system of education in this country where we have mandated training for all residents in human trafficking … If we can train all of the physicians across the country to at least have an awareness I think we could at least change the game.

However, when engaging residents and students, one provider provided an alternative perspective:

> I get a lot of requests to get trainees to come to my clinic and so far, I have turned down all of them. The trust issues with this population [are] larger than any I have seen … It does not serve the patient. There is something about sexual violence that just robs you for the ability to adjust. These people are dealing with their own demons … It is a tactic of the trafficker or a way of initiation that makes them think you choose it. It is just much too challenging to have somebody in the room and it really stops the conversation … One of my priorities is to figure out how to do this training framework: how can I include medical students and residents without compromising patient care?

The provider went on to list multiple survivor-centered alternatives to taking trainees into the room, including engaging trainees in research, advocacy, and sharing what was written in a patient chart.

Self-Efficacy Lever of Influence 3: Verbal Persuasion

According to Redmond (2016), verbal persuasion, or encouragement and discouragement, impacts levels of self-efficacy with level of authority influencing the level of persuasion; with more credibility, the impact of the verbal persuasion is greater. While this is considered a weaker form of influence for self-efficacy than past or ongoing performance, feedback and connection with peers was mentioned by providers to impact motivation, learning, and navigation of providing care for survivors of sex trafficking. In speaking of the value of feedback, one provider noted:

> So, I don't trust my own judgment but I do trust the feedback I have gotten from organizations that it is working. This is something that is incredibly needed by them. It isn't that I know how to do things any better from day one. I just kept getting good feedback … we are seeing so much positive feedback that that is actually what keeps me going.

Other feedback came directly from patients:

> Working in this field can be disheartening but once in a while, you are inspired by the resilience some people show and it is inspiring to see the one person who manages to break the cycle and break the chains, sometimes literally, and to possibly having a normal life … that is really inspiring. Every once in a while, you will have a patient who is just so thankful to you.

Engagement of Mentors and Peers

Influence in this space comes from both formal mentors and peers. One provider spoke of only being able to find two other providers doing similar work, suggesting a need for a provider network or mechanisms to meet other providers. However, the provider does connect with the other two providers expanding awareness calling it "case-shared learning." Another provider mirrored the value of peer colleagues:

> Peers help me by being there and we can throw things off of each other. We can talk about our clinical impressions to them and they may have a better idea of what to do. If I see something that I am not sure about I can call my colleagues from the room and say what do you think about me doing this … Or how soon do you think I need to bring her back? …I can ask if I should get labs. Just by being able to have them there and have my back.

One provider spoke about peer colleagues easing concerns in the work:

> I frequently … have been worried about patients who are not returning my calls and who I worry are back in trafficking lifestyle. I've called friends … who I can sort of air my anxiety and ask for advice on how to proceed … I would say that's the number one guide for me, sort of depending on my colleagues who have more experience than I do in treating these patients and understand the research and literature as well.

While peer mentorship was more common than formal mentors, some providers addressed the value of formal mentors. For example, one provider has an appreciation for multiple mentors, including one who supported navigation of state legislation:

> And that's been helpful for me to understand what that process is and how to work with legislators, how to talk with them. I will be starting an elective actually this coming week working with … [specific lawyer and organization] to understand better what are the other resources, legally, and also with regard to social services for patients who are victims of trafficking. So, I think things like that increase my knowledge base and help me feel more comfortable. Not necessarily understanding the patient population but in understanding the resources that are available and how to link them to those resources.

Self-Efficacy Lever of Influence 4: Physiological Feedback

According to Bandura (1997), "[p]eople experience sensations from their body and how they perceive this emotional arousal influences their beliefs of efficacy" (Bandura, 1977; as cited by Redmond, 2016). Mitigating task-based or task-generated worry or anxiety can support a sense of capability and strengthen beliefs of self-efficacy (Redmond, 2016). Examples of strategies to mitigate negative physiological or emotional arousal include "behavioral strategies (such as feedback-seeking or interpersonal negotiations), analytical strategies (such as breaking the task into subparts for ease of cognitive processing or identifying a simpler way of solving a problem than is typically considered), and psychological strategies (such as persisting despite difficulty, coping with boredom, or managing anxiety)" (Gist & Mitchell, 1992). Also, potentially impacting provider engagement, individuals "make judgments about anticipated performance based on how positively aroused (i.e., excited, enthusiastic) or negatively aroused (i.e., fearful, anxious) they feel when confronted with a particular task" (Bandura, 1988a, 1988b as cited in Gist & Mitchell, 1992). Additionally, Gist and Mitchell (1992) suggest "a person's immediate affect (or mood) may affect arousal and efficacy" with "higher self-efficacy scores for a positive state (mood) and lower self-efficacy scores for a negative state."

Identifying the Need for Self-Care, Coping, and Resiliency-Supportive Techniques

Describing the need for coping mechanisms, providers often related working in this practice environment was incredibly emotionally taxing, frustratingly complex, and held potential for vicarious trauma. In conveying frustration, one provider described:

> there are ten people waiting to be seen for very serious health issues and you are kind of rushed and you don't have a lot of resources and you can say to the person, go talk to [the] case manager or social work[er] because she is already helping a teenage mom and an abused child or an immigrant who cannot figure out how to get her cancer treatment. It is just overwhelmed by the community needs that are separate and independent from human trafficking. So that is really, really hard, both resource wise and emotionally hard to be a primary care provider in an underserved setting because it can get overwhelming very quickly.

Beyond frustration, a sensation of guilt was noted by another provider:

> you may only have one opportunity to … recognize it, to start probing about it, to actually have the person admit that that is what is going on and then to offer some form of help and it is incredibly, incredibly difficult to do that when you have [a] 15-to-20-minute appointment when you actually have to deal with some acute medical condition … So, the onus is on us but at the same time we cannot be expected to fix everything … so, it puts a lot on the clinician in terms of responsibility and sometimes even guilt, and even if you are pretty convinced that [trafficking] is what is going on but they won't admit to it, there is nothing you can do … That is often very, very frustrating and you go home and there is no resolution. And you know there may never be a resolution.

Practices for Self-Care, Coping, and Resiliency-Supportive Techniques

Every provider in this study relayed methods to cope with setbacks and the challenging work. These coping or self-care mechanisms are practiced individually, in relation to others, or supported by the healthcare setting. In defining the need to practice self-care, unique to primary care, one provider said:

> Part of this work is emotionally learning to cope with it because there is certainly some vicarious trauma that happens. You have to learn about that and be aware of it and deal with it as a person aside from being a healthcare professional. The other piece is just learning patience. Everyone wants to fix it right away after we identify the problem.

> This is almost never fixed in one visit. Learning patience is easier said than done. It is easier for me as a family doctor than an ER doctor. The situations that I encountered are people I knew I would see back, so I knew I didn't have to necessarily have to fix it in one visit, so understanding they may not agree with you or having to completely assess the situation on the first round.

Multiple providers referenced thinking about their own families and children; others warned of the risk for vicarious trauma:

> When you get involved more heavily, this kind of trauma can happen. Some of the people cannot handle that. If someone come with their own history of abuse, this might not be the type of work they should focus on. People need to be aware that just like every other form of medical practice, transference is real and recognizing what triggers you personally is hard. I think it was the process of having good friends and good mentors teaching me that this is why you are feeling this way and that is important. The other piece is drawing lines and having boundaries and understand what is okay for you to hear and experience … Knowing how to draw that line is important.

Many providers found challenge in the workload. While they were committed to the work, they did not have a break largely because they were the sole provider to address trafficking in their practice. Providers recognized the emotionally taxing nature of this work and workload:

> while I feel doing this work was not taking a significant toll on my psyche, what I realized is, I do things I don't realize I am doing in order to seem emotionally fine. I focus all my work on my patients …I had someone who was annoying … who works in my office. I could not handle it. I think that is because all my emotional energy goes into my patients and I don't have anything left … I didn't realize it until I got really mad.

Another provider commented on a similar manifestation of anger:

> I yell a lot. I don't know where my resiliency comes from. I am busy all the time. I do have some down time and make sure I take it. I am very selfish with my down time. I take time off. I do feel we are really, really busy and I don't know … maybe I am not self-aware but I don't know where my resiliency comes from. I get up every day and do what I have to do. And I go home … I live on the beach, I walk, I have family around me, I exercise and I drive a lot. Come to think of it, when I really get frustrated I do tend to take it out on the road. I do yell and I am not adversarial even though I get in trouble for yelling. I become verbally aggressive, not to the patients, but to the people around me. So that is what I do. I can still get up every morning and come to work. I have never not

> been able to see a trafficking patient and if I don't have time, I will do what I can to see them …

Multiple providers relied on talking about the work to find balance, such as reaching out to colleagues and commiserating or talking to friends when struggling. They found various methods to find balance, as one said, "I don't wait until I hit the wall, I try to be ahead of it." Another provider, spoke about immersion in the work but described talking about the work as a type of "pressure valve":

> People are always asking, what is your self-care and I don't even really like the term. I am not going to say everybody should do this. I am constitutionally oriented to [do] this work. I am the kind of person who goes running into the fire … It can be very personal as a woman. I think I compartmentalize it as well and that is just a part of my personality that I cannot control. I talk about it a lot. I am very vocal and I have lost all inhibitions. I am such a bummer at parties … I find if I didn't talk about it I would have no pressure valve. It actually really helps me to do the advocacy …

Other forms of talking extended to therapy or a workplace support group:

> I make sure I have a therapist I see and make sure I check in and really work on understanding my reactions. I want to understand my reactions, that I am really understanding what I am seeing.

> We have things like a balance group which is a provider group counseling session.

Multiple others spoke of keeping perspective, in that:

> this isn't 100 percent of the work that I do. It makes it easier in the sense that I find balance. These are very challenging patients to take care of. But I also have some really easy and lovely, you know, patients to take care of, so it makes doing this work even more stimulating and also kind of gives me a bit of balance and you know, I think at the end of the day, whether it's true or not, I sort of reassure myself that I'm doing better for them than what they would otherwise get …

Others relied upon practices such as writing, exercise, therapy, mindfulness practice, and the planning of daily activities to support balance. Some transmuted the frustration into action as in:

> When I get frustrated I channel it and think, how do I get around this barrier? What are all of the blockades? This is why I have been very involved nationally. It goes up to resources and policies. How do I get these resources to funnel down? How am I going to be able to hire, pay and train outreach workers who are on call 24/7 for this population? … I channel it that way and I guess I am stubborn. When I get angry or frustrated, it leads me to be more persistent.

4.3 Gist and Mitchell Lever of Influence: Cognitive Appraisal (Integration of Learning)

This section outlines themes according to Gist and Mitchell's second lever of influence: Cognitive Appraisal. This section includes the factors which contribute to providers' integration of learning, including: (1) analysis of task-requirements; (2) attribution of analysis of experience; (3) assessment of personal factors; (4) assessment of situational factors and (5) estimation of capacity (Table 5).

Table 5: Lever of Influence: Cognitive Appraisal (Integration of Learning)

Cognitive Appraisal (Integration of Learning)
Analysis of Task Requirements (e.g., level of determination, amount of time/effort) **Attribution of Analysis of Experience** (e.g., why believe accomplished task) **Assessment of Personal Factors** **Assessment of Situational Factors** (environmental/landscape) **Estimation of Capacity** (assessment of confidence)

According to Gist and Mitchell (1992), "when the individual is engaged in efficacy analysis, major questions are asked: what is required by the task, how much can I offer under the situation, and what is the relative contribution of each performance determinant." Within the Cognitive Appraisal level of influence, strategies for enhancing, refining, and describing self-efficacy emerge. In this level, providers can offer "a more thorough understanding of the task attributes,

complexity, task environment (primarily through the use of mastery and modeling experiences), and the way in which these factors can be best controlled" (Gist & Mitchell, 1992). As this clarity is defined, in the form of barriers and facilitators, strategies may emerge to support refinement of personal or environmental factors to further strengthen self-efficacy.

Self-Efficacy Lever of Influence 5: Analysis of Task Requirements

Analysis of task requirements includes reviewing level of determination and factors which may impact determination (Gist & Mitchell, 1992). Safety planning and visit length were two factors considered to impact determination due to the stress or frustration they may present to the provider; however, they may also fit in subsequent levers of influence including situational factors.

Safety Planning

Safety planning, for both survivors and the practice itself, was of paramount importance when supporting needs of survivors of sex trafficking. However, safety planning was a challenging consideration for providers. For example, of how to approach safety planning without a clear guidebook was a common challenge:

> I think the some of the hardest parts of taking care of this population is that you have to think about their safety at every step, which is not something I think we're trained to do with our other patients. So, all of the little things like who is going to call them to remind them about an appointment? And if they are not there, can a message be left? And when they arrive in this clinic? Is it better to do it during daytime hours when it looks like they are going to just a normal doctor's office or is it better to do it at night … I think it is also difficult because they are sometimes very unlikely to follow up and you feel, because you are thinking of their safety so much, you feel a very personal responsibility about, why didn't she show up for this appointment? …Was it me or was it her that sort of broke down the process?

Some providers had specific tools to approach safety planning. For example:

> So, we use Jackie Campbell's Lethality Assessment, a 20-item assessment tool. Sometimes just going through that makes women aware of some of the dangers, just talking it through … The assessment absolutely helps. If anything, it raises the consciousness of the patient about the safety issues. Strangulation is really important because if you have been choked you are ten times more likely to die in a violent episode than if you are not choked. We don't want to miss something…

Additionally, some knew aspects of the work poses certain risks but relied on patients to play a role in ensuring their safety:

> I ask them to please don't share my name with your abuser. I know that sometimes you go back and I won't judge you, that is your choice. I will always stand beside you, no matter what choice you make, but in order for myself and my family to be safe, don't share my information. And I am just hypervigilant. Sometimes I have to go to courts and the perpetrator looks at that, I am aware with my surroundings … Not to the point it interferes in my life but I am not naïve enough to think someone couldn't come walking in here someday pretty angry. So, I do think it is something we need to be aware of so the only cautionary thing is [to] not share my name and contact information.

Multiple providers mentioned security on site. One provider presented safety with a unique perspective in that the healthcare system is not fully equipped to safely support outreach in communities:

> These issues can be approached from a public health perspective. How can we reach out to the patient where they are at in the community as long as the worker is not threatened by the trafficker? That is the caveat, I don't ever want a healthcare worker to be in a dangerous situation. This is why a lot of people rely on criminal justice approaches. They are going to put their safety before any interactions. It is to be bold. We don't have those kind of public health responses or outreach from a public heath perspective yet. It is coming, maybe, down the line. Maybe it is a partner with criminal justice and public health or maybe adding social services. But we are not there yet. That is one big [needed] system change.

Visit Length

One of the most commonly cited challenges was visit length. For example, one provider felt they had taken on two jobs:

> Since we have taken this on, I had a fulltime, 80 hours-a-week job and I kind of tacked on another. There is no reimbursement. We need more help. We need people who are doing a lot of the leg work. We need people behind the scenes but I cannot do it forever. I will burn out.

Another referenced the need for the field to value reimbursement in this area and referred to creative ways of addressing this challenge as a "tap dance":

> I have to structure the way that I am paid in such a convoluted way in order to justify my time so it's not like the clinic is like 'sure, sure, see way fewer patients and we'll still pay you.' They're losing money—they would lose money—but what I end up doing is I do double work … I am doing a tap dance and that way I justify my salary but it's frustrating because I think I am doing significant work just by seeing the patients and that is totally undervalued.

The reimbursement issue also came up in grant funding for one provider:

> And often when I apply for grant funding they don't want to fund medical staff because they figure that you get reimbursed. They often want to fund social and legal stuff …when you do apply for funding, if you're eligible, they say 'well how is this going to be sustainable in the future?' and my answer is 'it's not.' It's never going to be sustainable. I am never going to make any money seeing patients with sexual trauma. You know? This is always going to be a money loser, but it's the right thing to do … I would like to put it on the radar for people … to understand that reimbursement impacts the way we see healthcare problems. If you reimburse a traumatized patient, you are valuing that.

The same provider spoke to needing institutional support to demonstrate the value through reimbursement and time:

> I'm not unhappy with what I make for a living and it's not why I went into it, but I do think that the pressures are unrealistic, and I am fearful of becoming a practitioner that is worried about staying afloat … feeling pressured by my institution to see … a certain number of patients every day or generate a certain number of RVUs [relative value units] rather than doing what I need to do, which may be especially in the case of the trafficked patient taking 45 minutes or an hour to get a thorough history and really work up the details and get that patient to a place where she or he needs to go rather than just deciding, you know what, 20 minutes is up I don't have any more time, out the door, come back another time, which they probably won't.

In terms of valuing work in this area, multiple providers stressed the need for longer visits. One provider said the healthcare system in general does not value time spent with patients, impacting

both the provider and the patient:

> I just find it abhorrent, the idea, that you would walk into a room and already have a patient naked. Right? Like I can't do it. I can't do it and so what ends up happening is that I take more time and then I don't eat lunch and I stay till seven. You know? But I just cannot stomach treating patients like objects on a factory line … when I have these incredibly needy patients—and needy in the sense that they have significant needs—[than] even more you need to think about the subtle messages you are sending with your efficiency … They are seeing doctors as technicians … I guess we're artists, scientific artists, I think that what we do is both a science and an art and both of those things take time. And I think particularly for these patients, you need to give them time.

Time was a critical need for providers in this space to be able to establish trust. Some providers referenced restructuring their practice to allow for more time when treating patients with known histories or current experiences of trafficking with an impact on trust. One provider who restructured their time, shared:

> you can establish that trust in that first visit but you cannot do it in five minutes. I see new patients for an hour and repeat patients for half an hour. Even then, some of the new patients take far longer than that. It depends because I don't like to rush patients but they understand. I give them my full attention.

In describing the challenge of time, another noted that screening for trafficking may not come up due to other priorities in a short visit:

> the hardest thing in primary care is that there's so many issues to always be thinking about for each patient, and very limited time to go through it. And so, in the hierarchy of things that are most common; like everyone kind of talks to their patient about weight management, about smoking cessation and you know, maybe they'll get down to domestic violence, because that's very common, and so much lower down the list is screening for trafficking or particularly talking to kids or adolescents about their risks for ending up in trafficking. And so, I think it's just hard to get people to see this as a core issue that they need to become more proficient in.

In explaining why they may avoid this work, one provider identified the risk of not being able to offer ample time. However, they defined having a care team as one method to help address that challenge:

> There are days when I think hey, could this person be a victim—but I don't have time to address it now … I am not going to ask the question, I have my suspicions, but I cannot deal with it, so we are missing out on helping people who really, truly need our help. I know it is happening but we just cannot do it all the time, [to mitigate this issue] I think

> the best thing that could help me is having more social work support where I could say hey, let me get the social worker or case manager to come in and talk with you more. And so, as a clinician, I could go see my next patient. I have already dealt with the medical issue but then there is a person who is actually trained to deal with the social context.

Self-Efficacy Lever of Influence 6: Attribution of Analysis of Experience

In understanding self-efficacy, Gist and Mitchell (1992) advise it is important to understand how an individual attributes or judges why a result was achieved. If providers have a higher sense of perceived control—or a sense of support—they may sense they are equipped to engage in behaviors to address trafficking in care. Control comes in the form of several cues, including the impact of external factors on a behavior (Gist & Mitchell, 1992). The primary themes in this lever of influence include: developing protocols; valuing team based-care; establishing a multi-disciplinary network of referral providers; forming partnerships with social workers and social service providers; and forming connections to legal services.

Developing Protocols

Protocols were often referenced as tools to support work, but they were not used broadly in care settings. One provider, in calling for a protocol, said:

> We have standards of care guidance for what to do in these cases but the unofficial protocol is called 'me' … the simplification factor would just be having a policy or protocol that is widely accepted in the institution so you know where to go, and what to do, when you have a potential victim in front of you.

In speaking about what made their work easier, a provider reflected:

> My agency and community partners helped create an identification tool and protocol that we want all our physicians to use … [the] protocol helped us think through how, in a clinic setting, we could reach out to patients who were being trafficked or how we could talk to them. We didn't have the language so we didn't know what to call it. Now we do. The protocol helps because it helps identity the resources in the community. This changes, however, as contact people change or as resources changes or grants go away and so maintaining those kinds of protocols change over time.

Another provider shared that protocols helped to streamline approaches to achieve efficiency:

> we trained all the staff on the protocol, and the protocol was written down, and all staff at all of the clinics had a copy of the protocol so they could refer to it … the medical environment is fast paced, patients are coming in every 15 to 30 minutes, and so in order to be able to provide a service, you need to have a streamlined process for addressing an issue. Without the streamlined process, people would rather not address the issue because it takes too much time … there's pressure in the medical community and medical environments around productivity and around how many patients need to be seen, and so that part can't be discounted … Having a protocol where you are handing off to community partner is best.

However, a risk of overreliance on the protocol or feeling that the work is too difficult without one also was a concern:

> A protocol is helpful but you don't need it. People may be afraid if they didn't get training they may not be able to identify and help someone who is in need. I don't want the protocol to be the barrier …

One called on the "muddy and murky" cases and the fact that protocols are simply a starting point and following intuition is important:

> we often are looking for the very tangible signs that we can sort of check them off the list and I feel like that's not what happens in most cases, and actually [specific name] … has a great statement where she says, 'you know, it's just when the patient walks in and something is off, and you have this sense that something is not quite adding up and you ask them a question and you don't really get a great answer, and it's not like asking you know, so do you have stomach pain, it's getting back this answer that doesn't quite make any sense, and in the setting of an emergency department and the clinic certainly … you don't often take the time to probe those questions of the practitioner because you have the pressures of, gotta get through, got to get next patient, I have four patients waiting … I feel like everybody is trying to make protocols, which is fine, how to check off certain signs of trafficking but to some degree I think that training goes a long way and then just working with patients and being open to their histories and taking the time to question, if something feels off, pursue it.

In celebrating the use of protocols, one provider shared:

> we have different entire protocols in places. A lot of hospitals have implemented these. Our hospital has put over a million dollars in implementation and training everybody. Those things are wonderful and they have to happen because it is ultimately important to be able to recognize and identify these victims …

One provider who is developing a protocol spoke about the web of decisions having a protocol could help address:

> I must confess we don't have [one] just yet, but we are working on that, what do you do if you suspect someone is…There is one pathway if they are admitting and another if you just suspecting, what do you for these people? Is there even a case manager or social worker or institution that knows where to go and what to do and how to approach these people.

One provider receives calls from former residents who are providing care without a protocol:

> Once in a while I will get a call from a former resident who will say … I think I am seeing a person who is trafficked and I am not sure what to do, we don't have a protocol. What do you think we should do?

Valuing Team-Based Care

The majority of providers mentioned the value of having a team trained and equipped to support them in addressing the needs of survivors. Providers placed particular significance in having everyone who is on the care team who wants to provide care trained:

> [We] now have four primary care providers who are trauma-sensitive [and] trauma-informed … I have some psychologists and social workers and advocates so I have built a team of people who get it and want to do it … I would never force them on anybody. If they don't want to [participate] they aren't going to do a good job. I have built a team who want to make this population better and to make sure we are all on the same plane. When I say trauma-informed care, we all understand each other.

Another provider indicated care goes beyond the medical provider to include outreach workers, referencing the domestic violence field:

> What helps the most is to have a team-based care, it just isn't the doctor. You need to have the outreach workers, whether they are doing outreach specifically at trafficking or whether they are outreach people who are going into the community to educate about the services [of the healthcare setting] … health educators, social workers, the whole team. It isn't just the doctor who has a check list of systems that we see, here are the questions, it is not like that, it is a team-based care. Just like in domestic violence [after] multiple interactions with people asking them about violence down the line, it finally comes to a level of awareness and an active stage for a victim or someone who is being abused to actually take steps to leave the situation that is very harmful.

Establishing a Multi-Disciplinary Network of Referral Providers

One critical element for providers practicing in this area is to make sure that standing referral relationships are in place to address the unique needs of survivors. It was important to plan how to communicate needs to referral providers—for example, navigating how to chart in a way to

communicate needs in a way that is respectful to patients. Providers also expressed a difficult time in knowing that referred specialists are prepared to care for patients. In the absence of this, one provider noted they will instead get a consultation. Many approaches are noted, but they shared a common thread of patient-centered approaches when engaging with referrals. In terms of the interdisciplinary nature of this work, and bidirectional referrals, one provider stated:

> the interdisciplinary aspect has been really helpful … I've become friends with many of the people who refer me patients because we're so often contacting each other, figuring out what's going on, and I learn from what they're doing and understand the broader framework in which these patients exist and use services, so that, I think, has been really essential. If I was just operating in a silo, I would not be as effective as I am.

Or in terms of the value of having connections in place in advance of necessary referrals:

> I think you know just being [in] a healthcare system where I would sometimes send in some of these women into the emergency room and you know the ER would ask no questions and be able to accommodate me, and let me take care of them the way I wanted to through the ER, so it was just kind of having … access to a good healthcare system but also to staff there that were really willing to help me see this through.

Another spoke of the benefits of being connected to known specialists via a patient-centered medical home model:

> we are also trying to create a multi-disciplinary approach. So, if I have a victim who comes in with a broken nose, I can send her to an ear, nose and throat doctor who has gone through some trauma and trafficking training. He is going to treat her appropriately and the same thing for physical therapy and everyone who we are going to send her to. We are trying to create a narrow network of providers within our area who are able to see the patients and give them care from that unique perspective.

However, potential gaps in referrals were perceived as one provider spoke of encountering denial among colleagues:

> I know that the surgeon with whom I worked in residency he operated on a patient who was trafficked and when I approached him and said I'd like to write a case report on her, he had no knowledge that she was trafficked, even though it was in her chart. And he has just not bothered to look, it had never occurred to him that with all her tattoos of expletives, late presentation to care, she came in specifically saying that she didn't want any opiates after the surgery because of her previous heroin habit, [it] never occurred to him to ask more about that, that she might be trafficked …

Forming Partnerships with Social Workers and Social Services Providers

Every provider underscored the significance of engagement with social service providers, and most commented on the value social workers play in their efforts in this space, yet there were not always enough resources. For example, in terms of social workers:

> quite frankly our social worker has to flitter around … so we share her, it is better than nothing but it would be far better to have a dedicated social worker … who could call to follow up on labs, and we don't have that in my current practice just because of financial issues here. But that would be immensely helpful as well.

Another provider spoke of the need to address overwhelmed social workers:

> I think the best thing that could help me is having more social work support where I could say hey, let me get the social worker or case manager to come in and talk with you more and so as a clinician, I could go see my next patient. I have already dealt with the medical issue but then there is a person who is actually trained to deal with the social context.

When engaging social service partners, providers noted the importance of understanding state legal frameworks and consent. Referrals to social services are guided by patient autonomy and a sometimes "delicate dance" for providers:

> There are a lot of similarities to working with victims of domestic or intimate partner violence in that we need to be incredibly, incredibly careful about consent … It is still an art more than a science when probing more deeply and asking the person if she wants to be helped … it is so delicate and so fraught with harm for the individual, so that is the most delicate dance I would say that we have to go through with the patient, with his or with her consent and referring them to services and to empower them to try to get out of those circumstances, which is not easy at all.

Even prior to consent, if screening is taking place, providers highlighted the need to have connections to social services at-the-ready:

> I think the key is to identify it and then to have the resources in your community. I mean there is a big ethical question about screening or asking deeper questions if you can't offer any resources or if you can't refer patients who want to or feel empowered to be referred to other resources. Until we figured out who to send people to or what the other social or case management or other support [was available], I felt weird about asking questions because you know, how was that going to be helpful to anyone if there was no next step?

Also, one provider observed not all services are equal, and the landscape can be political, but there is often a common goal:

> There are a lot of grass roots organizations and people like me who catch fire and get passionate about it and want to help. A lot of damage can be done that way too and you have to be careful but I think in the end, it will lead to greater cooperation in sharing best practices. So, that is a good thing. One of the things to celebrate is the different and diverse people and groups who are involved with this …We may argue about politics but when it comes to trafficking everyone agrees it is bad and has to stop. That is an important message. The other thing we see in this work is there is a lot of pissing matches—our agency has been doing it this way—it is depressing to see people fighting over who gets credit, or who came up with the protocol first … It needs to be simply what is the best for these people.

Also, sometimes services fall short, and are not equitable across the country:

> Another challenge noted was aftercare. If you are in a city where you have a wonderful nonprofit who can do aftercare, great, but most of America doesn't have that. Aftercare is the big thing for people that we just all fail at. I can get you hooked up with a women's shelter and I can get you social services but I cannot place you in a residential home for women who have been trafficked with specific programs designed to help woman who have been trafficked. In the beginning part of the movement was rescuing people and then we thought they lived happily ever after. We know that isn't true. Step one is getting them away from the trafficker and out of that situation of exploitation and into a safe situation. Then after that the real work starts. These people all have emotional and physiological harm—usually worse than physical … That is where we [as primary care providers] are the least equipped to help people … I feel that it is my responsibility not to make sure they are hooked up with social services but I need to deal with the PTSD and their depression and anxiety—not just the physical problems.

Some expressed the value of working synergistically with social service providers, but may not know all locations for care or have connections to send their patients, showing a gap in system. One provider reflected this in speaking of shelters:

> but I don't know where to refer them to. Homeland Security has sent them to some places and there are a couple of places here like [specific name] … that are really good places but there are other places that are taking the funding that is being offered from the state … and opening what they are calling trafficking shelters and they are crap. It is just a way for them to get the funding and pretend to do something but they are not really offering any service … I am doing only a small piece of what needs to be done and it is frustrating that these women don't have enough services [where they could be] somewhere for a couple of years so they can get back on track without being thrown back out on the street.

Multiple providers noted, basic needs such as connecting patients to food. For one, peer navigation provided to be an effective model for connecting survivors to services:

> We are very lucky because we have a peer navigator program … I can pair with the peer navigator … the person I am looking at and they can help address like when we are looking at housing options they will sit down and figure out what is feasible and what it costs. If they can't ethnically eat the food in the shelter, we can do a little fund raising so the peer navigator can run out and buy certain items so the people don't leave cold or hungry. These are things that people show up with. People haven't eaten in a couple of days. We try to do something about it at the point of care so when they leave it will be a little different.

The services are sometimes challenging to navigate in that they operate independently across different sectors creating an additional burden for the providers to navigate:

> There are social service organizations that do violence, trauma, housing, education, legal help, court advocacy but there isn't enough and they are very siloed into what they do. For example, legal aid doesn't sometimes do criminal stuff and sometimes patients have those issues.

However, one provider formed a bridge between the silos by creating a care team, which includes the participation of the survivor. This care team, including the survivor, her primary care provider and her social worker would meet on the phone together. The provider described the approach:

> We are going to have a conversation about what is coming up this month and what is her priority. It simplifies it because we are all on the same page and not any one person bears all the challenges of taking care of a patient. It is a team of people and the patient knows who to reach out to for what. So, when we have a team that is cogent and works well together, one can go on vacation and the other four are still around. It really does make it easier.

Lastly, while not a social service, a provider noted an approach to ensure survivors' spiritual needs are met:

> And one thing we often forget about is that providers need to be aware of spirituality. There are a fair amount of my girls from the African American community and at some time they had ties to the church. They have found it is source of healing … I have reached out to churches and clergy to have a conversation to see if they would be able to … unconditionally invite these women back to their church.

Forming Connections to Legal Services

Beyond connections to social services, a common theme among providers was the value of forming connections to legal services and working to understand legal frameworks to better support survivors. The need for greater awareness ranges from knowledge of local laws to federal policies. Providers noted aspects of legal issues such as coming to a mutual understanding with law enforcement and federal investigators about the specific needs of survivors, understanding state-specific reporting laws and requirements, having a clear understanding of the role and relationships on a state trafficking task force, and learning how to write affidavits.

In terms of federal and state rules, one provider referred to their experience in learning how to distinguish between federal and state regulations. Other providers were able to form relationships with a network of lawyers and law students. For example, one said:

> The lawyers and case managers are amazing and patient. I had a case on Saturday. It was very unusual but I know someone in the public defender's office so I could say what is the appropriate thing to do I here. I have a network that I can rely on because of what we have built based on community feedback.

To better support patients, one suggested building relationships with legal professionals paid dividends:

> Making sure they have good representation if they go to court. So, we have access to law school here and a number of large law firms … and we reach out to them for pro bono work. You have to build that relationship with them. You call a law firm and introduce yourself and say, 'if you ever have a pro bono lawyer, would you let me know?' And other times we know we have a resource and a directory of lawyers who will take some of these tough cases.

Self-Efficacy Lever of Influence 7: Assessment of Personal Factors

Active consideration and understanding of personal constraints and supports, such as an individual's capacity, effort, and knowledge in any particular area, also can impact self-efficacy

(Gist & Mitchell, 1992). The main personal factors contributing to self-efficacy for providers in this area included an understanding of their limitations to care for the mental health needs of survivors.

<u>*Limitations on Meeting Mental Health Needs of Survivors*</u>

Finding opportunities to address the mental health needs of survivors was a very common challenge noted by providers, particularly substance use recovery services and detox programs. Additionally, the trauma experienced by survivors was often noted to be a severe and challenging, and oftentimes beyond providers' ability to address in primary care. For example, one called the trauma experienced by survivors of sex trafficking sometimes "pretty raw" saying,

> I have consults … but it can get pretty foreign … Trauma psychologists who have been in practice twenty years have never seen this stuff.

Another provider described trauma as one of the most challenge aspects of their practice:

> I think the hardest … thing that people feel least confident about is how to provide the appropriate mental healthcare, and that's probably because there's different levels of trauma. So even [for] people who feel very good about providing trauma/mental health [care], you know that kind of repetitive, stranger-driven mental trauma that happens in trafficking I think is very, very hard to break down.

Among the more common challenges in meeting mental health needs of survivors is cost:

> We do our best to get them into the various resources that we can and that can take various methods and it is tough. It takes longer than I wish it did a lot of the time. I received some grant money that I have been able to allocate toward urgency needs so when people need urgent care, I can … get it written off. But that is not an endless pot of money. It is a tough situation and I don't think there is an answer to it.

One who provider shared the challenge of providing mental healthcare can be taxing said:

> I am not equipped to do the counseling or the therapy or the medical management [of patients] who have a lot of complex trauma. That should be left to psychiatry or psychology but, I can, in working in primary care, identify the issue and get the patients into that sort of care as my role … I have had patients with pretty severe psychological

> conditions or associative integration disorder or some of the victims' children have had such extreme forms of neglect that it is out of my scope, I sure can help get them into those resources, but I am sure it is true across the country getting them into mental health is extremely hard for patients without insurance.

Also, another provider mentioned patients may require different care based on their respective trafficking situation. For example, priorities for care were described by one provider as:

> If someone is in crisis mode, making sure their medical issues are attended to, if they need a safe place to go to, if they are in danger or in risk, making sure they end up in the hospital if they have something that needs to be more acutely managed and then long-term care if they have trauma or residual effects of being trafficked.

Self-Efficacy Lever of Influence 8: Assessment of Situational Factors

External factors with impact to providers such as time, staff, funding, model or design of practice are important influences on self-efficacy. These external factors can support or hinder capacity to complete a task or focus on a task with or without concern. For example, "distractions and risk may increase anxiety, which can reduce efficacy through thoughts of failure, physiological manifestations of stress, and the reduction of coping mechanisms (Lazarus & Folkman, 1984; as cited by Gist and Mitchell, 1992). The primary situational factors which emerged as themes in interviews included aspects of the practice structure itself: medical home models; trauma-informed care; methods of communication/approaches with patients; and funding for the practice.

Medical Home

A few providers noted the degree to which practice structure significantly impacted care. One approach sometimes described as a model to optimize care for survivors is the patient-centered medical home model, which one respondent called a "one-stop-shop" for survivors and their families. In this example, the medical home offers advantages over separate care provided over multiple providers and sites.

Knowing the model is valued by patients can boost provider self-efficacy. For example, one provider said their medical home approach:

> created an entirely different way of [care] process for these patients … they have particular medical staff for them to call who are assigned and will do follow-up care, and the feedback we have gotten from the care facilities and the victims and also from the physicians-in-training (the resident physicians themselves) has been overwhelmingly positive.

Prior to establishing a medical home model, one provider said, patients would be treated across multiple locations, but the medical home model offers a more holistic approach:

> we used to take care of a whole patient and now we have so many specialists … If you have a head issue, you go to behavioral specialist, if you have a back issue, you go to an orthopedist … I think when we did that and chopped the patient up—that is what you get—you get a bunch of pieces. What I am really pushing for in a primary care approach, [is that] less is more. For these patients, less is more. The more providers you put in their lives, your outcomes are probably not going to be as good … if you herd nine people and that is not unusual, who wants to engage in nine new relationships all at once?

In referencing care coordination under the medical home model, a provider shared:

> We do very much a grass roots medical home model. Even if everyone is not under the same room, we all connect. So, as providers, we take care of my patients, you have to agree to text messages and group text message and come on conference calls when we say we need them. We may need to do a quick huddle. They may just be 10 or 15 minutes, it is a quick consult and we do it in the healthcare setting all the time. That is one of the criteria to take care of the patents with complex needs like these women—you are willing to do something a little different when it is shown to make a difference.

Trauma-Informed Care

Another model, or philosophy, providers appreciated as a compass for guiding them in their work was trauma-informed care. Within this model, some providers spoke to meeting patients where they are in terms of trauma. In conceptualizing trauma, one provider offered:

> Everybody is different. I do not want to communicate this idea that every woman who experiences rape tends to spend the rest of her life traumatized. That concept is very disempowering. We have to go beyond 'how are you doing' … it could be part of a spectrum that in the aftermath of this experience you were not doing well but maybe now you are doing better but maybe you are not doing better … It has to be very personalized … It helps me understand it is a spectrum.

Another provider spoke of the role of trauma-informed care as:

> taking the medical model approach and shifting that paradigm to be a patient centered trauma-informed approach. It is different and it doesn't cost anything. It is reframing and restructuring your interactions with patients assuming that everybody has probably had some traumatic event in their lives and not treating everyone as so homogeneous.

Another provider mentioned they use the trauma-informed care framework because:

> We know that trauma is prevalent and that many people experience it but not all the people are going to tell us guess what happened to me … we understand that trauma is widespread and … that we understand the difficulty and that [the] unhealthy behaviors that we often see are survival strategies. Instead of judging this woman, we seek to understand … The patient with a hep C high viral load says to me that isn't important to me right now, housing, getting safe, keeping my kids, that is what is important to me. It is really letting the patient develop the plan of care and not having it be prescriptive. Not doing to them and for them but doing things with them. Our goal is that we don't retraumatize but empower them.

In using a trauma-informed care approach, the same provider shared they can learn patients preferred approaches:

> Then we really foster empathy and curiosity. Then we lead to more effective interventions and treatments that maybe we haven't even considered yet. We think we know better and what we are learning is that we have learned a lot from patients and makes them feel safe when they are with us. Do you care if I touch you? Do you want to leave your clothes on? Do you want to leave the door open? We just assume everyone wants everyone wants to be in a closed room but some people are claustrophobic. But giving them options and choices and checking back in [can be beneficial]. [Asking] Do you want me stop? Are you okay? There are lots of things we can do to retraumatize people, so we do things in a less traditional way…

In learning about this model, one provider expressed more job satisfaction, and better patient care:

> Being honest with myself has helped me in understanding what we were doing wasn't working. If you engaged with a victim of human trafficking, I was hearing over and over again, they have fallen out of care, they didn't keep their appointments. I tried to understand why weren't they engaging with us … I consulted with a national expert I

> have come every year who serves as my mentor to develop this trauma influenced approached. I have never felt more satisfied as a practitioner. I feel better than I have ever felt about the work. It is the framework. It is a healthy framework and it makes a lot of sense.

Acknowledging trauma helped one provider in interactions and modulating responses:

> It is very clear. People who have a history of trauma, trafficking or exploitation they may interact or have different interpersonal interactions because they may be more suspicious because, in the past, the healthcare setting … [was] not attuned to the history of trauma. They may be very distrustful. Or they may be very aggressive or very passive and reticent to speak about anything. Or they may just outright not give you the truth because for whatever reason don't trust the interaction. You have to think about all these things when you are talking to the patients so you as a provider can modulate your own responses and try establish that therapeutic alliance with the many different tools in your box …

Varied Methods of Communication and Creating Empowering Spaces

Many basic approaches were noted by providers to help them in their work. These miscellaneous tips included a range of topics such as: offering same day appointments; providers creating an open space by letting patients know they aren't rushed and are there to listen; being mindful of resistance to touch and body language; asking questions only when you need to know—not drilling deeper from a stance of curiosity or judgement; having phone or in-person interpreters for almost every language; and asking patients how they prefer to communicate—text, phone, etc.

Other recommendations included thinking about the experience of the patient, for example, noting:

> Things that people care about, like we have metro cards if you need them. I point out where the chargers are in the room. I always have extra chargers for Android, or iPhones because people feel badly for asking for things. If you can proactively offer it, it relieves that worry or burden in some ways.

Another provider shared their level of engagement:

> If I have patients who I am more concerned about, I will call and follow up on a pretty regular basis just to check and see how they're doing. I try to walk that careful line of not harassing them but also letting them know that they're cared for and that somebody is thinking about them.

One described how they approach care to empower the patient. They shared their approach as:

> do little things that emphasize the empowerment aspect, so for example I make sure there is a gown, and a sheet that covers them well and they don't feel exposed when I come on the other side of the curtain so I make it clear what I am doing is very clinical. I only expose one body part at a time. I do a breast exam and I do full exam and I explain what I am doing as I do it. They don't feel out of control … If they are not okay I do more hand-holding … I finish the exam and I need to reassure and I have learned to tell them everything is normal because I learned that the experience from everyone has psychological damage also [thinks this] equals physical damage. That was a big revelation for me that they were making a silent assumption that something must be wrong when it usually isn't. I positively reinforce how well they handled the exam. And then at the end I do a lot of explaining depending upon their level of education and level of understanding healthcare …

Also, patient education may take a different form:

> A lot of them … don't understand the concept of primary healthcare and that you can see a doctor when you are not sick. So, I will do some of that and some of them I will summarize their symptoms and what I see going on. I will make the connection between what seems like somatic symptoms and trauma and some are actually willing to acknowledge that … they are under incredible level of stress from trauma which might be causing their symptoms.

Multiple providers spoke about charting in a manner that dignifies the survivors' experience. For example, in describing charting best practices:

> a lot of it is just being respective of people and how they have processed their trauma. I have had people who have been trafficked, they may not refer to what is going on as being trafficked, they may not refer to their experience or sexual assault. They may call it something else, like an encounter. When I do my writing, I also show people the screen as I am typing so it is not like I am adversarial and I am secretly writing them down … I try to reflect how people have conceptualized their experience so I remove any of my own interpretation. In the diagnosis part I may say it is multi-factorial. There are many elements and that it is an accurate reflection … Don't use words like *alleged* or *they*

> *refused to have a test*, better to say *they declined at this time*. Don't say things people didn't declare themselves.

<u>*Insurance/Coverage for Care*</u>

One of the most trying aspects of providing care was lack of coverage or navigating coverage of care for patients. Almost all providers expressed difficulty in overcoming this hurdle. The type of practice sometimes helped providers navigate this area. For example:

> we are a Medicaid clinic that welcomes underserved patients and especially a framework for seeing uninsured patients. If I didn't have that it would be very difficult…has an excellent public hospital system that has developed a structure to treat people who are underserved and undocumented and being in such a progressive city is so helpful because I don't have to scramble around to figure out how to get care for the patient. It's not my salary but it is the overhead, how do [we] get social services, how do you get an ultrasound? Other places work in private hospitals they have charity care which comes with limitations. For example, there are other clinics that do overlapping work, that might say … I cannot do an IUD. These patients I have found have very high unattended pregnancy rates. You cannot address, really, their healthcare needs if you are putting limits on that.

One spoke about the complexities of accessing pro bono care or hospital assistance funds:

> I think you know for every hospital system does have some kind of fund out there, you know, for pro bono care, it's just that it's very difficult and convoluted to figure out where that fund exists, and how to access it and for what kinds of patients that's available. I think that there needs to be a little more transparency about, you know, if we have a very vulnerable population and somebody who we all agree needs timely and good and sometimes very comprehensive care, how do we access those funds? Why is it that it takes jumping through 50,000 hoops to get that money, which could take months?

Another commented on the challenging aspects of securing Medicaid noting the limitations of "charity care" and the importance of provider networks:

> I don't have a relationship with CMS … I am the clinician and I don't have time to be involved with the non-clinical stuff. We have been in some problems with funding; getting insurance, some of these women cannot even get Medicaid … We have been trying to get them help through charity care. And charity care doesn't pay for things like ultrasound. Every woman that you get who is a victim of sex trafficking has pelvic pain

> and you know why they have, and you know the psychological reason why they have it, but you cannot rule out that there is not something else… You have to get a sonogram done. Fortunately, we have a team that has ability to get in touch with other people who could do things who could get us to the head of the hospital that made it all work.

On why they do not feel equipped to treat this population with unique needs, one provider shared:

> The biggest barrier is health insurance. It is crippling. I have diagnosed people who absolutely need to see a specialist right away. They need to get ultrasounds, they need to get medication, and they need to get labs and my hands are tied. I can do the best I can to fund raise or get them into a public hospital but it just isn't fast enough. The system doesn't work within the needs of this population. If someone misses an appointment, then that is it … It's fine, but that is not how other systems work. That care coordination is extraordinarily difficult. We fight like crazy to see if they are eligible for emergency Medicaid or we try to leverage personal connections so the specialists might be able to see them. That is why the peer navigators are wonderful because they will do everything to try to help them like see them in a public hospital. Beyond that it is a bit limited.

In commenting about what would help, a provider shared:

> I think things in the practice that could make it easier would be funding, so that we could have free resources for these patients, such as birth control … I've had to call for prior authorization for birth control, which makes no sense in this day and age, and have better access to things like LARC, the long acting reversible contraceptive for patients that we can offer it the same day, if need be. There's a lot of hassle around insurance issues and, I'd say the social workers are key for that.

Self-Efficacy Lever of Influence 9: Estimation of Capacity (Assessment of Confidence)

All preceding levers of influence contribute to an estimation of self-efficacy strength or "the amount of conviction an individual has about performing successfully at diverse levels of difficulty" (Van der Bijl & Shortridge-Baggett, 2002; as cited by Redmond, 2016). It is estimation of capacity that supports a provider in asking "[h]ow confident am I that I can address sex trafficking in primary care?" Confidence supports high self-efficacy, however overestimating confidence can lead to poor performance or "overconfidence in one's aptitude, which creates a

false sense of ability … employing the wrong strategy, making mistakes … [and] lower effort and attention being devoted to the task" (Stone, 1994; as cited by Redmond, 2016). Many conveyed that they are confident in part due to training including that received in residency programs.

The lack of standardized clinical guidelines impacted provider confidence. One provider shared:

> [what] we are all searching for in U.S. healthcare is, what are best practices? I know how to treat a STD and get you into counseling but are there specific ways to ... Maybe the standard practice of working with mental health isn't going to work here and there are other ways to treat them that will work better including the use of medicine or social programs or any of that. Right now, all of us in this field [are] just guessing. What would help me in my practice is for groups … to say we have collated all this information and work. I would like someone to tell me the best way to help people, versus just doing what we think we know is best.

Another provider who echoed the need for best practices, considered themselves to be actively contributing to the evidence-base:

> There aren't really any best practices in the care of what people are experiencing. Making sure that we document well what we are seeing and making sure that we can actually share the information so that on a broader scale … if people are interacting with survivors in different settings … they would be able to also know what to look at or for as a health perspective and potential ways to ask questions and talk about the issues.

Another provider reported being "moderately confident" in practicing in this space:

> I would say none of us have a lot of experience yet because we haven't learned to recognize it, so none of us have a ton of confidence. But I would say I [am] moderately confident having had the training that I have had but if I know I am confronted with a trafficking victim, I know what to do.

Others noted a change in confidence level over time:

> I had zero confidence. I was incredibly intimidated when we began but as we got into it and starting seeing results, the confidence increased dramatically. That is where it is coming from though, just from the feedback.

One provider was conflicted about the role (and that of other providers), reflecting diminished confidence:

> Very unconfident. You never know, the whole issue of probing and potential harm, and who to report to and the potential harm is so fraught with ethical questions and you always ask yourself, what is the motivation? A lot of doctors, and I think I am included in that, have the savior complex. Am I really saving anybody and what am I doing and what is my motivation, these are questions I ask myself a lot. There is a lot of frustration and [questions of] am I making a difference in anyone's life … and if dealing with one individual is enough or do you deal with the bigger picture?

On the other end of the spectrum, a different provider said:

> I feel confident. I feel like I am very aware of resources in my local community. I am aware of my limitations. I'm aware of the law, about my mandatory reporting. And as far as referring them to appropriate services, I feel confident. I don't feel confident in the number of services that are available … there is a drastic shortage of beds, emergency beds, for these patients; there isn't enough shelter and there isn't enough programs to help these patients and I think the ones that do exist … they are very strapped financially, they lack appropriately trained supervisors, house staff, medical providers, so I am more frustrated with the resources available than I am in my own capacity.

4.4 Gist and Mitchell Lever of Influence: Consequences (Established Self-Efficacy)

This section outlines themes according to Gist and Mitchell's third lever of influence: Consequences. This section includes results of established self-efficacy for providers: (1) established goals; (2) established behavior; and (3) outcomes and impact.

Table 6: Lever of Influence: Consequences

Consequences (Established Self-Efficacy)
Established Goals **Established Behavior** **Outcomes and Impact**

The culmination of each preceding lever of influence led to self-efficacy generated consequences or impact. While the focus of the semi-structured interviews was not

consequences, some themes did emerge in the interviews, including: the development of ambitious goals related to addressing trafficking; engagement in advocacy; impacting the healthcare system; and detailed examples of impact on survivors and settings of care.

Self-Efficacy Lever of Influence 10: Goals

For many providers, a high level of self-efficacy was expressed through goals and plans to impact the healthcare system at large. For example, one provider wanted to create a sustainable clinic, a medical home for trafficking survivors:

> I think that my goal is to set something up that is an initiative that's larger than me.

Another expressed the need for a systems-wide impact:

> My goal in this work is to see … there is national [health system] attention to this issue with dollars following so … I will say it went from zero to wow.

Another expressed developing a home for trafficked girls:

> that would actually help … [what is being done] now is that girls are frequently taken out of trafficking and stuck in a home that has very little stimulation whereas they've come from an environment that is over-stimulated and dangerous and risky and exciting … to this sort of idyllic place that's out in the middle of nowhere where there is no stimulation … so ultimately, I would love to design a program that's successful in rehabilitating these young women and men and I'd oversee it.

Others spoke about the need to extend lessons learned to future generations of providers:

> [We need] to grow the next generation of providers so they can be informed and carry the workload because I don't see this going away.

Also, a provider spoke of the need to share lessons learned to benefit the healthcare system:

> My goal isn't to have a million of these clinics but my goal is to be able to wisely disseminate the lessons we have learned so even if someone cannot put in everything into their routine practice, [implementing] even some of them would be tremendous …

Self-Efficacy Lever of Influence 11: Behavior

Many providers expressed the ways they had radically shifted their approaches to care. For example:

> I don't just ask about domestic violence anymore. I ask about sexual assault and I ask about human trafficking. I ask about coercion into sexual activity.

Three others engaged in behavior change and goals beyond practice in the form of advocacy:

> I hope to help other people learn about how to see these patients, starting with writing a book. I would like to advocate on the subject in general … Being able to speak about what my patients have been through and also kind of give voice to them, although I would rather have them be able to speak for themselves. Often their psychological or social situation is not such that they feel they can speak up. We are trying to create advocacy opportunities for patients. We are designing a survey to see how many of the patients would be interested in speaking opportunities and actually sharing their voice through writing.
>
> I think what I really have focused on is helping the medical community understand that trafficking is a healthcare issue, that it's not just a policy issue or an immigration issue, or something that lawyers and NGOs work with, that this is really something that we need to understand in the healthcare community. [In speaking of patients] the fact that their status had never been addressed, and that nobody had ever really talked to them before about their life, and about trafficking or offered any help I think is a sign of how badly we do in the healthcare system in identifying this. So that's really been my role both locally and nationally … to try to get that awareness.
>
> I have always been involved in advocacy, so I'd like to continue writing and working with legislators to create laws that make sense, to help to develop resources.

Self-Efficacy Lever of Influence 12: Outcomes

Providers described finding ongoing inspiration in the outcomes around them. For example, one provider noted seeing steady progress over the long term:

> That sustains me. So, there has been so much momentum and positive wind for this issue. How much further can we go and how much policy can we change? There are many programs popping up to address this issue. I hear from colleagues around the country who are asking about this issue. There is a lot of government change on this issue. Resources have not necessarily followed but hopefully it will down the line. There has been a lot of legislative changes on the legal side. There is so much more lay media coverage and maybe it is not quite right but people are talking about it. The truth will

> prevail and show how it has impacted the patient and to think that I had just a little part of it. It is very affirming.

Others cited impact in their practices:

> Care organizations … they talk about losing victims all the time continuously … especially at the initial point and being a resource to come back to. They are now able to keep victims in their safe house, flowing though different programs and reintegrated in everything from parent programs to trade schools. They are getting phenomenal outcomes.

For one provider, it was personally rewarding to encounter a patient in their community:

> It is pretty fun to go to a coffee shop and have the barista—someone who was a former victim—now working in a very positive place.

For another, it was inspirational to hear how such training is being received by residents:

> We have heard feedback from the residents-in-training, they are delivering babies, running coding in the ICU, running surgeries and doing crazy stuff in the hospital … They do all this stuff that is incredibly impactful but I get feedback that this [learning how to treat trafficking in primary care] is the most impactful thing they have done in their residence. That part is huge, the impact it is making on providers. It is unbelievable.

For one provider, the impact is subtle but still meaningful:

> So, there are some days when I think, I just had one encounter where I think I made a slight difference and the difference may be just as slight as just acknowledging to the patient, I think you may be living in a situation where you are not doing what you are doing out of your own free will, just if you say that, and you have one kind of look in the patient's eyes and that is where it ends, maybe that is enough for that day. As opposed to law enforcement raiding some bar you know and everybody being rescued. So, you have to convince yourself that a little nod or a knowing look or something like that [is enough].

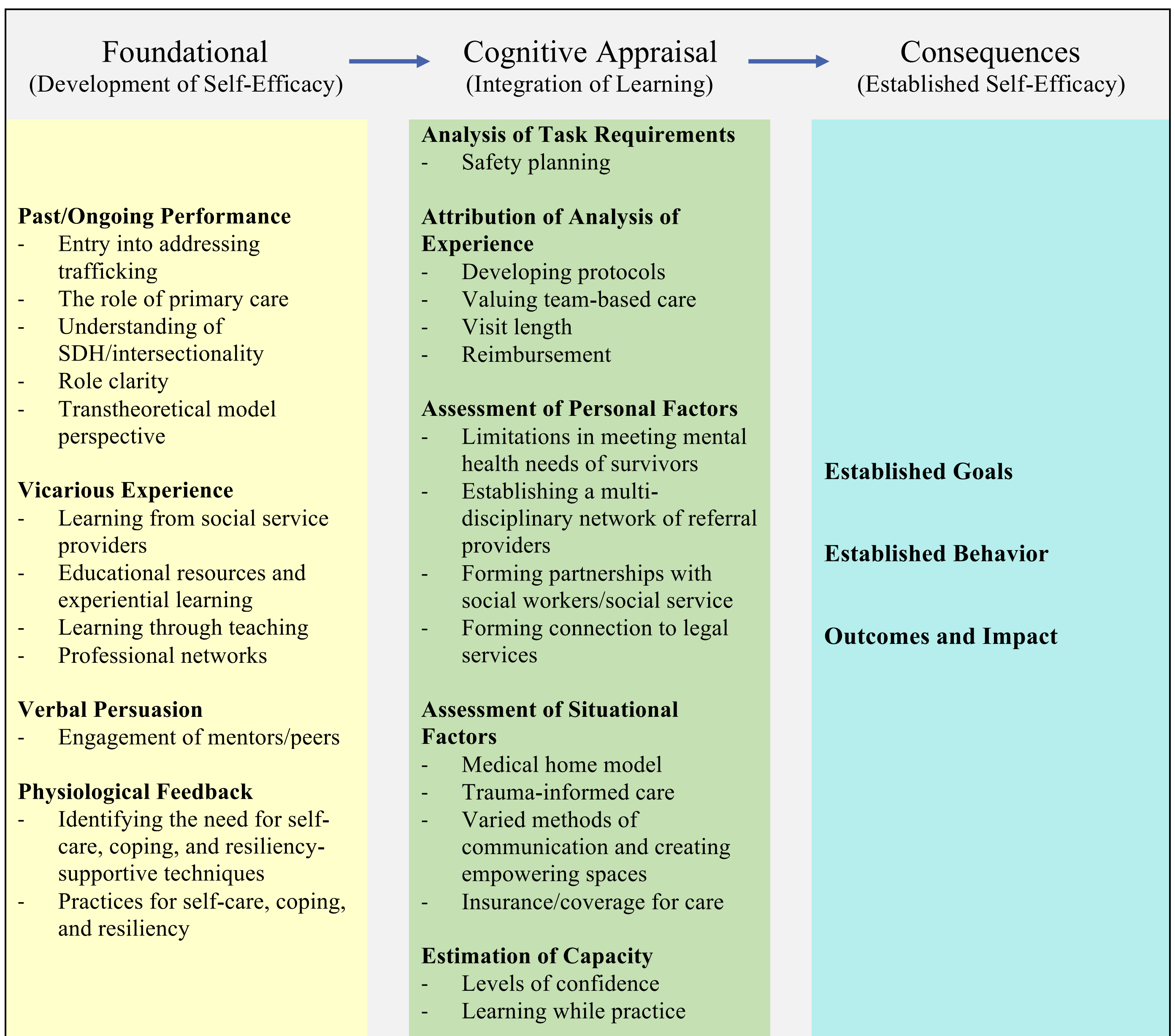
Lastly, one provider spoke about the outcomes they attribute to their resiliency:

> [It's] the small things, [a] patient going into court and she is getting her kids back. I sent her a text message saying, 'Good luck, and I am thinking about you this morning.' The next thing, the phone rings and it is her: 'I wanted you to be the first to know I am getting my kids back.' I almost hung up the phone bawling my eyes out. Happy tears. I just swell up when I think about that. She did such hard work and got her kids back. And I celebrate when a patient just shows up.

4.5 Summary of Themes

Multiple themes, in the form of both barriers and facilitators emerged from the 11 provider interviews. These themes were organized according to a modified version of Gist and Mitchell's self-efficacy framework (Self-Efficacy–Performance Relationship Model) (Figure 3). Identified themes are listed under each lever of influence to self-efficacy (Table 7):

Table 7: Levers of Influence to Achieve Self-Efficacy by Theme
(Modified from Gist & Mitchell, 1992)



Foundational (Development of Self-Efficacy) →	Cognitive Appraisal (Integration of Learning) →	Consequences (Established Self-Efficacy)
Past/Ongoing Performance - Entry into addressing trafficking - The role of primary care - Understanding of SDH/intersectionality - Role clarity - Transtheoretical model perspective **Vicarious Experience** - Learning from social service providers - Educational resources and experiential learning - Learning through teaching - Professional networks **Verbal Persuasion** - Engagement of mentors/peers **Physiological Feedback** - Identifying the need for self-care, coping, and resiliency-supportive techniques - Practices for self-care, coping, and resiliency	**Analysis of Task Requirements** - Safety planning **Attribution of Analysis of Experience** - Developing protocols - Valuing team-based care - Visit length - Reimbursement **Assessment of Personal Factors** - Limitations in meeting mental health needs of survivors - Establishing a multi-disciplinary network of referral providers - Forming partnerships with social workers/social service - Forming connection to legal services **Assessment of Situational Factors** - Medical home model - Trauma-informed care - Varied methods of communication and creating empowering spaces - Insurance/coverage for care **Estimation of Capacity** - Levels of confidence - Learning while practice	**Established Goals** **Established Behavior** **Outcomes and Impact**

Chapter 5: Discussion

The themes identified in provider interviews can be applied individually or in combination to support public health-based interventions in the care of survivors of sex trafficking. This chapter sequentially provides: (1) an overview of the identified themes; (2) responses to the three original thesis research questions mapped to Gist and Mitchell's levers of influence (Foundational, Cognitive Appraisal and Consequence); (3) limitations to the study design; and (4) recommendations for public health and further study.

5.1 Discussion of Research Questions

Through interviews with 11 providers, this study aimed to identify primary care providers' barriers and facilitators for addressing sex trafficking of women.

Opportunities identified in this study to support self-efficacy include: building upon an existing primary care culture which addresses social determinants of health and intersectionality; ensuring role clarity for providers; employing team-based and trauma-informed care approaches; learning experientially in practice and through discourse with social service providers, peers, professional networks, and mentors; addressing vicarious trauma through resiliency-supportive techniques; establishing practice-based safety planning; and utilizing protocols. Connections beyond the practice also were key to support self-efficacy and include engaging a multi-disciplinary network of referral providers and forming partnerships with social service providers and legal services.

The primary barriers to providers' self-efficacy includes addressing the mental health needs of survivors, visit length, and navigating coverage for care. Incorporating elements to support provider self-efficacy when designing public health interventions may drive provider behavior

and contribute to improved health outcomes for survivors both individually and at a population level. A more detailed review of research findings is provided in the following section.

Research Questions

Interview responses were used to address three original research questions:

(1) Which factors, including both barriers and facilitators, contribute to primary care providers' ***motivation*** to address the needs of patients who are survivors of sex trafficking?
(2) Which factors, including both barriers and facilitators, contribute to primary care providers' ***active engagement*** to address the needs of patients who are survivors of sex trafficking?
(3) Which factors, including both barriers and facilitators, contribute to primary care providers' sense of ***interaction with the social environment beyond the healthcare setting*** to address the needs of patients who are survivors of sex trafficking?

In this section, the barriers and facilitators to self-efficacy for primary care providers to identify and address the healthcare needs of adult women survivors of sex trafficking are outlined in detail. There is some crossover between themes under each question. Gist and Mitchell's "Foundational" lever of influence describes barriers and facilitators related to motivation and active engagement. The "Cognitive Appraisal" lever of influence describes barriers and facilitators to both active engagement and interaction with the social environment beyond the healthcare setting. The "Consequences" lever of influence describes barriers and facilitators related to all three original research questions. Pertinent sections of the overarching table of barriers and facilitators (Table 7, above) are listed under each original research question below.

Research Question 1: Motivation

Identified barriers and facilitators to self-efficacy which impact primary care providers' ***motivation*** to address sex trafficking are listed under the "Foundational" lever of influence (Table 8). Results in this section outline themes which support providers to begin addressing sex

trafficking in primacy care and continue to learn, engage in peer support, and practice resiliency-supportive techniques so as to maintain determination and lessen the risk of burnout.

Table 8: Foundational Levers of Influence to Achieve Self-Efficacy by Theme [Subset of Foundational Themes – Section I]

(Modified from Gist & Mitchell, 1992)

Foundational (I) (Development of Self-Efficacy)
Past/Ongoing Performance Provider entry into addressing trafficking Building upon the role of primary care Understanding of SDH/intersectionality Role clarity Transtheoretical model perspective **Vicarious Experience** (modeling and training) Learning from social service Educational resources and experiential learning Professional networks Learning through teaching **Verbal Persuasion** (coaching/evaluative feedback) Engagement of mentors and peers

Past/Ongoing Performance

Themes under *past and ongoing performance*, the first lever of influence in the figure above are barriers and facilitators which inspire, motivate, and drive providers to first elect to address and then continue to address trafficking. *Provider entry into addressing trafficking* was supported by either personal and/or institutional decisions. When entry was a personal decision, providers relied on their own motivations to respond to an existing need and ensure social justice. Multiple providers referenced remembering missed cases in reflection after learning about trafficking as a motivation to begin to address trafficking in practice. When an entry was institutionally supported, providers began to work in this space based on clinic leadership decisions to establish new protocols, form partnerships with social service or the Department of

Homeland Security (to bring trafficked patients into practice), or recommendations to address trafficking as a model of care. In these instances, the environment around the provider shifted to support their engagement in this area. Multiple providers, who determined to engage in addressing trafficking on their own, alluded that their institutions could either create barriers or provide support in this space. To appeal to provider engagement, intervention approaches could be designed so that practice leadership or institutional support for providers to address trafficking is transparent and conveys the need to appeal to provider motivations.

Providers interviewed for this thesis expressed motivation and preparation to work in this area based on the *culture of primary care.* Many providers noted their training in their residency programs provided preparation to address trafficking. However, transcending training, some providers interviewed indicated the specialty of primary care uniquely positioned them to view patients from a life course perspective, in the context of their communities, with an appreciation for *social determinants of health (SDH)*. As expressed in the literature review, addressing SDH is a common role for primary care with much overlap between implicit paradigms in SDH and primary care including: a focus on health equity; the opportunity to promote empowered communities and the social environment; and seeing health as more than the absence of disease (Rasanathan, et al., 2010). Responses in the research aligned with this view of primary care and also considered *intersectionality* as inherent and central to the approach and training of primary care as a specialty. Providers interviewed for this thesis considered the role culture, adverse childhood experiences, domestic violence, and substance use, including opioid use, play when treating survivors. Intervention approaches to support this lever can capitalize on an existing *culture of primary care* and convey that addressing trafficking aligns with an existing care philosophy.

Providers offered varying but concrete interpretations of their role to address trafficking, conveying a sense of *role clarity* as a facilitator. Personal perspectives on the role of a provider to address trafficking are formed by past performance and grounded in how providers interpret their role as a provider in general. While role definition varied across providers, most prioritized caring for immediate health needs and identification of red flags. Beyond this, providers pointed to a variety of roles such as creating a trauma-informed space, establishing a therapeutic alliance, connecting patients to social service organizations, offering comfort and being a "constant presence." A few providers defined their role in terms of prevention, contributing to the evidence-base of what works to support providers, and engaging in advocacy. Intervention approaches to support this lever can aim to provide direction and reflection to support *role clarity*.

The last theme, listed under past and ongoing performance, relates to provider comfort formed in approaches to care which mirror the *transtheoretical model of change*. This common theme asserts survivors' readiness to change behaviors takes place on a continuum and on the survivors' own terms. Some providers saw this a difficult role, but for others it was an approach that helped them maintain perspective when interacting with patients. Perspectives aligned with the transtheoretical model also offered some providers a sense of comfort as outcomes may require time and patience to realize. In terms of this model of change, one provider shared: "It's not your job to save these patients. No one thing that you do is going to save them. Your job is to provide compassionate care ..." This theme supported earlier research findings which suggest providing care to survivors along a continuum of needs (Zimmerman et al., 2011).

Vicarious Experience

Themes under *vicarious experience*, the second lever of influence in Table 8, help providers gain knowledge to practice through modeling and training. Providers expressed *learning from social service providers* as a key facilitator to help them understand the local and national landscape of social services and resources available to support survivors. Interventions can be designed to support providers to establish relationships with local social service partners and state human trafficking task forces, with materials tailored to be relevant to the local needs of the provider. Providers also may benefit from interventions which point to national resources and regularly updated state and national policies. *Educational resources* such as conferences, lectures, and articles were offered as important facilitators to equip providers to learn; however, the most commonly reported facilitator to learning came from *experiential learning* in the form of ongoing practice over time. This latter facilitator suggests learning opportunities should be tiered to give providers the opportunity to build effective hands-on experience over time.

Vicarious experience was also gained through *professional networks* and engaging with a broad community of providers. This key support for learning, noted across most interviews, suggests designing interventions which expand primary care provider connections to professional networks with a focus on the role of healthcare to address trafficking. One final theme was *learning though teaching* and producing educational content for other providers and providers-in-training. Multiple providers also engaged in informal conversations with peers as a form of teaching and learning opportunity, which may serve as a facilitator to help providers generate self-efficacy. Multiple providers expressed commitment to training the next generation of residents, but one provider cautioned that having a resident in a room may compromise trust for

survivors; this was not a theme but warrants further exploration to design interventions which support providers-in-training and residents who are patient-centered and trauma-informed.

Verbal Persuasion

The next lever of influence to self-efficacy, *verbal persuasion* was attained through feedback from patients, mentors, and peers. *Engagement of peers and mentors* for feedback was a key method to support learning noted across multiple interviews. One provider reported having found only two other providers who do similar work yet pointed to interactions with them as profound opportunities for "case-shared" learnings. While peer mentorship was more common than formal mentorship, a few providers spoke about the value of formal mentors. Some providers reported obstacles to finding peer support, suggesting a need for interventions which support provider connection to professional networks and peers.

Research Question 2: Active Engagement

Identified barriers and facilitators to self-efficacy which impact primary care providers' ***active engagement*** to address sex trafficking are listed under the "Foundational" and "Cognitive Appraisal" levers of influence (Tables 9 and 10). Results in this section include provider reflection on the resources and constraints which impact their ability to be actively engaged in addressing trafficking. The "Cognitive Appraisal" lever of influence supports integration of learning or being able to identify what characteristics support treating survivors of sex trafficking. In this lever of influence, strategies emerge which support refinement of personal and environmental factors to strengthen provider self-efficacy.

Table 9: Levers of Influence to Achieve Self-Efficacy (Foundational II)
[Subset of Foundational Themes – Section II]
(Modified from Gist & Mitchell, 1992)

Foundational (II) (Development of Self-Efficacy)
Physiological Feedback Identifying the need for self-care, coping, and resiliency-supportive techniques Practices for self-care, coping, and resiliency-supportive techniques

Physiological Feedback

The lever of influence to self-efficacy under "Foundational" titled *Physiological Feedback* within this framework was expanded to include emotional self-regulation and reflection. A key facilitator to practicing in this area was to first acknowledge and then identify practices that support *self-care, coping, and resiliency.* Many providers described the potential for vicarious trauma in this work and shared that the work was difficult, emotionally taxing, and frustratingly complex. In response, multiple practices to support self-care, coping, and resiliency to continue to work were described. The majority of techniques were self-directed such as exercise, therapy, mindfulness, and managing stress. Other practices were supported by institutions such as a workplace balance group. Some providers turned to approaches that may not be effective in the long term such as getting angry or "just dealing" on their own with stress. Whether self-directed or offered with institutional support, interventions which promote provider awareness and engagement in self-care, coping, and resiliency techniques may support self-efficacy for providers to maintain active engagement in addressing trafficking in care.

Table 10: Levers of Influence to Achieve Self-Efficacy (Cognitive Appraisal I)
[Subset of Cognitive Appraisal Themes – Section I]
(Modified from Gist & Mitchell, 1992)

Cognitive Appraisal (I) (Integration of Learning)
Analysis of Task Requirements Safety planning **Attribution of Analysis of Experience** Developing protocols Valuing team-based care

Analysis of Task Requirements

The first lever of influence to achieve self-efficacy to support active engagement under "Cognitive Appraisal" is analysis of *task requirements*. Within task requirements, *safety planning* for both patients and care settings was identified as an important aspect of practice. Safety was referenced repeatedly as a consideration for both providers and survivors. One provider noted that a reason for avoiding this work would be "if it threatens my immediate personal safety, and [if] I don't have a way to have more support or ensure my safety then I'm not willing to do more." The provider went on to note that hotline and crisis intervention numbers help *both* patients and providers in that a provider can make a report but not compromise safety. Safety planning for patients was supported for one provider by an assessment tool, but, for the most part, this was described as a challenging area without a clear guide for providers, which suggests opportunities for interventions that define specific approaches for safety planning. For example, while not previously stated in the results, the significance of safety planning for the practice was noted:

> Safety is always an issue and something that should always be in the front of our minds; if providers advertise or sort of hang a shingle that they are screening or helping to support within the life of exploitation then they have to really have safe security or measures in place to make sure the staff are safe and that the patients are safe.

There are safety concerns common to both patients and staff. In another example, also not previously noted in results, one provider noted:

> If the exploiter found out after the visit that a woman disclosed, I would want to make sure that we could keep that woman safe at that time. If she would want to leave that exploiter that day and the exploiter is there, we have to make sure we could keep the patient and the staff safe … that really means all of our security staff also being informed in a way … and being put on alert but not in a way that makes the environment uncomfortable but just being aware of who is in clinic and what we're concerned about.

Some providers acknowledged they understood aspects of the work pose certain risks but relied on patients to play a role in ensuring their safety and remained "hypervigilant" and "aware of surroundings":

> Not to the point it interferes in my life but I am not naïve enough to think someone couldn't come walking in here someday pretty angry.

A provider expressed a need for more outreach workers to connect patients to primary care but observed that the healthcare system is not fully equipped for outreach in communities:

> These issues can be approached from a public health perspective. How can we reach out to the patient where they are at in the community as long as the worker is not threatened by the trafficker? That is the caveat, I don't ever want a healthcare worker to be in a dangerous situation.

Barriers to conducting direct outreach in communities by outreach workers may impact the extent to which survivors encounter primary healthcare services.

Attribution of Analysis of Experience

The second lever of influence to self-efficacy under "Cognitive Appraisal," *Attribution of Analysis of Experience,* includes elements of the practice which providers' credit with providing them the support they need to address sex trafficking. Some literature reviewed in this study

suggests *protocols* offer an important intervention that may improve provider self-efficacy and downstream public health outcomes (Section 2.5). This finding was mirrored in provider response. The first support identified by providers included protocols, often referenced as a key tool to support work that is sometimes “muddy and murky.” Protocols were not noted to be used broadly in care settings in this study but providers who did use them considered them to be helpful tools for identify survivors and streamlining practice. While not necessarily discouraging protocols, one provider did caution against overreliance on a protocol or providers feeling that the work is too difficult without one and that they “don’t want the protocol to be the barrier ...” However, on the whole, responses consider protocols an important consideration when developing interventions to support providers in addressing trafficking.

An additional approach which conferred to providers the sense that they could engage in addressing trafficking was *team-based care*. Team-based care involved preparing *all* staff to be aware of trafficking and equipped providers to optimize care in this space. The majority of providers mentioned the value of having a team trained and equipped to support them in addressing the needs of survivors. The value placed on teams took many forms including: appreciating the role diversity of staff perspectives plays in caring for survivors; having patient advocates on-site; extensively training all staff on the issue including front desk and janitors; supporting emotional health across staff; and placing particular value in providing training to anyone on the team with an interest in providing care in this space. With relevance to the third research question, when providers described *teams* the use of this term this could extend beyond the care setting to include social service partners and a multi-disciplinary network of referral providers. The medical home model was mentioned as one promising approach to team-based care.

Research Question 3: Interaction with the Social Environment Beyond the Healthcare Setting

Identified barriers and facilitators to self-efficacy which impact primary care providers' *interaction with the social environment beyond the healthcare setting* to address sex trafficking are listed under the "Cognitive Appraisal" lever of influence (Table 11). Results in this section include provider reflection on the resources and constraints which impact their ability to actively engage in addressing trafficking. This section includes themes that impact provider self-efficacy related to provider interaction beyond their practice in the broader healthcare system.

Table 11: Levers of Influence to Achieve Self-Efficacy (Cognitive Appraisal II)
[Subset of Cognitive Appraisal Themes – Section II]
(Modified from Gist & Mitchell, 1992)

Cognitive Appraisal (II) (Integration of Learning)
Analysis of Task Requirements Visit length Reimbursement **Attribution of Analysis of Experience** Establishing a multi-disciplinary network of referral providers Forming partnerships with social workers/social service providers Forming connection to legal services **Assessment of Personal Factors** Limitations in meeting mental health needs of survivors **Assessment of Situational Factors** Medical home model Trauma-informed care Varied methods of communication and creating empowering spaces Insurance/coverage for care

Analysis of Task Requirements

A lever of influence to achieve self-efficacy under *task requirements* (which acts as both a barrier and facilitator) is visit length. Increased visit times helped providers feel they could offer more effective care for survivors. Lack of adequate time challenged the ability of providers to

work effectively in this space and also posed risks to patient trust. Many providers were going above and beyond their regular duties as providers to carve out time to address the needs of survivors of sex trafficking. This care was sometimes provided without reimbursement and contributed stress but their commitment to survivors often trumped the risk for burnout. Multiple providers noted that short visits are a challenge for treating this population with unique needs. Time constraints warrant creative intervention opportunities to support flexibility in treatment length. Interventions to mitigate this issue, in a healthcare and public health systems-wide manner, must be addressed beyond the level of the primary care setting. However, some providers involved in the study restructured their practices or blocked specific longer visits to meet the needs of providers and survivors. With connections to reimbursement, changing visit length is not a feasible approach across all primary care settings warranting policy and public health interventions to address this challenge.

Attribution of Analysis of Experience

Mirroring the literature, providers emphasized engagement of systems outside of the four walls of the practice to better serve survivors. This included establishing a *multi-disciplinary network of referral providers, forming partnerships with social workers/social-service providers, and forming connections to legal services*. Formalizing partnerships was a critical approach to empower providers to provide effective care to trafficking survivors. While many approaches to support referrals were noted, most providers placed emphasis on patient-centered approaches when establishing referrals. To navigate referrals in a patient-centered approach, providers spoke of having formed standing networks of provider relationships and making connections to social services.

While every provider underscored the significance of engagement with social service partners, and most commented on the value social workers play in their efforts in this space, resources and services were sometimes siloed or limited. Providers also saw the value in working synergistically with social service providers, but not all knew appropriate locations to refer patients, showing a key opportunity for intervention. The value of engaging social service and legal partners helped providers engage their SDH orientation noted earlier in this chapter. For example, partnerships played a key role in connecting patients to shelter, legal services, and even basic needs such food security. However, forming and navigating relationships with a broader external care team was not always straightforward and resources are not always adequate. One provider removed silos by creating phone-based care teams, consisting of the primary care provider and social worker, with the survivor present. This was helpful to the patient but also supported provider self-efficacy (and work-life balance) in that "when we have a team that is cogent and works well together, one can go on vacation and the other four are still around. It really does make it easier."

Assessment of Personal Factors

Limitations in meeting mental health needs of survivors in primary care was often cited by providers as a barrier to self-efficacy. Providers often shared that they were not equipped to treat complex trauma and mental health needs of survivors of trafficking, especially services related to detox and substance abuse, making this one of the most challenging aspects of providing care for survivors. One provider described the trauma experienced by survivors as the hardest part of practice:

> because there's different levels of trauma, so even [for] people who feel very good about providing trauma/mental health [care], you know that kind of repetitive, stranger-driven mental trauma that happens in trafficking I think is very, very hard to break down.

Due to the complex trauma experienced in trafficking, many providers made references to interventions going beyond the capabilities of primary care; however, connecting survivors to mental healthcare came with its own challenges, such as finding specialists and navigating coverage.

One approach identified to support providers in establishing relationships with referral providers and care for the mental health needs of survivors is the patient-centered medical home model.

Assessment of Situational Factors

Providers pointed to a variety of situational factors that can support approaches to care including the *medical home model*, *trauma-informed care*, and varied *methods of communication with patients and creating empowering spaces*. Because it reflects the literature and the significance given to team-based care by multiple providers in this study, the medical home model appears to be a viable care model in this space. In describing care prior to the establishment of a medical home model, patients would be treated across multiple locations; the medical home model offered a more holistic approach for care-coordination. Another model, or philosophy, that multiple providers appreciated in guiding them in this space was trauma-informed care. One provider combined both philosophies and noted that they were "taking the medical model approach and shifting that paradigm to be a patient centered trauma-informed approach." The trauma-informed care approach was suggested to contribute to improved care for patients and provider satisfaction.

Methods of communication and creating empowering spaces for patients varied across providers. These miscellaneous tips, noted in more detail in the results chapter, included a range of methods to empower patients: offering same day appointments; creating an open space by

letting patients know they aren't rushed; being mindful of survivors' resistance to touch and body language; asking questions of survivors only on a need-to-know basis; having phone or in-person interpreters for almost every language; and asking patients how they prefer to communicate—text, phone, etc. Some providers shared they were particularly thorough in explaining steps of the care plan to make sure patients could navigate care once they leave the practice. One provider described the need for a universal electronic medical record, suggesting this would be "transformative" for reducing redundant tests and improving longitudinal care. Multiple providers spoke about charting in a manner which reflects what a survivor shares, thus dignifying the survivor. The piecemeal nature of the above approaches suggests the importance of testing and sharing best practices among providers.

The most challenging situational factor identified was patients' lack of insurance or limited care coverage. Interventions to mitigate this issue must be addressed beyond the level of the primary care setting. Almost all providers expressed difficulty in overcoming this hurdle but some care settings developed structures to treat underserved patients, such as through pro bono care. In speaking to why they may feel ill-equipped to treat this population, one provider shared:

> The biggest barrier is health insurance. It is crippling. I have diagnosed people who absolutely need to see a specialist right away. They need to get ultrasounds, they need to get medication, and they need to get labs and my hands are tied.

Provider responses conveyed a critical need for systems-level interventions to support increased funding to practices to provide care for survivors and models which support coverage for all survivors.

Consequences of Motivation, Engagement, and Interaction Beyond Healthcare

Within the Gist and Mitchell framework, self-efficacy leads to an estimation of capacity (i.e., assessment of self-confidence) where a primary care provider considers themselves equipped,

motivated, and able to address sex trafficking in practice (Table 12). Providers were asked about their levels of confidence to address trafficking; they generally expressed a high degree of confidence, tempered by an awareness of their limitations.

Table 12: Levers of Influence to Achieve Self-Efficacy (Consequences I)
[Subset of Cognitive Appraisal Themes – Section III]
(Modified from Gist & Mitchell, 1992)

Cognitive Appraisal (III) (Integration of Learning)
Estimation of Capacity (assessment of confidence) Levels of confidence Learning while practice

Table 13: Levers of Influence to Achieve Self-Efficacy (Consequences II)
(Modified from Gist & Mitchell, 1992)

Consequences (Established Self-Efficacy)
Established Goals **Established Behavior** **Outcomes and Impact**

For providers engaged in this study, the culmination of the preceding levers of influence contributed to *consequences* or impact (Table 13, above). Underscoring the value of supporting provider self-efficacy, this impact or goals include: establishing new clinics; advocacy to alter the healthcare system; and examples of improved social and health outcomes for survivors. Within the Gist and Mitchell model, consequences become part of a feedback loop which informs prior levels of self-efficacy, meaning providers interviewed in this study, and others in the field, are poised to continuously learn and generate greater levels of impact. Despite meaningful outcomes, providers highlighted this as an emerging field with room for improvement and increased understanding, with one provider noting “we are flying the plane

while we are building it." A public health approach could bring change in behavior to a broader set of primary care providers, driving *health outcomes and impact* for survivors and communities impacted by trafficking.

5.3 Limitations

There were multiple limitations to the design of this study. First, other than limited inclusion criteria, there was no formal way to validate providers' existing level of engagement and self-efficacy prior to an interview. However, this did have the benefit of encouraging a diverse array of perspectives. Provider respondents were identified through existing professional provider networks and snowball sampling, which may have introduced bias to the study. Due to time constraints, the interview guide was not tested with a sample of providers before being deployed, which could have strengthened the instrument and impacted results. Many providers shared that even as they were practicing in this space they were actively contributing to the evidence-base and provided insights suggesting there is still much to be learned to support survivors in primary care settings. To this end, this study described the *current* approaches being actively utilized by providers, but these may not reflect the most promising approaches or evidence-based practices for providing care for survivors of trafficking. However, as promising approaches or evidence-based practices emerge in the field, this study offers methods to support providers' self-efficacy to employ new approaches.

5.4 Recommendations

The Need for a Public Health Response

The themes generated in this study, organized according to Gist and Mitchell's (1992) framework, suggest multiple methods to strengthen primary care provider self-efficacy to address the healthcare needs of adult women survivors of sex trafficking. Policies and programs,

within a comprehensive public health response, could be designed using these themes to support provider self-efficacy, thus cultivating primary care as a key point of public health intervention. A public health scientific framework should be employed to ensure more widespread primary care provider engagement to address trafficking, through *defining the scope of the problem, identifying risk and protective factors, developing and testing prevention strategies, and assuring widespread adoption* (Marcy et al., 1993).

In Chapter 1, the Social Ecological Model (SEM) was presented as a public health framework to suggest that comprehensive public health prevention must employ multiple levels of intervention, across the social ecology, spanning individuals, relationships, communities, and society (Dahlberg and Krug, 2002). To underscore the need for multiple points of intervention to address this public health challenge, the five-tier *Health Impact Pyramid* also was introduced in Chapter 1; a key tenant of this model suggests clinical interventions are a critical point of intervention in public health practice, but require significant individual levels of effort to generate impact (Frieden, 2010). Therefore, self-efficacy to equip providers to have "confidence in the[ir] ability to exert control over .... [their] motivation, behavior, and social environment" is of critical importance to affect provider behavior (Forsyth & Carey, 2017).

Recommendations for a Public Health Response

To generate public health impact, in this case through clinical settings, both the SEM and the *Health Impact Pyramid* necessitate responses at multiple levels of the social ecology. A series of recommendations are presented below, across multiple levels of the social ecology, that are drawn from the themes identified in provider interviews. The following recommendations are offered as options for further research to increase primary care provider self-efficacy to identify and respond to the healthcare needs of female survivors of trafficking:

(1) Models to Support Practice and System Redesign:

a. Federal and state-based public health agencies can establish guidelines and incentivize healthcare systems and standalone practices to establish *coordinated care models*. Coordinated care models can assist primary care settings to designate champions to drive practice redesign towards high-functioning care team-based approaches to address trafficking. Practice champions can navigate practice redesign to make appropriate changes to visit length, encourage use of a protocol, and make connections to social service partners and a multi-disciplinary network of referral providers equipped to appropriately respond to the unique needs of survivors. Coordinated care models can be designed to engage social service providers, complex trauma specialists, and other specialists to provide comprehensive care for survivors.
b. Healthcare systems (including federally qualified health centers or academic, public or private health systems) can design models which support practice leadership to champion implementation of trainings, practice redesign, and protocols tailored to primary care to address trafficking. Healthcare systems can support primary care practices to establish policies which are: in support of optimal visit length; encourage patients are seen alone for a portion of every visit; and care settings have defined methods to foster communication with survivors, such as designated lines to record messages.
c. Primary care practices and healthcare systems can implement supportive structures to encourage self-care, coping, and resiliency such as mindfulness trainings, workplace peer support groups, and work-life balance programs.
d. Because the evidence-base to address trafficking in primary care is nascent, federal and state-based public health agencies and healthcare systems can implement models to pilot new approaches and practice structures, such as survivor-centered patient-centered medical homes, and share learnings across healthcare systems.
e. Federal and state-based public health agencies and healthcare systems can meet to develop consensus on clinical guidelines, standardized measures, and ICD-10 codes, thus ultimately supporting measurement of health outcomes and reimbursement to address trafficking in primary care (and all specialties). Reporting on these measures, plus survivor-centered care and referrals, can be supported by universal or interoperable electronic health records across primary care settings.
f. Federal public health entities and academic medical settings can support translation-based research to promote evidence-based practices across primary care settings.
g. Federal and state-based public health agencies and healthcare systems can support approaches to address trafficking by aligning efforts with other existing initiatives and topical areas such as intimate partner violence, opioid use, and housing.
h. Federal and state-based public health agencies and healthcare systems can design approaches to bridge divergent perspectives between justice and healthcare in support of survivors.

(2) Models to Expand and Support Primary Care Provider Training:

a. Medical, nursing and pre-professional schools and residency programs can incorporate training on social determinants of health and trafficking in all curricula to support a new generation of primary care providers to address trafficking and normalize universal education and screening for trafficking in practice. Opportunities for experiential learning should be designed to be trauma-informed and survivor-centered.
b. Federal and state-based public health agencies and healthcare systems can deploy new or enhance existing curricula to train current primary care providers.
c. All trainings should be defined with the tenants of trauma-informed care.
d. All trainings should include components which support primary care providers to: clearly define roles and limitations; underscore intersections with other conditions and social determinants; encourage connections with mentors; and emphasize practices for self-care, coping, and resiliency.
e. Trainings should be staggered to support experiential learning and allow techniques to be practiced safely over time, in support of the needs of survivors.
f. Healthcare systems can develop approaches to ensure trainings measure and demonstrate health impact (beyond simply assessing for pre-and-post training levels of confidence).
g. Trainings should occur as an ongoing series to encourage discussion between providers and reflection on prior cases.
h. All trainings should include train-the-trainer components to empower primary care providers to train peers and colleagues.
i. All trainings should include a mechanism to incorporate survivor input and feedback on services received.

(3) Models to Foster Peer Learning, Partnerships, and Support for Primary Care Providers:

a. Federal and state-based public health agencies and healthcare systems can partner with existing state trafficking taskforces to establish state-based databases of healthcare providers (across specialties) and social service providers (across types) who are prepared to address the unique needs of survivors. This database should support primary care providers' ability to make referrals and engage with other providers and social service partners. The database also can include a directory of services for providers and social service agencies such as shelters, aftercare, employment, coverage for care, and legal services. The design of this database should be comprehensive enough to include a mechanism to incorporate survivor input and feedback on services received.
b. State trafficking taskforces can maintain a website of current consent and reporting laws to help providers navigate requirements.
c. Federal and state-based public health agencies and healthcare systems can partner to develop national and local learning communities and technical assistance centers to serve as virtual and face-to-face forums for primary care providers to share promising and best practices and amplify stories of impact to addressing

trafficking in healthcare. These learning communities can include a formal mentorship program and offer techniques for effective peer-to-peer mentorship.

d. Federal and state-based public health agencies and healthcare systems can partner to establish a formal tele-health model for provider consults.
e. Provider networks should be supported and promoted in trainings and initiatives. Provider networks should determine approaches to support specific provider specialties to engage in advocacy, establish peer-support, and learning.

Recommendations for Further Study

Further study is suggested to detail which barriers and facilitators, or collections of barriers and facilitators, create the most impact on providers' behavior. Even though this study only considered sex trafficking, some of the same approaches may be relevant to labor trafficking. Further study should determine the barriers and facilitators which apply to labor trafficking. This study focused on providing care to women survivors of sex trafficking but only a limited number of gender-responsive approaches were defined. Further study could define gender-responsive approaches for providers. This study focused only on adult women and further study is recommended to address the unique considerations of commercially sexually exploited children and youth.

When identifying barriers and facilitators, provider responses in this study were often focused on *secondary* and *tertiary* prevention. Only a few providers spoke offered details on their approaches to affect *primary* prevention through targeting risk factors for entry into trafficking. For example:

> There are ways to ask a question about exploitation that gets at young women or adult women who may be being groomed for exploitation but haven't yet been exploited. So, for instance saying, 'has anybody ever asked you to have sex with another person?'

More study is needed to understand barriers and facilitators to self-efficacy for providers to address *primary* prevention of trafficking.

The majority of providers interviewed pointed to primary care as an effective point of intervention to identify and address the healthcare needs of adult women survivors of sex trafficking. However, this assumption was challenged in two interviews. One provider expressed skepticism that primary care providers are not equipped to handle the level of trauma associated with trafficking; another provider questioned the role of primary care providers in identifying trafficking:

> I am not convinced that medical providers are the best or most common way to detect trafficking. If you have an opportunity, then you should detect trafficking and it can be done safely, but from what I have seen, most of my patients get freed by being arrested or leaving or escaping. While I would like to capitalize on an opportunity to detect, the data isn't very clear that the patients are interacting with the healthcare system in a meaningful way.

In conjunction with themes identified in this thesis, these comments suggest that while self-efficacy for providers can be improved, more research should be conducted to ensure interventions are evidence-based, survivor-centered, and support improved health outcomes.

5.5 Conclusion

Taken together, the literature and provider responses suggest multiple roles for primary care providers to provide care to women survivors of sex trafficking, often outside the realm of direct healthcare interventions and aligned with social determinants of health. Multiple barriers and facilitators to provider self-efficacy to address sex trafficking were identified in this study. Respondents generally expressed a high self-estimation of confidence to address sex trafficking. However, barriers to provider self-efficacy remain, underscoring the need to strengthen approaches in primary care and the healthcare delivery system to support providers in addressing sex trafficking. Methods to encourage facilitators and reduce barriers to self-efficacy can be further integrated into public health interventions to support primary care providers as they respond to, identify, and provide care to women survivors of sex trafficking.

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Appendix

I. IRB Oral Consent Form

Emory University
Consent to be a Research Subject

Title: *A qualitative analysis of primary care provider's self-identified barriers and facilitators in healthcare settings to address sex trafficking of women.*

Principal Investigator: Jane Segebrecht, BSE, Emory Executive MPH Prevention Science Track

Introduction
You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study or not to be in the study. It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. You can skip any questions that you do not wish to answer.

Before making your decision:

- Please carefully listen to this form being read to you
- Please ask questions about anything that is not clear

You can have a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By orally consenting after this form is read you will not give up any legal rights.

Study Overview
The purpose of this study is:

- to learn more about what helps providers respond to sex trafficking of women in primary healthcare;
- to learn about the gaps in responding to sex trafficking of women in primary healthcare; and
- to generate themes that can inform policy or program development to better equip primary care settings to respond to sex trafficking of women.
- Approximately 10 providers will be interviewed as a part of this study.

Procedures
This study consists of a 1 to 1.5-hour long phone interview.

Risks and Discomforts
Risks are minimal. While every effort will be made to maintain confidentiality, potential risk includes breach of confidentiality or inadvertent disclosure of data.

Benefits
This study is not designed to benefit you directly. This study is designed to learn more about what supports primary care providers in their response to sex trafficking of women. Study results may be used to help others in the future.

Compensation
You will not be offered payment for being in this study.

Confidentiality
Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at your study records. These offices include the Emory Institutional Review Board and the Emory Office of Research Compliance. Emory will keep any research records private to the extent required to do so by law. A study number rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when this study is presented or results are published.

Study records can be opened by court order. They may also be produced in response to a subpoena or a request for production of documents.

Voluntary Participation and Withdrawal from the Study
You have the right to leave a study at any time without penalty. You may refuse to do any procedures you do not feel comfortable with, or answer any questions that you do not wish to answer. If you withdraw, you can opt to request to not have your responses included in the study.

Contact Information
Contact Jane Segebrecht at (xxx)-xxx-xxxx:

- if you have any questions about this study or your part in it.
- if you have questions, concerns, or complaints about the research.

Contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

- if you have questions about your rights as a research participant.
- if you have questions, concerns or complaints about the research.
- You may also let the IRB know about your experience as a research participant through the Research Participant Survey at *[web link to SurveyMonkey provided]*.

Verbal Consent

Do you have any questions about anything I just said? Were there any parts that seemed unclear?

Do you agree to take part in the study?

Participant agrees to participate: *Yes* *No*

If *Yes*:

____

Name of Participant

____

Name of Person Conducting Informed Consent Discussion

____

Signature of Person Conducting Informed Consent Discussion

Date ________ Time ________

II. Exemption of Human Subjects Research

Institutional Review Board

Date: December 29, 2016
Jane Segebrecht Principal Investigator Unassigned Department

RE: Exemption of Human Subjects Research IRB

A qualitative analysis of primary care providers' self-identified barriers and facilitators to address sex trafficking of women in healthcare settings.

Dear Principal Investigator:

Thank you for submitting an application to the Emory IRB for the above-referenced project. Based on the information you have provided, we have determined on 12/29/2016 that although it is human subjects research, it is exempt from further IRB review and approval.

This determination is good indefinitely unless substantive revisions to the study design (e.g., population or type of data to be obtained) occur which alter our analysis. Please consult the Emory IRB for clarification in case of such a change. Exempt projects do not require continuing renewal applications.

This project meets the criteria for exemption under 45 CFR 46.101(b)(2). The primary objective of this project is to understand what helps providers' respond to sex trafficking of women in primary healthcare, to understand the gaps in responding to sex trafficking of women in primary healthcare, and to generate themes that can inform policy or program development to better equip primary care settings to respond to sex trafficking of women. Specifically, you will conduct semi-structured interviews with healthcare providers to identify barriers and facilitators in healthcare settings to address sex trafficking of women.

- Segebrecht, Jane_Scientific Protocol.doc_12.22.2016
- Segebrecht_Jane_Semi-structured Interview Guide Recruitment Email.docx
- Segebrecht_Jane_Oral
- Consent Document_12.27.16

Please note that the Belmont Report principles apply to this research: respect for persons, beneficence, and justice. You should use the informed consent materials reviewed by the IRB unless a waiver of consent was granted. Similarly, if HIPAA applies to this project, you should use the HIPAA patient authorization and revocation materials reviewed by the IRB unless a waiver was granted. CITI certification is required of all personnel conducting this research.

Unanticipated problems involving risk to subjects or others or violations of the HIPAA Privacy Rule must be reported promptly to the Emory IRB and the sponsoring agency (if any).

In future correspondence about this matter, please refer to the study ID shown above. Thank you.