ALASKA STATE LEGISLATURE
SENATE JUDICIARY STANDING COMMITTEE
March 13, 2024
1:46 p.m.

MEMBERS PRESENT

Senator Matt Claman, Chair
Senator James Kaufman
Senator Cathy Giessel
Senator Löki Tobin

MEMBERS ABSENT

Senator Jesse Kiehl, Vice Chair

COMMITTEE CALENDAR

PRESENTATION(S): REPORT ON RELATIONSHIPS BETWEEN INTIMATE PARTNER VIOLENCE AND ALASKAN WOMEN'S HEALTH

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

INGRID JOHNSON, Associate Professor
UAA Justice Center
Anchorage, Alaska
POSITION STATEMENT: Delivered a presentation on Relationships between Intimate Partner Violence and Alaskan Women's Health.

ACTION NARRATIVE

1:46:17 PM
CHAIR MATT CLAMAN called the Senate Judiciary Standing Committee meeting to order at 1:46 p.m. Present at the call to order were Senators Kaufman, Tobin, and Chair Claman. Senator Giessel arrived immediately thereafter.

PRESENTATION(S):
REPORT ON RELATIONSHIPS BETWEEN
INTIMATE PARTNER VIOLENCE AND ALASKAN WOMEN'S HEALTH

1:46:46 PM
CHAIR CLAMAN announced a presentation on Relationships Between Intimate Partner Violence and Alaskan Women's Health from the Alaska Justice Information Center (AJIC), University of Alaska Anchorage (UAA). He invited Ms. Ingrid Johnson to put herself on the record and begin the presentation.

1:47:25 PM
INGRID JOHNSON, Associate Professor, UAA Justice Center, Anchorage, Alaska, delivered a presentation on Relationships between Intimate Partner Violence and Alaskan Women's Health. She said she is an associate professor at the UAA Justice Center and the principal investigator for the Alaska Victimization Survey (AVS). She said this presentation is based on a specific report that was published November 2023.

1:47:40 PM
SENATOR GIESSEL joined the meeting.

1:48:05 PM
MS. JOHNSON moved to slide 2, Overview and History of the Alaska Victimization Survey (AVS):

[Original punctuation provided.]

Overview and history of AVS

- General methodology
  - General population survey of adult women residing in Alaska.
  - Respondents randomly selected and contacted by landlines and cell phones.
  - Modeled after the National Intimate Partner and Sexual Violence Survey (NISVS) administered by the CDC.
  - Questions about victimization are "behaviorally specific" and include a wide range of violence against women.
  - Survey procedures designed to maximize the safety and confidentiality of respondents.

- Joint effort between the Alaska Council on Domestic Violence and Sexual Assault (CDVSA; funders) and the University of Alaska Anchorage Justice Center (research implementation).

- Conducted statewide surveys in 2010, 2015, and 2020 (quinquennially)
  - 13 regional surveys were conducted 2011 – 2015

MS. JOHNSON explained that regional surveys were conducted to obtain region-specific prevalence estimates. She stated that with all the data now combined, more in-depth analyses are possible due to the larger sample size.

1:49:27 PM
MS. JOHNSON moved to the chart on slide 3 and stated that the report she is presenting to the committee today includes all individuals who ever participated in the AVS. She said this represents nearly 13,000 women from all of the statewide and regional surveys.

[Original punctuation provided.]

Location, years, and sample sizes of statewide and regional AVS.

12,985 Alaskan women participated in regional or statewide Alaska Victimization Surveys between 2010 and 2020.

Year	Location/Region	Sample Size
2010	**Statewide**	**871**
2011	Municipality of Anchorage	718
2011	**Bristol Bay Region**	**373**
2011	Fairbanks North Star Borough	745
2011	**City and Borough of Juneau**	**604**
2012	Kodiak Island Borough	415
2012	**City and Borough of Sitka**	**282**
2012	Yukon-Kuskokwim Delta	509
2013	**Kenai Peninsula Borough**	**987**
2013	Ketchikan Gateway Borough	648
2013	**Matanuska-Susitna Borough**	**1,190**
2014	Nome Census Area	265
2014	**North Slope Borough**	**169**
2014-2015	Aleutian/Pribilof Island Region	82
2015	**Statewide***	**3,027**
2020	Statewide	2,100

Notes

***** The 2015 statewide sample included enough cases to also generate Municipality of Anchorage specific prevalence

estimates and to add an additional 38 cases to the Aleutian/Pribilof Island sample to generate estimates for that region.

1:50:39 PM
SENATOR TOBIN, referring to slide 3, asked about the percentage of non-English speaking, non-institutionalized women in the Matanuska-Susitna Borough who were represented by the 1,190-sample size.

1:51:03 PM
MS. JOHNSON replied that the information is available through the UAA AVS ScholarWorks repository. The repository has a PowerPoint or report containing population percentages for each region. She offered to gather that information for the committee.

1:51:39 PM
SENATOR GIESSEL sought confirmation that those who participated in the survey were non-duplicated individuals.

MS. JOHNSON replied that she could not confirm that.

SENATOR GIESSEL asked whether some participants could have moved, for example, from Juneau to the Mat-Su, between 2011 and 2013 and been included in the survey twice.

MS. JOHNSON replied in the affirmative and clarified that respondents could have participated in both the statewide and in a regional sample. She explained that the survey is not designed to track participants over time. Surveyors randomly select individuals from landline and cell phone lists and there is no way to determine whether someone has already participated.

1:52:18 PM
SENATOR GIESSEL asked whether the survey included a question such as, "Have you participated in a survey like this before?"

MS. JOHNSON answered that she was unsure whether respondents would recognize it as the same survey, given that there are other surveys covering similar topics. Other surveys include the National Intimate Partner and Sexual Violence Survey (NISVS), AVS is designed after the NISVS, and the Behavioral Risk Factor Surveillance System (BRFSS).

1:52:49 PM
MS. JOHNSON moved to slide 4, Why this Report on Health:

[Original punctuation provided.]

- Research has consistently demonstrated the negative impacts intimate partner violence (IPV) has on physical and mental health

- Raise awareness in Alaska about
  - Different forms of IPV and their impacts on health
  - Impact of recent and historical IPV on health

MS. JOHNSON explained that the report includes different types of IPV, such as:

- coercive control and entrapment

- psychological control and aggression

- physical aggression

MS. JOHNSON said historical IPV experiences are not commonly explored in literature and expressed interest in examining whether such experiences impact health.

1:54:53 PM
CHAIR CLAMAN asked about the timeframe parameters used to determine whether historical IPV has health implications, for example, whether there are still health impacts 10 years later.

MS. JOHNSON replied that she uses a somewhat crude measurement, explaining AVS questions start with:

- How many partners have ever done this to you in your lifetime?

If the answer is one or more, then the respondent is asked:

- How many intimate partners have done this in the past year?

MS. JOHNSON stated that the survey collects both lifetime and past-year experiences but does not specify whether incidents occurred 10 years ago or 20 years ago. It only identifies whether the experience happened within the past year.

1:56:05 PM
MS. JOHNSON moved to slide 5, Forms of IPV:

[Original punctuation provided.]

Forms of IPV

Table 1: Percentage of adult, non-institutionalized Alaskan women who participated in the Alaska Victimization Survey (AVS) with historical and recent experiences with various forms of intimate partner violence (IPV; [a] N = 12,985).

Details on the specific behaviors in each of these forms of IPV are included in the report Appendix.

	[b] HISTORICAL	[c] RECENT	[d] ANY LIFETIME
ANY INTIMATE PARTNER VIOLENCE	**44.3**	**16.9**	**61.2**
Control	**31.3**	**9.5**	**40.8**
Reproductive control	9.9	1.9	11.8
Threats of harm	**36.3**	**7.3**	**43.6**
Harm infliction	**42.4**	**12.5**	**54.9**
Indirect harm infliction	22.2	3.7	25.9
Direct harm infliction	42.1	11.8	53.9
Psychological aggression	35.1	10.3	45.4
Physical violence	35.5	4.6	40.1
Minor physical violence	33.7	4.1	37.8
Severe physical violence	27.5	2.8	30.3
Sexual violence	16.7	1.3	18.0

[a] N for each form of IPV varies slightly under 12,985 due to missing data on each item.

[b] Women were classified as having historical experiences if they had experienced a form of IPV in their lifetime but not in the year prior to participating in the survey.

[c] Women were classified as having recent experiences if they experienced a form of IPV in the year prior to participating in the survey. Participants with recent experiences may also have had historical experiences, but are only included in the recent category for this report (i.e., historical and recent are mutually exclusive categories).

[d] Adding together the historical and recent percentages gives the total percent of women experiencing a form of IPV ever in their lifetime.

1:59:52 PM
SENATOR TOBIN asked whether respondents who self-identify as women need to provide documentation.

MS. JOHNSON replied that the survey can include transgender women. She said respondents who volunteer that information are included in the survey.

2:00:12 PM
CHAIR CLAMAN asked her to elaborate on the meaning of reproductive control within the context of the survey.

MS. JOHNSON replied that reproductive control means:

- The partner attempted to get the respondent pregnant when she did not want to be or tried to stop the respondent from using birth control.

- The partner refused to us a condom when the respondent wanted to use one.

MS. JOHNSON said that while slide 5 lists the different forms of IPV, the following slide presents six health measures. These include four specific health conditions, along with a self-rated physical health measure and a self-rated mental health measure.

2:00:46 PM
MS. JOHNSON moved to slide 6, Physical and Mental Health:

[Original punctuation provided.]

Physical and Mental Health

Table 2: Percentage of adult, non-institutionalized Alaskan women who participated in the Alaska Victimization Survey (AVS) reporting various health conditions and overall physical and mental health status ([a] N = 12, 985)

	PERCENT
HEALTH CONDITIONS	
Frequent headaches	17.5
Chronic pain	25.3

Difficulty sleeping	31.6
Health-related limitations	33.2
SELF-RATED PHYSICAL HEALTH	
Excellent	16.7
Very good	33.6
Good	32.6
Fair	13.3
Poor	3.7
SELF-RATED MENTAL HEALTH	
Excellent	28.6
Very Good	36.1
Good	26.5
Fair	7.5
Poor	1.3

a N for each health condition varies slightly under 12,985 due to missing data on each item.

2:01:39 PM
MS. JOHNSON explained that these percentages represent the overall sample of participants experiencing these different conditions, not just participants who experienced violence. She reviewed the data set: nearly one-third of respondents reported difficulty sleeping, one-quarter experienced chronic pain, 17.5 percent reported frequent headaches, and one-third experienced some form of health-related limitation.

MS. JOHNSON discussed self-rated physical and mental health, noting that participants were asked to choose from five rating options: excellent, very good, good, fair, or poor. She observed that many respondents selected "very good" or "good," which seemed encouraging. However, some participants may have chosen to rate their health more positively than their actual condition to avoid appearing as though they were complaining.

MS. JOHNSON stated that although self-rated health is not a perfect assessment method, existing research supports its value as a reasonably accurate indicator of general health. She pointed out that very few participants selected "fair" or "poor," which resulted in small subgroups. She stated that having a large, combined sample size of approximately 13,000 cases allows for meaningful analysis even within these small subgroups. With only one year of data or a limited sample size, the level of analysis done in this report would not be possible.

She expressed enthusiasm about being able to conduct these analyses.

2:03:42 PM
CHAIR CLAMAN expressed his understanding that given the overall large size of the dataset, meaningful analysis is still possible despite the relatively small percentage of participants who selected "poor." He sought confirmation that the small percentages still represent sufficient numbers for analytical purposes.

MS. JOHNSON replied that the large sample size is beneficial because it yields enough cases even within small percentage groups. She explained that with a sample size of 1,000, 1.3 percent would represent only 13 cases, whereas with 10,000 cases, the same percentage yields 130 cases. This is enough to support more robust analyses. She emphasized that this is particularly important when examining past-year experiences involving less common forms of violence. There should be at least, at a rough estimate, 15 to 20 cases representing a specific experience for analyses to be statistically meaningful. With a dataset this large, even a small number of reports related to poor health or uncommon forms of violence can still produce reliable findings.

2:05:06 PM
CHAIR CLAMAN asked whether there are statistics that compare these findings with a group of individuals who have not experienced intimate partner violence (IPV).

MS. JOHNSON replied that the next slide addresses that comparison.

2:05:26 PM
MS. JOHNSON moved to slide 7, The Relationship Between IPV and Health:

[Original punctuation provided.]

The Relationship Between IPV and Health

> A significantly larger percentage of those who experienced any IPV (either historically or recently) have negative health outcomes than those who never experienced it.

Table 3: Percentage of **any intimate partner violence** groups (never experienced, historical experience, and recent experience) endorsing each health outcome.

	ANY INTIMATE PARTNER VIOLENCE		
	NEVER (N=4,900)	**HISTORICAL (N=5,592)**	**RECENT (N=2,130)**
Frequent headaches	11.9	18.3	28.0
Chronic pain	17.5	29.1	32.2
Difficulty sleeping	20.9	36.3	43.6
Health-related limitations	23.4	38.2	40.6
Self-rated physical health			
Excellent	22.0	14.4	11.5
Very Good	38.5	32.2	27.2
Good	28.7	34.3	37.1
Fair	9.0	14.9	18.4
Poor	1.9	4.3	5.7
Self-rated mental health			
Excellent	37.6	25.1	17.8
Very good	37.5	37.4	30.1
Good	21.2	28.0	33.3
Fair	3.3	8.4	14.7
Poor	.3	1.1	4.1

Note: N for each row varies slightly due to missing data on each item.

All differences between the Historical group and the Never group, as well as between the Recent group and the Never group, are significant at the $p<0.001$ level using Pearson chi square tests of independence.

2:09:25 PM

MS. JOHNSON moved to slide 8, The Relationship Between IPV Subtypes and Health. She stated that this section of the report breaks down the various subtypes of intimate partner violence, such as reproductive control, direct harm, indirect harm, minor physical aggression, and severe physical aggression and examines how each relates to the identified health outcomes. She stated that overall nearly all subtypes of IPV, whether experienced historically or recently, are associated with negative health outcomes. She noted that a few items within the reproductive control category did not yield significant results, those exceptions are clearly identified in the report.

2:10:16 PM

MS. JOHNSON moved to slides 9 - 12 to discuss multivariate results beyond the report. She explained that the report

primarily presents bivariate results, which examine the relationship between one form of intimate partner violence (IPV), such as psychological aggression, and a single health outcome. She emphasized the importance of multivariate analysis, noting that IPV often involves multiple, overlapping forms of harm that may simultaneously co-occur. Individuals who experience physical harm are also subjected to threats and control, thus experiencing multiple forms of intimate partner violence at once.

2:11:11 PM
MS. JOHNSON moved to slide 10, IPV Subtype Co-occurrence:

[Original punctuation provided.]

IPV Subtype Co-occurrence:

	Control - Yes		Control - No	
	Threat-Yes	Threat-No	Threat-Yes	Threat-No
Harm-Yes	*32.3 percent (n=4129)	**5.1 percent (n=653)	**8.3 percent (n=1056)	***9.7 percent (n=1242)
Harm-No	**1.0 percent (n=131)	***2.8 percent (n=358)	***2.3 percent (n=296)	38.4 percent (n=4900)

N=12,765

*32.3 percent experienced all three forms of IPV
**14.4 percent experienced two of three forms of IPV
***14.8 percent experienced one of three forms of IPV

2:11:16 PM
MS. JOHNSON stated that the table identifies three main categories of intimate partner violence (IPV): control, threats, and harm. According to the data, 32.3 percent of respondents experienced all three forms. While it is unclear whether these experiences occurred within the same relationship, the findings indicate that nearly one-third of the approximately 13,000 participants had experienced at least these three types of harm—potentially from different partners, or possibly from the same one.

MS. JOHNSON explained that the table also breaks down combinations of the three categories. The data show that 14.4 percent of respondents experienced at least two of the three forms, and 14.8 percent experienced only one. She noted that

these findings raise questions about the limitations of bivariate results. For example, it becomes difficult to isolate whether negative health outcomes are specifically linked to psychological aggression, or whether such outcomes are more directly attributable to accompanying physical violence.

MS. JOHNSON stated that multivariate analysis can address these questions by allowing researchers to control for one type of IPV, such as physical aggression, while examining the independent effects of another, such as psychological aggression. With a sample size this large, it is possible to perform such analyses and determine whether those who experienced psychological aggression, but not physical violence, still show poorer health outcomes.

2:13:08 PM
MS. JOHNSON moved to slide 11, Multivariate ([Ordinary Least Squares] OLS Regression) Results. She noted that the table on this slide is complex but was included for reference purposes. The following bullet points provide an overview of the results in the table:

[Original punctuation provided.]

- Approximately 12 percent of the variance in both physical and mental health can be explained by the three forms of IPV along with the demographic control variables

- Experiences with control IPV lowers one's physical and mental health scores by 0.10 and 0.14 (respectively), holding all other forms of IPV and demographics constant

- Experiences with threat IPV lowers one's physical and mental health scores health score by 0.08 and 0.07 (respectively), holding all other forms of IPV and demographics constant

- Experiences with infliction IPV lowers one's physical and mental health scores health score by 0.15 and 0.19 (respectively), holding all other forms of IPV and demographics constant

2:13:12 PM
MS. JOHNSON moved to slide 12, Conclusion from Multivariate Results:

Conclusion from Multivariate Results

- Summary
  - Control, threats, and infliction subtypes of IPV matter for current health independently of one another
    - Note, however, that financial strain has greater impact on health than history of IPV

- Implications
  - Control and threats are bad for health regardless of whether harm was ever inflicted – important for outreach, assessment, and treatment

MS. JOHNSON stated that multivariate analyses are somewhat more limited than the bivariate analyses and noted she is available to discuss this further if needed. She explained that the implications for outreach, assessment, and treatment highlight the importance of considering all forms of intimate partner abuse, even in the absence of physical aggression. It is not just physical violence that matters for health outcomes.

2:14:11 PM
CHAIR CLAMAN contrasted the mostly negative values shown on slide 11 with the positive values presented on the other slides. He asked her to elaborate on the meaning of the values in the table on slide 11.

MS. JOHNSON replied that slide 11 presents multivariate analyses focused on self-rated physical and mental health. She explained that the first two columns correspond to physical health models, and the next two to mental health models, labeled Model 1 through Model 4.

MS. JOHNSON noted that self-rated health is measured on a scale from zero to four:

- zero = poor health
- one = fair health
- two = good health
- three = very good health
- four = excellent health

MS. JOHNSON explained that the values in the table reflect how much a respondent's self-rated health changes in relation to

experiences of intimate partner violence. These values are not percentages. A negative value indicates a decline in self-rated health associated with that experience.

2:16:49 PM
CHAIR CLAMAN referred to the upper left box on the slide and sought confirmation that the value of -0.17 represents a reduction in the respondent's self-rated physical health score, with four indicating excellent health and zero indicating poor health.

MS. JOHNSON replied that she is fairly confident the reduction reflected a change from the mean score of the sample.

2:17:38 PM
CHAIR CLAMAN referred to slide 7 and the values listed under the groups "NEVER," "HISTORICAL," and "RECENT." He asked where the -0.17 is a reduction from.

MS. JOHNSON replied from the mean; however, the mean is not shown on those slides.

2:18:06 PM
CHAIR CLAMAN asked whether the -0.17 value represented a reduction from the mean of everyone who took the survey compared to people who experienced control, or from the "NEVER" group compared to those who experienced control.

MS. JOHNSON replied that the -0.17 reflected a comparison between those who had ever experienced control and those who never had. She referred to slide 11, Model 1, the first coefficient for control, explaining that this group's score would be 0.17 lower than the mean.

2:18:51 PM
CHAIR CLAMAN sought confirmation that reduction was from the mean of the "NEVER" group.

MS. JOHNSON clarified that it was a reduction from the mean of the whole sample.

CHAIR CLAMAN stated that he would be interested in learning more about the significance of those values and invited her to follow up with the committee if she wished.

2:20:18 PM

MS. JOHNSON expressed her belief that the important details are summarized in the bullet points on slide 11:

[Slide 11 bullet points are as follows:]

- Approximately 12 percent of the variance in both physical and mental health can be explained by the three forms of IPV along with the demographic control variables

- Experiences with control IPV lowers one's physical and mental health scores by 0.10 and 0.14 (respectively), holding all other forms of IPV and demographics constant

- Experiences with threat IPV lowers one's physical and mental health scores health score by 0.08 and 0.07 (respectively), holding all other forms of IPV and demographics constant

- Experiences with infliction IPV lowers one's physical and mental health scores health score by 0.15 and 0.19 (respectively), holding all other forms of IPV and demographics constant

MS. JOHNSON said that she will get back to the committee with precise interpretations of those values.

2:21:35 PM
SENATOR TOBIN expressed interest in the demographic breakdowns referenced in the presentation. She asked whether an additional document on demographic breakdowns exists. She further asked whether the data reflect race, socioeconomic class, or household composition variations, such as the presence of children or elderly family members. She wondered whether there would be further analysis exploring these factors.

MS. JOHNSON replied that the dataset includes racial identity categorized as: Indigenous, any versus other, and White, only versus other. The children variable reflects whether the respondent has ever lived with children under the age of 18, which she described as a relatively rough measure. She expressed her belief that financial strain is based on two variables: difficulty paying bills and whether one of them had foregone medical care due to cost. She stated that further analyses could be conducted though the capacity to do so depends on staffing. She noted particular interest in exploring Indigenous

experiences with violence compared to non-Indigenous individuals.

MS. JOHNSON shared a particularly interesting finding unrelated to violence, stating that financial strain showed a stronger negative association with health than any of the IPV variables. She noted that the coefficient for financial strain was much larger than those for the violence-related items.

2:23:56 PM
SENATOR TOBIN commented that she had heard a strong anti-violence program is also a strong jobs program and stated that the data on financial strain reinforces that idea.

SENATOR TOBIN referred to slide 2, which showed that statewide surveys were conducted in 2010, 2015, and 2020. She shared that in 2010 she was identified as Black and White in the U.S. Census, while in 2020 her classification included Black, White, and American Indian. She noted that the way questions are framed can influence how individuals self-identify. She asked whether the AVS questions remained consistent across the 2010, 2015, and 2020 surveys, and whether researchers considered how respondents' identification of race or ethnicity may shift over time. She remarked that in the 1990 U.S. Census, she was identified only as Black.

2:24:50 PM
MS. JOHNSON replied that the survey questions used in the analyses have been worded the same over time. Although some questions in the Alaska Victimization Survey (AVS) vary across versions, the core questions relevant to these analyses have remained consistent for comparison and collective use. She mentioned one minor exception, a stalking related item. Wording was slightly revised to reflect changing technology; a reference to MySpace was replaced with Snapchat or a more up-to-date social media platform. Aside from that, all key items remained unchanged.

MS. JOHNSON said other questions can be added to the survey, but then they cannot be used across different surveys. For instance, adverse childhood experience questions were added to the 2020 survey, but those questions are specific to that year and can only be analyzed using 2020 data.

MS. JOHNSON responded to the self-identity question, stating the survey does not have a reliable mechanism to account for changes in self-identity over time. However, surveyors always allow

participants to identify as more than one race, so that data is available historically.

2:26:06 PM
CHAIR CLAMAN referred to slide 11 and pointed out a significant distinction in the table. He said the physical health finding for individuals identified as "White, only" is a positive value, which presents a striking contrast to the physical health finding for those identified as "Indigenous, any."

MS. JOHNSON stated that she would probably revise how the race categories are structured if she could. She explained that the current model uses three race categories, with "Indigenous, any" encompassing all individuals with any Indigenous identity. The "Other" category includes a range of groups such as Black and African American to Asian, Pacific Islander, and East Asian. She noted that due to limited sample sizes, the survey cannot analyze these racial groups individually.

MS. JOHNSON said ideally, "White, only" should be used as the reference category in the model. This would allow comparisons between "Indigenous, any" and "White, only," as well as between "Other" and "White, only." At present, the structure compares "White, only" to "Other," but not to "Indigenous, any." She said that this is something she would redo and then see how the race results come out. She stated that restructuring the model in this way would not affect items, such as control, threats, infliction, children, or financial strain, but how those racial variables perform might change.

2:27:42 PM
SENATOR TOBIN noted that the research focuses on English-speaking, non-institutionalized individuals. She expressed curiosity about how Alaska's growing refugee populations might impact the data. She asked whether the Alaska Justice Information Center (AJIC) had considered collecting data from those communities in the future, stating that many of Alaska's refugee populations could substantially shift the reporting outcomes.

MS. JOHNSON responded that there have been requests over the years to offer the survey in languages other than English, but doing so presents complications. She explained that this would require having translators available for any variety of languages, which raises challenges. Deciding which languages to prioritize is also difficult. She noted that expanding the survey beyond English would represent a significant

methodological change and could affect the comparison of results across different years.

2:29:15 PM
MS. JOHNSON commented on phone access, stating some individuals, particularly those in controlling relationships, may not have access to a phone or may not be permitted to participate in a phone survey without interference. She stated that partners have insisted on listening in or forced participants to hang up in some cases. She said these are considered hard-to-reach populations, which are inherently difficult to study through a survey like this.

MS. JOHNSON surmised that accessing those populations would almost require a different study. Any prevalence estimates would be imprecise due to the inherent challenges in reaching those groups.

MS. JOHNSON outlined two tasks she would complete at the request of committee members:

- Gather survey sample information that includes relevant region-specific population percentages.

- Provide a clearer interpretation of the coefficients presented on slide 11.

2:30:38 PM
CHAIR CLAMAN expressed appreciation to Ms. Johnson.

2:30:56 PM
There being no further business to come before the committee, Chair Claman adjourned the Senate Judiciary Standing Committee meeting at 2:30 p.m.