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EXAMINING H.R. _____, THE TRAFFICKING AWARENESS TRAINING FOR HEALTH CARE ACT OF 2014

THURSDAY, SEPTEMBER 11, 2014

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:03 a.m., in Room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Burgess, Ellmers, Pallone, Green, and Barrow.

Staff Present: Leighton Brown, Press Assistant; Brenda Destro, Professional Staff Member, Health; Sydne Harwick, Legislative Clerk; Katie Novaria, Professional Staff Member, Health; Tim Pataki,

Professional Staff Member; Heidi Stirrup, Health Policy Coordinator; Ziky Ababiya, Minority Staff Assistant; and Hannah Green, Minority Policy Analyst.

Mr. Pitts. The committee will come to order.

The chair will recognize himself for an opening statement.

Today's hearing focuses on H.R. 5411, The Trafficking Awareness Training For Health Care Act of 2014. The bill would support the development of evidence-based best practices for healthcare providers to identify and assist victims of human trafficking. Healthcare providers are among the few professionals who have the opportunity to interact with trafficked women and girls.

Because of unusual House scheduling conflicts today, we had to delay the start of today's hearing. And, therefore, we will dispense with members' oral opening statements. However, members' full written statements will be included in the record.

[The opening statements of the Members follow:]

******** COMMITTEE INSERT ********

Mr. Pitts. On our first panel today, we have Ms. Katherine Chon, a senior policy advisor at the Administration for Children and Families at the Department of Health and Human Services.

And I understand that Ms. Chon must leave by 10:30 today for the airport. So to maximize members' opportunities for questions of Ms. Chon, I will ask her to please summarize her statements in a few minutes.

And, with that, Ms. Chon, you are recognized. You may begin.

STATEMENT OF KATHERINE CHON, ADMINISTRATION FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. Chon. Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, thank you for inviting me to testify to share with you the Department of Health and Human Services work to prevent and end human trafficking in all of its forms.

HHS recognizes that human trafficking is not only a violent crime, but it is also a global health problem. The goals of The Trafficking Awareness Training for Health Care Act of 2014 would complement HHS's anti-trafficking efforts to build a capacity of first responders to identify and serve victims of human trafficking.

In our ongoing engagement with healthcare providers, this week HHS started a series of our pilot SOAR to Health and Wellness Training for Health Care Professionals, in which "SOAR" stands for "stop, observe, ask, and respond to human trafficking."

This training seeks to increase knowledge on the diversity of human trafficking, identify indicators, utilize trauma-informed care, and connect with local and national service referral resources for trafficking victims.

We are partnering with local hospitals and community clinics in

Atlanta, Boston, Houston, Oakland, and Williston and New Town, North Dakota, for the trainings, which will be evaluated later this fall.

While the SOAR trainings currently target healthcare providers through hospitals and community clinics, the bill broadens the reach of training efforts to health professions schools.

In addition to accredited schools of medicine and nursing, we recommend dental and social work schools as important target audiences because research has shown that victims of trafficking have encountered dentists and hospital- and clinic-based social workers are often responsible for managing the follow-up services once a victim has been identified.

The bill also references evidence-based practices. Since there is little evidence-based research specifically on the intersection of the healthcare system and human trafficking, the anti-trafficking fields maybe be able to adapt lessons learned from efforts in related issue areas, including the treatment of domestic violence and sexual assault victims in healthcare settings.

Additional opportunities for healthcare engagement include building the capacity of public health professionals to help prevent human trafficking, including interventions like the John schools, which provide information to purchasers of commercial sex who have been arrested and then participate in educational programs on the health

and behavioral health consequences of their actions.

The Administration looks forward to working with each of you to build the capacity of healthcare professionals to address the needs of victims of human trafficking.

Again, thank you for the opportunity to testify today. And I would be happy to answer any questions.

Mr. Pitts. Thank you.

[The prepared statement of Ms. Chon follows:]

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Mr. Pitts. We will begin the questioning. I will recognize myself 5 minutes for that purpose.

Ms. Chon, according to the Compendium of State Statutes and Policies on Domestic Violence and Health Care, which was funded by HHS, it states that, "The goals potentially served by mandatory reporting include enhancing patient safety, improving healthcare providers' response to domestic violence, holding batterers accountable, and improving domestic violence data collection and documentation. However, upon closer examination, it becomes apparent that mandatory reporting does not necessarily accomplish these goals."

This statement seems to discourage mandatory reporting by healthcare workers. Is that the position of HHS? Is there research to support this position?

Ms. Chon. So I am less familiar with the mandatory reporting guidelines around domestic violence. But one thing that we have heard from healthcare providers specific to human trafficking is that there have been concerns -- or questions from healthcare providers on reporting requirements balanced with HIPAA regulations when it comes to identifying victims of human trafficking.

And so what we are encouraging in our SOAR to Health and Wellness training is being familiar with HIPAA requirements, but also familiar with the local and State statutes around mandatory reporting and the

healthcare institutions' protocols around reporting.

And, universally, though, we do encourage identifying referrals for follow-up social services within the context of institution and State and local guidelines as well as Federal.

Mr. Pitts. Well, you know, that statement seems to discourage mandatory reporting by healthcare workers.

Does that or should that position apply to human trafficking?

Ms. Chon. Well, in terms of mandatory reporting for human trafficking, part of it depends on the type of human trafficking that a healthcare provider may come across.

So for victims of child sex trafficking, for example, in many States, they are also victims of child abuse, according to the State laws, and there are very strict mandatory reporting guidelines there.

In our SOAR to Health and Wellness training, we do go over the specific situations in which mandatory reporting would be required by law.

Mr. Pitts. Can you explain what the stop, observe, ask, respond to human trafficking in the SOAR training program entails, how the training was developed and how the cities participating in the pilot were chosen.

Ms. Chon. Sure. This training is part of one of our many commitments in the Federal Strategic Action Plan on services to victims

of human trafficking. It is an interagency plan which HHS co-chaired with the Departments of Justice and Homeland Security.

And during the public comments process, the anti-trafficking field called for increased training for healthcare providers. So we identified and formed a national technical working group of subject matter experts, including many healthcare professionals across a wide spectrum of specialties that have experience in training healthcare providers.

We also had service providers and survivors of human trafficking inform the training. It went through Federal interagency review and was based on a literature review as well.

The sites were selected -- because this is a pilot, we selected five sites in areas where we could develop strong partnerships with local stakeholders and healthcare providers who were already experienced in responding to this issue. So Boston, Oakland, Atlanta, and Houston were chosen for those reasons.

And then New Town and Williston, North Dakota, was chosen because there were concerns around the increase in various forms of violent crimes, including human trafficking, and the need for the healthcare system to receive training to identify and respond to a relatively new issue that they felt they were seeing in that area.

Mr. Pitts. Can you explain how HHS was involved in the

development of the Federal Strategic Action Plan on services for human trafficking in the United States. And what goals has HHS set in the Strategic Action Plan?

Ms. Chon. So the goals are -- the Strategic Action Plan has four primary goals set not just by HHS, but through a collection of more than a dozen Federal agencies and partners. It is available online. We would be happy to also provide a copy of it as well.

And, as I mentioned, we co-chaired this process with the Departments of Justice and Homeland Security. The draft plan was based on a number of community listening sessions across the country, national calls as listening sessions as well, literature review.

And the draft was released for public comments last spring. And then Federal agencies reviewed the public comments throughout the summer and fall, finalized it, and then the final version was released this January.

Mr. Pitts. The chair thanks the gentlelady.

Now yields to the ranking member, Mr. Pallone, for 5 minutes of questions.

Mr. Pallone. Thank you, Mr. Chairman.

Last week I had the opportunity to visit the U.S.-Mexican border, and the Administration for Children and Families plays an important role there, providing critical health and welfare services to the

unaccompanied children who cross that border every day.

We all know that the unprecedented number of unaccompanied minors have arrived in the U.S. and needed ACF's services this year. And Congress clearly has the responsibility to ensure that this agency has the resources that it needs to do this work.

We don't want the Administration for Children and Families to be forced to relocate funds -- to reallocate funds from other important programs, such as the ones we have heard about this morning.

So can you just discuss the importance of providing adequate funding for the Administration for Children and Families programs to address the needs of both domestic and foreign victims of human trafficking.

And in its fiscal year 2015 budget, ACF proposed an increase of 8.2 million to specifically assist domestic victims of human trafficking. Can you comment on the type of work the ACF plans to do with that money.

Ms. Chon. Sure. Well, the good news is we have not had to reallocate any of our anti-trafficking funds to address some of the unaccompanied minor needs that have risen over the past year.

In terms of the budget requests, the increase in funding will allow HHS to serve victims of all forms of trafficking, so foreign nationals as well as U.S. citizens and lawful permanent residents.

Pretty much over the last decade or so the budget on addressing human trafficking has been fixed around 10 million, primarily going to serve foreign national victims of trafficking.

In this current fiscal year, we received an increase in appropriations, which gave us enough to provide demonstration grants to start serving domestic victims of trafficking, so U.S. citizens and lawful permanent residents.

And so what we intend to do, if there is a further increase in the budget, is to bring parity at least in the budget that goes to serve domestic victims to match up the budget that has been going to serve foreign national victims.

Mr. Pallone. Thanks.

I also wanted to hear more about the SOAR for Health and Wellness initiative and the pilot trainings that are beginning this week.

So let me ask what kind of interest you have seen from the communities that are conducting pilot training over the next few weeks.

And after participants complete the pilot trainings, what kind of evaluations do you have planned? And what do you plan to use these evaluations for to think about the future of the SOAR program?

Ms. Chon. Sure. So there has been significant interest in the specific pilot locations, registrations. We have been meeting our goals for this pilot program. We were targeting about 45 participants

per site. And in some sites, like in North Dakota and Houston, there are multiple trainings that are being held.

And it is not just the pilot sites, but we are hearing from other communities. Healthcare providers are asking for additional resources on training and technical assistance, which HHS partly provides through our National Human Trafficking Resource Center. Healthcare providers can access that at any point.

And then, in terms of the evaluation, there is a pre- and post-test for this training and a 3-month evaluation survey, and a subset of the participants will participate in qualitative surveys as well. And we will release the findings of the evaluation next spring.

Mr. Pallone. All right. Earlier this year the Departments of Justice, Homeland Security, Health and Human Services released a Federal Strategic Action Plan on services to victims of human trafficking in the U.S., and it outlines a number of specific actions that different Federal agencies are going to take.

I understand you were involved in the development of this plan. What types of comments did you receive from healthcare professionals during this process regarding the need to improve the healthcare systems' response to victims of human trafficking?

Ms. Chon. The overwhelming response that we received in the public comment process from healthcare providers was a need for

additional training and resources, especially if it could be in some standardized way and, also, tailored to the specific healthcare professions. We also heard comments on having screening tools, especially if they could be validated and be evidence-based.

And the type of training that we are providing is different from a longer-term curriculum that could be available through educational institutions, but we also heard the importance of developing skills through curriculum-based efforts in educational institutions.

Mr. Pallone. All right. Thanks.

I just wanted to say, with regard to the SOAR training, I am glad that HHS has evaluation and steps in place to assess the effectiveness of the pilot program, and I think this work would provide helpful feedback as we think about what role Congress and the Federal Government can play in assisting the healthcare community to respond to the needs of trafficking victims.

So thanks again.

And thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

And I now recognize the gentlelady from North Carolina, Mrs. Ellmers, for 5 minutes for questions.

Mrs. Ellmers. Thank you, Mr. Chairman.

And thank you, Ms. Chon, for being with us today. And I know you

have limited time; so, I will try to get through my time so that we can allow anyone else for questions.

I really want to focus -- first of all, I want to say thank you for what you are doing, and the SOAR program sounds like we are moving forward on a really good HHS initiative.

We feel very strongly that we want to expand that, and we want to make sure that we are reaching out and including our education for medical students, nurses. And that really has to do with what we are trying to achieve here with the bill that we have.

And, of course, as you know, funding is an issue. We want to make sure that there is adequate funding for this project.

And I was wondering if you could comment from that perspective on some funds that are available through HHS, the Prevention and Public Health Fund, or the PPHF, which basically helps to fund innovative projects and outreach.

I believe that this is one of those areas that -- especially when we are moving forward with health care, that this could be a positive funding source through HHS that is already there and, you know, call on Congress to appropriate funds to it.

Would you like to comment on that?

Ms. Chon. Sure. In terms of my knowledge of those particular funds, I don't believe they have been used for anti-trafficking

training purposes in the past. But I certainly -- I will ask the appropriate divisions within HHS how those funds could be used for these purposes and then would be happy to get back to you on those possibilities.

Mrs. Ellmers. Great. That would be great if you could get back to the committee on the response to that. Because I think, there again, as we are moving forward, we would like for this to move as quickly as possible. And, you know, we, too, have suggested a pilot program with feedback so that we know what is working and what isn't.

And I think the training and the education piece of it -- component of it for our medical students and our nurses so that they are being exposed to this information -- one of the things that I found over time that is so vital is that many people do not realize this is happening here in the United States and that this is something that we have to make sure that our healthcare providers are understanding and aware of.

I will yield back.

I just again want to thank you for being here today and thank you for sharing your information, and I am looking forward to working together on this.

Ms. Chon. Thank you.

Mrs. Ellmers. I yield back.

Mr. Pitts. The chair thanks the gentlelady.

I now recognize the gentleman from Georgia, Mr. Barrow, 5 minutes of questions.

Mr. Barrow. No questions.

Mr. Pitts. The chair recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes of questions.

Dr. Burgess. Thank you, Mr. Chairman. I apologize for being late. There is a lot going on this morning.

Ms. Chon, thank you for being here. Your agency is one that has perhaps come to the attention of this subcommittee a great deal more over the last 6 months for a variety of reasons.

But as we are here today to discuss the prevention of human trafficking, I seem to detect that there is a system of best practices with evidence-based research and a system of promising practices.

Could you help me understand a little bit the differences between the two and why you favor one over the other.

Ms. Chon. Well, in the scientific community, there is always a prioritization around evidence-based practices, meaning -- so, for example, the reason why we put funding into evaluating our trainings was because we wanted to have the evidence that the training was impactful and met the goals that we set out for it as opposed to best practices or promising or emerging practices are those practices that

seem to have impact, but there have not yet been rigorous evaluation just because the research funding wasn't there.

Dr. Burgess. Well, what population of providers -- or professionals are you likely to train in the program?

Ms. Chon. So it is healthcare providers across the spectrum from doctors, nurses, dentists, mental health providers, clinical social workers, school-based nurses as well because they truly are at the frontlines of early identification and, also, prevention of human trafficking so that the problem doesn't happen in the first place.

Dr. Burgess. Might I just gently suggest that perhaps you could talk to professionals who are in the Office of Refugee Relocation, who are also under the Administration of Children and Families?

Because it does seem to be a -- it seems to be missing from some of the hearings and briefings we have had on the issue of the unaccompanied minors in the lower Rio Grande Valley in my State of Texas.

In fact, your physician -- and, unfortunately, a physician was only hired by ORR in May of this year, even with the understanding that the problem was tumultuous and growing for several months before that. And your doctor reported to us that they only investigated cases of sexual assault if the victims so self-identified. Of course, these are children that we are talking about who are coming into these

centers.

In the State of Texas, it is a reportable crime. I am a physician. I was required by law to report to State authorities if I thought a child had been abused, let alone was a victim of sexual assault. But I was required by law and, if I didn't report it, I was in trouble.

And, yet, you have these children streaming across the Rio Grande River as unaccompanied minors, giving themselves up when they get across into Texas, taken into centers, evaluated by sometimes DMAT teams. And although they do great work, the level of training you have got to wonder about. ORR had just hired a doctor right before the summer started and, yet, they were only investigating cases where a child said, "Yeah. I was a victim."

And, I mean, I was down in those intake centers. You would have groups of kids sitting on a cement bench, a group of little 5-year-old boys -- I have got a 5-year-old grandson. I know how hard it is to get a 5-year-old to sit still -- five 5-year-old boys just sitting on this bench stone-still, staring into space. That is not normal. That is not normal behavior for a 5-year-old.

The cell that -- was holding what looked like a class of third-grade girls except, yeah, you realized they were all brought there by -- or had turned themselves in. And these people had gotten across the entire state of -- the entire country of Mexico through the

deserts and the jungles and the difficulties by coyotes, who are human traffickers.

Why aren't they further investigated? And when those cases are found, why are they not reported to State authorities so someone can go after the people who are the perpetrators and stop this problem at least -- if not once and for all, a least have a better handle on starting it?

We are enablers right now, as far as I can see. We are co-dependents with the child traffickers. And it is not a pretty story and does not reflect well on your agency. It does not reflect well on the Office of Refugee Resettlement. And it needs to stop.

Thank you, Mr. Chairman. I will yield back my time.

You may respond if you wish.

Mr. Pitts. Yes, please.

Ms. Chon. I think we have the same goals in mind in terms of protection for these unaccompanied minors. And I thank you for your passion and your concern for this population.

The Office of Refugee Resettlement, they are a part of a working group -- departmental working group on human trafficking, and I will learn more about what their practices are on the health piece in their screening for trafficking.

Dr. Burgess. Let me just provide you some information. Every

young woman or child, girl, who's brought into the center over the age of 10 is given a pregnancy test. I presume there is a reason for that, because they think something might have happened during this long journey up here. But then they are not further queried about the possibility of sexual assault.

It is sort of like we are indifferent to the fact that these children may have been assaulted on the way up here. We are never going to be able to stop the bad guys if we don't do the fundamental police work. And your agency is sort of the -- you are the tip of the spear there. That is where it should be happening, and, unfortunately, it is not.

Again, thank you, Mr. Chairman, for the indulgence.

Mr. Pitts. The chair thanks the gentleman and thanks the witness for answering all your questions.

We know that you have to leave to catch a plane. We will send follow-up questions. And I know other members will have questions in writing to you. We will ask that you please respond promptly.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

[The information follows:]

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Ms. Chon. Thank you very much.

Mr. Pitts. Thank you very much, Ms. Chon, for your time.

And so we will dismiss our first panel and introduce the second panel at this time.

On our second panel we have -- and if the staff can set that up and I will introduce them in the order of their presentation -- first, Ms. Vednita Carter, Founder and Executive Director of Breaking Free. Then we have Ms. Laura Lederer, Director of the Bastian Center for the Study of Human Trafficking, Indiana Wesleyan University. Then we have Dr. Hanni Stoklasa, emergency physician, Brigham and Women's Hospital, and, finally, Dr. Ken Miller, President American Association of Nurse Practitioners.

So if you will take your seats. Thank you all for coming. Your written testimony will made a part of the record. You will each be given 5 minutes to summarize your testimony.

And, Ms. Carter, we will start with you. You are recognized for 5 minutes.

STATEMENT OF VEDNITA CARTER, FOUNDER AND EXECUTIVE DIRECTOR, BREAKING FREE; LAURA J. LEDERER, DIRECTOR, THE BASTIAN CENTER FOR THE STUDY OF HUMAN TRAFFICKING AT INDIANA WESLEYAN UNIVERSITY; HANNI STOKLASA, M.D., EMERGENCY PHYSICIAN AT BRIGHAM AND WOMEN'S HOSPITAL; KEN MILLER, PH.D., PRESIDENT OF THE AMERICAN ASSOCIATION OF NURSE PRACTITIONERS

STATEMENT OF VEDNITA CARTER

Ms. Carter. Chairman Pitts, Representative Ellmers and distinguished members of the committee --

Mr. Pitts. If you can press that button. Pull it up close so the light is on. Thank you.

Ms. Carter. Chairman Pitts, Representative Ellmers, and distinguished members of the committee, thank you for inviting me to testify today to support this groundbreaking bill for the training of healthcare professionals to better work with victims of human trafficking.

My name is Vednita Carter. I am a survivor of sexual exploitation. I am also the founder and executive director of Breaking Free, a nonprofit agency in St. Paul, Minnesota.

Breaking Free's mission is to educate and provide services to

women and girls who have been victims of abuse and sexual exploitation and need assistance escaping violence in their lives.

Breaking Free is a survivor-led organization and provides services to more than 500 victims each year. In the case of virtually every sex-trafficking victim we have worked with, they were recruited, coerced, defrauded, or forced into prostitution.

Once girls and women are involved in the life of sex trafficking, it is extraordinarily difficult for them to escape. We can never forget that sex trafficking is modern-day slavery.

Sex trafficking causes tremendous trauma for victims from the physical abuse, emotional abuse, sexual abuse, kidnapping, and torture they have experienced. It is a terrifying and dangerous life.

83 percent of our clients at Breaking Free were assaulted with a deadly weapon. 57 percent were kidnapped before they escaped sex trafficking. 86 percent suffer from some type of emotional, physical, or mental disability. 71 percent of the victims we serve suffer from post-traumatic stress disorder.

One survivor's story illustrates some of the health issues victims of sex trafficking face. As she told me, "I was trafficked when I was 11 years old by my foster mother, who let her boyfriend sell us to other men. By the time I was 12, I had a pimp. During this time, I was beaten, burned, raped, and assaulted. Sometimes I went to a local

neighborhood health clinic to be treated, but no one ever asked me what had happened to me. And, if they did, I lied because I was afraid of my pimp. I had severe depression, anxiety, paranoia, and mental health issues, even after I became free. I got pregnant six times and had six abortions during this time. I had severe scar tissue from these abortions because there was no follow-up care. In a couple of cases, I had bad infections, so bad that I eventually had to have a hysterectomy. To this day, I have physical, mental, and emotional issues as a result of that time on the street."

Another survivor told me, "I was beaten, strangled, kicked, punched, raped, and hit on the head by my pimp. I wasn't able to escape until I was diagnosed with cervical cancer and, since then, I have been battling serious physical and mental health problems, including headaches, shortness of breath, bronchitis, chest pain, chlamydia, vaginal infections, and urinary tract infections. I also suffer from depression, anxiety, and panic attacks. I attempted suicide several times."

All too often victims of sex trafficking slip through the cracks of our medical system. Without appropriate training, health professionals are not able to put the pieces of the puzzle together to see that the woman or girl in their examination room is a sex-trafficking victim, or if the professional is able to see the signs,

she or he doesn't know how to talk to a victim without shaming or retraumatizing her, or the professional may be unaware of community resources to help the victim.

Healthcare professionals are in an excellent position to identify and help victims, but they need coordinated, evidence-based, and trauma-informed training to be able to do so.

The Trafficking Awareness Training For Health Care Act of 2014 offers the medical community the opportunity to develop best practices for identifying and caring for victims and the opportunity to help thousands of victims in our Nation break free.

Thank you.

Mr. Pitts. The chair thanks the gentlelady.

[The prepared statement of Ms. Carter follows:]

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Mr. Pitts. Now recognize Ms. Lederer, 5 minutes for opening statement.

STATEMENT OF LAURA J. LEDERER

Ms. Lederer. Thank you, Mr. Chairman, and members of the committee. Thank you for the invitation today to testify and for calling this hearing to address the health effects of human trafficking and the need for training for the healthcare provider sector.

Over the last decade, we have looked at human trafficking as a human rights abuse and as a criminal justice problem, but in the past five years, it has become clear that human trafficking also has serious public and private health consequences and that we need public policy and programmatic responses to train healthcare providers to identify victims and to respond appropriately.

Today I want to share with you the preliminary findings from a series of focus groups we conducted with domestic survivors of sex trafficking around the country. These focus groups provide evidence that women and children who are trafficked into prostitution are physically, mentally, emotionally devastated by the crime and this devastation is lasting with illnesses, injuries, and impairments starting during trafficking, but lasting often years longer.

The full set of findings in charts and tables is available in my written testimony. I am only going to outline the basic findings in my testimony here today.

Survivors suffer tremendously, virtually without exception. In our study, 99.1 percent reported that they had at least one physical health problem during trafficking, and the majority reported dozens of health issues ranging from neurological, cardiovascular, respiratory, gastrointestinal, gynecological, dental, and dermatological problems.

Survivors were also overwhelmingly traumatized not only physically, but mentally. The brutal treatment they endured created ongoing psychological and mental conditions in many victims and also exploited existing mental instability in others.

98.1 percent reported at least one psychological issue during their captivity, with an average of more than a dozen psychological health problems indicated, including depression, flashbacks, panic attacks, helplessness, hyper-alertness, disassociation, depersonalization, suicidal ideation, attempted suicide, post-traumatic stress disorder.

Not surprisingly, survivors also reported significant numbers of reproductive health problems. More than two-thirds of the survivors we talked to contracted some form of sexually transmitted disease or

infection, some STD or STI, including gonorrhea, syphilis, herpes, or chlamydia.

Survivors also reported many issues around pregnancy. 71.2 of the survivors we talked to reported at least one pregnancy while being trafficked. 21.2 reported five or more pregnancies. 57.7 percent said they had at least one miscarriage. 29 percent said they had more than one miscarriage while being trafficked. 55.2 percent reported at least one abortion, with 30 percent reporting multiple abortions during the time that they were trafficked.

The prevalence of forced abortion is an especially disturbing trend in sex trafficking. Prior research has noted the occurrence of forced abortion in victims of sex trafficking outside the United States, but our survivors indicated that they often did not elect to have abortions.

More than half of those who answered the question indicated that their abortions were forced upon them. In addition, many more said they felt forced to choose abortion by the circumstance of being trafficked.

"How can I take care of my baby when he" -- her pimp -- "forced me out on the street every night to make money?", one victim noted. Another said, "In most of my six abortions, I was under serious pressure from my pimp to abort the babies."

Notably, the phenomenon of forced abortion in sex trafficking transcends the political boundaries of the abortion debate. It violates both the pro-life belief that abortion takes an innocent life and the pro-choice ideal of a woman's freedom to make her own reproductive choices.

Survivors were also the victims of violence and abuse at the hands of their traffickers. 95.1 percent in our study experienced some kind of violence or abuse, as Vednita said, including being shot, strangled, burned, kicked, punched, beaten, stabbed, raped, penetrated with a foreign object.

Survivors also reported threats, intimidation, verbal abuse, and humiliation. Violence was the rule rather than the exception in trafficking. As one survivor said, "My pimp had his girls out on the street every night. It was either you made the quota of money for him or you got beaten."

Many survivors reported being dependent upon drugs and alcohol while they were being trafficked either because the substances were forced on them as a control mechanism by their traffickers or because the substance abuse was a means of coping with their dire circumstances.

84.3 percent reported use or abuse of drugs, alcohol, or both during the time they were trafficked, and the most common substances mentioned were alcohol, marijuana, cocaine, crack cocaine, Ecstasy,

and heroin.

Perhaps the most shocking finding of our study was that 87.8 percent of our survivors had sought medical care during the time that they were trafficked. The most frequently reported treatment site was the hospital emergency room, with 63.3 percent saying that they sought health care there.

Survivors also had significant contact with healthcare clinics -- that is 57.1 percent -- including Planned Parenthood, urgent care clinics, women's clinics, and neighborhood clinics, in that order.

So, clearly, health providers are first responders and they have a unique opportunity to communicate with and to intervene on behalf of victims. And for this reason healthcare providers must be aware of the signs of trafficking in order to identify victims.

An important part of this training will be to help health providers understand the coercive dynamic of trafficking, especially the extreme degree of control exercised by the trafficker and the prevalence of criminal exploitation of women and children. So we need specialized trainings tailored for the healthcare sector. These are a critical part of the solution.

Setting up internal protocols and procedures and regulations may also further assist the healthcare providers in identifying, treating

and responding to and reporting as well as referring, where necessary, trafficking victims.

Finally, we absolutely need more research to help us understand the healthcare problems and the needs of trafficking victims as well as to identify best practices and to create national, State, and local responses to health consequences of trafficking.

The medical community can play a vital role in the ongoing fight to eliminate modern-day slavery, and H.R. -- whatever the number is going to be -- the Trafficking Awareness Training For Health Care Act of 2014, is an important step in helping to equip them for this fight.

And I thank you so much for having us here today to begin this conversation.

Mr. Pitts. The chair thanks the gentlelady.

[The prepared statement of Ms. Lederer follows:]

******** INSERT 1-3 ********

Mr. Pitts. Now recognizes Dr. Stoklasa, 5 minutes for opening statement.

STATEMENT OF HANNI STOKLASA, M.D.

Dr. Stoklasa. Chairman Pitts and Ranking Member Pallone, thank you for inviting me to testify today.

And, Representative Ellmers, thank you so much for putting forth this bill.

And I would also like to express my appreciation to Vednita Carter for her courage in sharing the survivor perspective.

I am an emergency medicine physician at Brigham Women's Hospital in Boston as well as faculty at Harvard Medical School. In Boston, I convened a citywide task force, looking at developing a health protocol for victims of trafficking when they come to our healthcare settings.

In addition, I do international research on human trafficking, including the monitoring and evaluation study of anti-trafficking programs in India as well as looking at the health consequences of human trafficking among construction workers in Kazakhstan.

I co-founded HEAL Trafficking in the fall of 2013. "HEAL" stands for "health, professional, education, advocacy and linkages." And our

vision really is to unite health professionals who are working on the issue of human trafficking.

We are divided into working groups that are working on the issues that are the crux of health and trafficking, including education and training protocols, research, direct service, prevention, and advocacy.

HEAL Trafficking brings together a broad range of health providers, including administrators, researchers, dentists, social workers, nurse practitioners, and physicians. And we are pleased to work very closely, especially our education and training group, with the SOAR initiative within the Department of Health and Human Services.

I am going to share with you a story from the emergency room. This was early on in my training, and it was a busy overnight shift, seeing lots and lots of patients. And I took care of this young woman, who was Cantonese-speaking, who came into the emergency room, and her chief complaint, the main reason that she was there, was she had abdominal pain.

And from a medical perspective, it was a really straightforward case. We diagnosed her with a sexually transmitted infection. We treated her appropriately. And then we discharged her home.

I knew that something wasn't right. I couldn't put my finger on it. And there was this dynamic in the room with an older, also

Cantonese-speaking woman, but I didn't have any training on human trafficking. And so I missed this case of human trafficking.

Later on, as I learned what trafficking was and that it was actually happening in the United States, I realized that I missed this opportunity with this young woman, this opportunity to intervene at her time of need in her interface with the healthcare setting.

Unfortunately, this happens all too often. Victims of trafficking are coming to our hospitals and clinics, and they are leaving unrecognized and uncared for.

There are three crucial considerations when we look at developing a healthcare initiative for education of our health providers nationally. These considerations are who, what, and then, "Then what?"

So the "who." And Katherine Chon alluded to this. But we really need to train all healthcare providers across disciplines as well as across specialties. In terms of the disciplines, we need to train social workers, EMTs that are responding in ambulances, physicians, nurse practitioners.

And we need to train across specialties. We need to train obstetrics and gynecology specialists, dermatologists, emergency room providers, surgeons, family medicine providers. We need to train the full spectrum.

And, in addition, we need to train them across the spectrum of their education. So from the physician perspective, from medical school all the way on up to my board-certification process, this needs to be integrated at every stage.

The second is the "what." The content of the training -- you know, the Department of Health and Human Services is working on developing the evidence-based content, and I think crucial in that is having trauma-informed, survivor-led expertise.

When I talk to survivors, their everyday "live" experience is often a very deep-seated, complex experience of PTSD due to the repeated physical and emotional and sexual abuse that they experienced during the time that they were exploited, and our health settings and our health providers need to be sensitive to that.

They need to provide a welcoming environment where they aren't even inadvertently revictimizing victims of trafficking. And, you know, if they don't trust the health provider, if they don't trust that setting, there is no way that that health provider is going to get the information they need to be able to identify them as a victim.

The last piece here is that we need to develop a strong referral infrastructure. The current state of resources for survivors is inadequate and disorganized. Just imagine, as we identify further victims of trafficking, what that is going to do to burden our already

burdened system.

Survivor care is a long-term process, and survivors need to know that they are better off in our healthcare system than they are in the arms of their exploiter.

So, in summary, who should we train? We should train all healthcare providers. In terms of the "what," it needs to be trauma-informed and survivor-led, and we need to expand resources for referral.

Thank you so much.

Mr. Pitts. The chair thanks the gentlelady.

[The prepared statement of Dr. Stoklasa follows:]

******** INSERT 1-4 ********

Mr. Pitts. And I now recognize Dr. Miller for 5 minutes for an opening statement.

STATEMENT OF KEN MILLER, PH.D.

Mr. Miller. Thank you, Chairman Pitts, Ranking Member Pallone, and members of the subcommittee. I appreciate the opportunity to speak with you today on behalf of the American Association of Nurse Practitioners, the largest full-service professional membership organization for NPs of all specialties.

With nearly 52,000 individual members and over 200 organization members, we represent the more than 192,000 nurse practitioners across the Nation.

My name is Ken Miller, and I am currently serving as the President of the American Association of Nurse Practitioners. I have also served in many different academic administrative roles across the country. I have also worked as a family nurse practitioner in New Mexico, Delaware, and the District of Columbia.

NPs have been providing primary, acute, and specialty care for a half a century. We are rapidly becoming the healthcare provider of choice for millions of Americans. In fact, we conducted over 900 million patient visits throughout the United States in 2013.

NPs practice in every community in this country, both urban and rural, and see patients from all economic and social backgrounds. We provide care in all types of settings, which include clinics, hospitals, emergency rooms, urgent care sites, private physician or NP practices, nursing homes, schools, colleges, retail clinics, public health departments, and homeless clinics.

It is also important to remember that, in many of these settings, NPs are the lead provider on site. In fact, there are many NP-owned and -managed clinics across the United States. It is in these various settings, particularly public health departments and primary care clinics, where NPs play a key role in recognizing many of the at-risk, vulnerable populations they treat.

NPs, with their emphasis on primary care, health promotion, and education, coupled with their nursing background, approach the care of their patients holistically.

Their expert assessment and interviewing skills, combined with their education and preparation, uniquely positions them to gather information which not only allows them to treat symptoms, but also research causality, crucial to effective prevention of emotional, physical or sexual abuse.

Knowing the correct assessments to perform and the right questions to ask when treating patients that are victims of other types

of violent crime and abuse is a skill set similar to what NPs must call upon when recognizing and treating victims of human trafficking.

We know today that practicing NPs are confronted with patients whom they suspect are victims of human trafficking and that we must lead and work with other provider groups to develop best practices and procedures that will allow all providers to attain the skills needed to ensure that these victims are identified, treated, and assisted.

It is imperative that providers are given clear instruction and guidance on how to identify these victims as well as the steps to be taken to ensure that victims receive the proper protection and care. These best practices need to be carefully developed, given the variety of providers and the different care settings in which these victims may surface.

Victims of human trafficking can be extremely difficult to locate after their initial healthcare visit due to the transient nature of these criminal acts.

It is critical that best practices include a program that provides guidance and gives providers the tools necessary to assist victims as quickly as possible. We must ensure that providers and victims, working together, can develop these evidence-based best practices and work to implement them across the healthcare spectrum.

In closing, it is important to note that strategies may vary from

clinic to clinic and from state to state. Developing best practices to identify signs and symptoms and best screening tools is paramount to identifying those who are trafficked.

Reporting procedures are key to removing the victim from their deplorable situation. For any program to be effective, all healthcare professionals that come into contact with suspected victims of abuse must be educated and clinically trained to identify these individuals.

We are pleased to continue to work with Congresswoman Ellmers and other members of the subcommittee to develop legislation that addresses this issue in a provider-neutral manner.

This ensures that all practicing providers and healthcare personnel who may come in contact with victims of human trafficking are able to identify and assist them.

As the voice of nurse practitioners, AAMP can reach the rapidly growing NP profession throughout the country with this important information.

We thank you for your time and respectfully request that we continue to work together on this important issue.

Mr. Pitts. The chair thanks the gentleman.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

[The prepared statement of Mr. Miller follows:]

******** INSERT 1-5 ********

Mr. Pitts. Thanks to all the witnesses for your very important testimony, very moving testimony.

I will begin questioning and recognize myself, 5 minutes for that purpose.

Ms. Carter, let me start with you. While anyone can become a victim of trafficking, are there certain populations that are especially vulnerable to trafficking?

Ms. Carter. Yes. There really are. I think the Native American community and African-American women are very highly -- they are preyed upon. They are preyed upon.

And those are the communities that -- Breaking Free is in Minnesota. And so Minnesota is -- less than 10 percent of the population are African-American. Less than 2 percent are Native American.

Yet, still the majority of the 500 women and girls we work with a year are African-American and Native American. So those are the populations that are very highly susceptible to being trafficked.

Mr. Pitts. Thank you.

Ms. Lederer, because human trafficking is considered to be one of the fastest growing criminal industries, the U.S. government and academic researchers are currently working on an up-to-date estimate of the total number of trafficked persons in the United States annually.

Do you know how they collect this information?

Ms. Lederer. In the United States?

Mr. Pitts. Yes.

Ms. Lederer. Chairman Pitts, I don't believe that there is a solid number yet.

I would like to add to what Vednita said. I absolutely agree that those populations are vulnerable, but there are also many other populations that are vulnerable to being trafficked.

We know that runways and the homeless and what we call the throwaway kids, the kids who don't really have homes where they have a loving environment, are very vulnerable to trafficking.

And in all of the survivors that I have interviewed, there was something that happened in the home early on, some abuse, either physical, sexual, that drove these children out on to the streets. And then out on the streets they are much more vulnerable.

We have some estimates of those vulnerable populations. We have heard that it is somewhere between a million and 1.5 that are these runaway, homeless and throwaway youth, and they are all susceptible to trafficking and are preyed upon by traffickers who know exactly what to look for and where to find them.

And so I think that part of what we have done is we have begun to identify large, vulnerable populations, and what we need to do next

is take a much more critical laser-like look at what is happening in those populations.

For instance, we know that street gangs are now preying on children in middle schools and that they are literally going to middle schools and high schools and recruiting from there, but we don't know the who, what, when, where, how of that. And we will need specific studies to be able to identify that.

And I am with you. I think we need to be able to figure out on the front end who are these vulnerable populations and prevent the trafficking so that we are not constantly doing the cleanup that we have been doing over the past 10, 15 years.

Mr. Pitts. Thank you.

Dr. Stoklasa, you mentioned your specific patient. You said you missed the stage of trafficking -- I think that is what you said -- and you must establish trust.

What are the indicators that you look for to identify trafficking victims, in your experience as a physician in Boston?

Dr. Stoklasa. Thank you for the question.

I would couch this by saying we need more evidence and we need more research to show us what those signs and symptoms are.

But in talking to survivors and from the studies that we have thus far, some of the signs and symptoms -- and I kind of go head to toe

whenever I train healthcare providers on this -- general malnutrition, a discrepancy between their story and what you are seeing.

So they say -- just very similar to intimate partner violence, they are saying, "Oh, I fell down the stairs" when there are bruises that are at multiple stages of healing on their body, cuts or lacerations without an explanation, tattoos where they are afraid to talk about them.

Maybe it is a pimp or maybe it is his branding on them. I have spoken with survivors that have been literally hogtied and branded. So that is on the skin side of things.

They may have eye damage from either being beaten or being kept in dark places. And so their vision may be impaired from that. Signs of oral trauma, including sexually transmitted infections that may even present in the mouth. Pulmonary disease. Lung trauma.

And then, on the reproductive side of things, scar tissue that is unexplained, presentations of sexually transmitted infections that have gone farther than one would expect before they sought medical care, and retained foreign bodies either in the vagina or in the rectum, from a female perspective, being forced to have sex during her menses.

I could go on from there, but those are some of the signs and symptoms that would be concerning.

Mr. Pitts. Thank you.

Dr. Miller, health clinics, hospitals, social welfare offices, police, frequently and unknowingly experience face-to-face contact with trafficking victims.

How do you think this bill will help improve identification of trafficking victims from among healthcare providers?

Mr. Miller. I think one of the most important things that it will do is it will establish a program to educate all healthcare providers.

I think many of us get pieces of that throughout our programs when we are working for our degrees, but I don't think there is any real focus that is totally limited to trafficking.

I think we talk a lot about abuse and we get a lot of information about that, but there is nothing specific to trafficking. And I think having this program will really aid us in being much more astute in identifying patients who are in human trafficking.

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Mr. Pitts. Chair thanks the gentlemen, all the witnesses, for your answers.

I have gone over my time. I yield 5 minutes to the ranking member, Mr. Pallone, for questions.

Mr. Pallone. Thank you, Mr. Chairman.

Earlier this morning we heard from Ms. Chon about the SOAR to Health and Wellness Training initiative at HHS, a pilot program to improve healthcare professionals' response to human trafficking.

I wanted to ask Dr. Stoklasa, since you participated in the technical working group for SOAR, I would like to get your thoughts on this new initiative. The pilot training for SOAR began this week and is happening -- it is happening in five States over the next month.

So will you be involved in the training in Boston next week? And what did you see for the type of training that SOAR offers in your community?

Dr. Stoklasa: Thank you so much for the question.

So both on the HEAL national level as well as individually, I have been really pleased to be involved in the SOAR initiative to health and wellness, and part of it is based on a very well-thought-out process

in the development of the curriculum and really addressing this unmet need in terms of educating our health providers.

Our -- the HEAL trafficking group, especially the education and training group, has been interfacing both in terms of input on the technical advisory group, both in terms of myself as well as others, and the development -- we are really pleased with the ultimate outcome of the pilot training.

But it is that. It is a pilot training. And we are pleased that what this is going to do is add to the evidence base on educating and training our health providers.

Mr. Pallone. Have you seen much interest in the SOAR program in Boston? And what types of healthcare providers have already signed up for the SOAR pilot training.

Dr. Stoklasa. So I will be -- along with a couple other colleagues, will be doing the training in Boston. And it is been -- there has been an overwhelming response within the Boston healthcare community, both within my own hospital system as well as across the city of Boston.

And those that have signed up have come from the spectrum of healthcare disciplines as well as specialties, including social workers, dentists, from obstetrics and gynecology to trauma surgeons.

So we are very thrilled to see that response, and I think it is

reflective of the hunger for this education and training and the realization that -- that we are interfacing with victims of trafficking, but we don't have the tools, as health providers, to identify them or care for them.

Mr. Pallone. Well, thanks.

After the pilot sessions this month, participants in SOAR training will complete evaluations of their experience, which will help HHS to assess the effectiveness of the program and determine how to move forward.

What are your hopes for the future of the SOAR training program?

Dr. Stoklasa. So, you know, this is -- this is the pilot round, as you said, and my hope is that this will provide an evidence base so that we can have fidelity for the education and training of health professionals nationally. As Katherine Chon mentioned, this is kind of the 101. This is the aware -- the general awareness piece.

Certainly every health provider in the United States, once we have shown that this is an effective model, should be -- should be trained, and that should be incorporated at all stages, as I mentioned earlier, of our education and training, from the very early ages -- early stages within professional school all the way along through our accreditation process -- processes as -- in whatever board certification or professional accreditation processes are specific to those individual

disciplines. And I see HHS really taking a lead in facilitating this effort.

Mr. Pallone. Well, thanks.

And I want to say I look forward to learning more about the results of this pilot program so we can determine how the Federal Government can best help healthcare professionals along with any other individuals likely to interact with the trafficking victims.

I did want to ask you one more thing, though. Current -- oh, no. I am sorry. This would be either to you or Dr. Lederer.

Current statistics on human trafficking in the U.S. are limited. And as Ms. Chon noted in her testimony, while researchers like Dr. Lederer have begun to look at the health effects of trafficking, more research is clearly needed to better understand the health needs of victims of human trafficking as well as how healthcare professionals can best address the needs.

Could either of you ask -- what need do you see for further research regarding the interaction of victims of human trafficking with the healthcare system, either Ms. Lederer or Dr. Stoklasa or both of you?

Ms. Lederer. Thank you for the question, which is an excellent question.

I think we are in the foothills of consciousness in terms of

figuring out what kind of research needs to be done. I believe that we need to -- like Dr. Stoklasa's head to toe, we kind of need to go very beginning and track.

So I have talked to 150 survivors across the United States over the last year, and I have heard recurring themes. And I would start with those recurring themes. One of them is abuse in the home.

Once somebody's been abused, they have been sexually assaulted, they have been raped, they have been molested by, you know, a relative, they are pushed out into the streets. And so we need to do a lot more research on the link between early abuse in the home and trafficking.

Then foster care systems. Once they are out of their homes, they are into our foster care system. And we need more research on how foster care system is working. I believe that those systems are failing and are facilitating trafficking at this point in time. So we need more research in that area.

Educational systems. We need more research on the link between bullying and trafficking, on the link between the ways that street gangs and others prey on -- what is the role of the educational system right now? How do they facilitate or how are they failing to counter trafficking?

And I can go through each of the various sectors. I think that is important.

I agree with Dr. Stoklasa that all of this needs to begin from the listening to survivors. If we listen to survivors, they can tell us how to proceed. They know the hell of this. They know what works and what doesn't work. They can tell us better than any textbook what we need to do. And so we need to incorporate survivors into all our programs.

And then the last thing I would say is that the huge, huge need, which is the elephant in the room, is the resources and referral. Once we have got these trainings in place -- and, Representative Ellmers, thank you so much for taking the lead on this. This has been such a long time coming.

But once we do have these trainings and we begin to identify these victims, we will need thousands of Breaking Frees and we will need to have them up and running so that they can do their work properly.

So there is a lot of research. I would be happy to do a fledgling list for you, just a beginning, and think about this further with my colleagues, but that is a start.

Mr. Pallone. Thank you.

Dr. Stoklasa. And, if I may, I would like to add on to that and concur with Laura Lederer's comments.

One of -- one of the gaps that I see is the populations that we have data on thus far in terms of intersection with health care. So

there is -- there is more information, though it is still not as much as I would like, on sort of the pediatric or the child populations specific to sex trafficking.

We don't know a lot about labor trafficking. We don't know a lot about -- as much as I would like about the adult populations and transgender population and boys.

There are a lot of men and boys that are involved in trafficking, and we -- they are largely in a hidden population hidden within that. And they are especially vulnerable, and we don't have much data on them.

The other thing that I would like to add here in terms of the need to add to the evidence base is in terms of going back to trauma-informed care.

Trauma-informed care is something that healthcare providers really have no training on at all. And I mentioned earlier victims of trafficking especially are in this reality that we are not trained to deal with and, as a result, we accidentally, in most cases, re-victimize them when they enter into our health facilities. And, therefore, they are not going to disclose what is really going on.

We need more data around trauma-informed care to show what works and what doesn't work, and we need to train our healthcare workforce in it. And it is not only applicable to victims of trafficking, but we, as healthcare providers, interact with patients that have

experienced violence along the entire span of their life, unfortunately, from child abuse to elder abuse, to intimate partner violence. And, yet, we still have no training in trauma-informed care.

So I think, in some ways, this give us an opportunity to expand that very much needed tool kit for healthcare providers. And I would echo Laura's comments in terms of needing more resources dedicated both to the research as well as to the aftercare for victims of trauma.

Doctors -- and I am speaking from that perspective just personally. You don't want to ask the questions if you don't have a plan, if you don't have a solution, to be able to provide.

And so, if you know that the shelters are limited for somebody that is being trafficked, it is -- in some ways, it is like an unconscious decision, but you would rather not even ask and explore that. And so we are also missing opportunities because of that.

Mr. Pallone. Thank you.

Mrs. Ellmers. [Presiding.] Thank you. The gentleman yields back.

I am now going to finish up. If any of our other colleagues come in, we will certainly allow them time for questions.

I do -- I want to start off -- and, at first, I just want to say thank you to our panel. Thank every one of you. Ms. Carter, especially for your bravery for taking your experience and turning it

into something positive. It is hard for me to talk about without getting emotional. So I apologize.

This is -- we should have done this a long time ago. The fact that we are here today on September 11th and -- in recognition on a very emotional day for us, as Americans, and talking about this issue, I think is significant.

Ms. Carter. It is.

Mrs. Ellmers. And, again, I thank all of you. Because it is all of us working together on this issue where we are going to solve this problem in this country. My goal is to eradicate human trafficking.

And, Dr. Stoklasa, you touched on the labor trafficking that occurs. We are also looking at that as well because that is another area that, although we, as Americans, know that it exists, we really don't want to accept that it exists. And we need to be able to identify that.

And, Ms. Carter, I do have a -- well, first, I want to make a comment just about the prevalence here in this country and reference an NIH study in regard to trafficking.

NIH estimates that 50,000 people are trafficked each year in the United States, with as many as 400,000 of our minor children involved in trafficking, resulting in -- and this is -- this is the question.

The question is: Why is this happening? What -- what is the

precipitating factor that creates trafficking? And the answer is the dollars, the dollars. It is a very profitable criminal industry, resulting in billions of dollars being generated from it.

And I do -- Ms. Carter, I want to just go back to your testimony and your experience and now what you are learning when you are working with victims.

One of the things that hit me as -- you know, working as a nurse for so many years, Dr. Stoklasa, I know exactly what you say when you know something's wrong, but you just can't put your finger on it, and then what would you do if you were to get that knowledge, that information, from that patient.

One of the things that I was struck by was the fact that many of the pimps or the human traffickers that -- it is the attraction, the security, and the love that the victim feels that they are receiving from that individual.

Because of their life experience, this may be the most secure thing that they have ever, ever encountered, and that is why sometimes it is so difficult to identify them.

Ms. Carter, can you speak a little bit about that? Is that something that you have also seen?

Ms. Carter. Yes. Definitely. I want to say it is a brainwashing process because we know that the average age of entry in

our country is between 12 and 14 years old. So when you have a 12-year-old that has ran away from home, that is out there on the street, it doesn't take a trafficker a lot of effort to convince her that he is going to help her and he understands what she has been through.

So there is a -- it is kind of like a two-phase process. First, he gets her to believe that he is going to do all these things for her. And, second, he tells her now that she owes him for doing all these things for her.

So at 12 years old, you are full of fear because you have been told that, "If you don't do this, I am going to go and I am going to do this to your sister," "I am going to kill your brother," "I am going to" -- you know, just all kinds of threats. So it doesn't take a lot of convincing to get a child involved in this life.

And there are different types of pimps. You have just your hard-core pimp. He knows you are on the run. He knows you are out there, you have no place to go. He immediately just turns you out.

And then you have the other kind that just convinces you that he is everything to you, and she believes it. Why wouldn't she? She can't go get a job. She can't rent an apartment. She can't do anything. And she can't go back home because that is where all the abuse started. So it is a process.

Mrs. Ellmers. Thank you, Ms. Carter.

Dr. Lederer, one of the things in going over and -- with the focus group information that you have provided to us, that was the eye-opening experience that I had.

Again, understanding and knowing the healthcare community and how much any healthcare provider would want to be able to identify these victims and then to find out that -- from your focus groups that 87 percent go to our healthcare providers, to our clinics, to our emergency rooms, and receive care, it was difficult for me to accept that because I just assumed that these things were happening behind the scenes, they were -- they were not out in the open, and that we, as healthcare providers, would not be able to identify those victims.

But when you think about it, it makes perfect sense because, there again, they are the product and that product has to continue to be sold. So, therefore, they do seek health care. Their -- their traffickers do seek health care.

And one of the points -- and, there again, I realize we are just at the tip of the iceberg here. This isn't -- this is going to be an ongoing discussion into the future so that we can, again, eradicate this terrible, terrible crime.

But one of the things -- and I am going to have -- Dr. Miller, I would like for you to comment on this as well.

As far as -- as, you know, expanding, we have all discussed areas

where we need to go with this. I do want to go back to our schools with our school nurses and our social workers.

Dr. Lederer, do you believe that this is an area that we also need to incorporate into these programs?

And then, Dr. Miller, I would like for you to --

Ms. Lederer. Absolutely I do. And I am not a healthcare provider. So I don't know all of the various subsectors of that sector.

But I think the disappointment over the last 15 years is that all these trainings have been like a one-off. If there has been a training, it is been a hospital -- it is been two things. It is been a hospital calling and saying, "We would like the training this -- to do as part of this seminar that we are putting on. Will you come?" And then the anti-trafficking organization comes, gives a -- you know, Tip 101 and goes home. So it is not only one off, it is reactive instead of proactive.

And what we need is both proactive and we need a methodical approach. And, again, I like Dr. Stoklasa's approach of, from the beginning, in the academies all the way through all of these -- the sector and the subsectors, we absolutely need training.

And I believe we need training tailored to each of those subsectors. So school nursers will need a specialized training because they are dealing with a specialized community, and they will

need to know not only what to look for, but how to respond, you know, properly without driving the kids back out onto the -- you know, onto the streets, as I am -- as I think, if you are not equipped, you can do if you are a counselor or a nurse and -- and don't know what to do, what to say, and who to refer to.

So that is a perfect place to begin, and it is at the early stage where, if we can prevent it from happening, we are way ahead of the ballgame. Because once somebody's been trafficked, they are, as we have all been saying, physically, mentally, emotionally, spiritually devastated, and building that person back up again is almost impossible.

We spend a lot of time and money. No one's done the cost-benefit analysis. That is the other big study that needs to be done. How much is this costing us to -- to do these rescues, restorations, reintegrations? It is huge. So this is -- that is a good place to start.

Mrs. Ellmers. Dr. Miller.

Mr. Miller. Yes. I believe that the academic institutions, whether it is grade school, high school, or collegiate level, need to be much more proactive. And the only way they are going to be proactive is if they get the education that they need.

And, again, I can tell you that, in many of the programs around

the country, what you hear on abuse is -- you may have one or two classes and that is it. And what they really need is to have a workshop, and that workshop needs to be incorporated throughout the entire curriculum for the entire length of time that the person is in the program.

But I also concur that one of the things that needs to be done is it has to be focused on whatever level. If it is a school nurse, if it is a nurse practitioner, if it is a physician, if it is a social worker, whatever their program of study is, it really has to be focused in that area. So that means we are going to have to be developing programs that are really attentive to those types of disciplines.

Mrs. Ellmers. Thank you.

And my last question -- or discussion, really, because I am going to direct this to Dr. Stoklasa, but I would like anyone else who would like to comment as well.

There again, getting back to the objective that we have -- or, obviously, our goal is to incorporate programs, if you figure out ways, protocols, for best practices on all of these issues.

And, there again, to the point of prevention, it is so important. You know, Ms. Lederer was talking about the cost or cost-benefit analysis in the long run.

You know, one of the other areas that we are working on here on the House subcommittee is need for mental health reform. And when I

think of the number of victims who now fall into and need med -- you know, mental health care, and that -- that opens up another door to more cost and continued life situations that -- they will be affected their entire lives.

What I would like to know, Dr. Stoklasa, from your perspective right now -- I was paying special attention to what you were identifying to the chairman about what you see or what your -- some of the identifying signs and symptoms that you see today in the emergency room.

One of them, of course, was -- was -- you had mentioned tattooing and branding, and that -- a light bulb went off in my head and I thought: My goodness, these -- I mean, when we are talking about modern-day slavery, these women, these children, these men, are being branded.

And we attribute much of that, too, to gang activity and -- and, you know, there again, I can see how healthcare professionals would just make the assumption that this is a gang member or a prostitute on the street and chosen lifestyle versus someone who would fall into that human-trafficking victim category.

What -- there again, my mind is going crazy with ideas of what we need to do into the future. What do you see now -- if a patients comes into the emergency room and you identify them as a potential sex-traffic victim, what do you do from that point on? And what barriers exist that we need to be identifying today so that we know

where to go tomorrow?

Dr. Stoklasa. Thank you for that question.

And you brought up a lot of points along -- along the way that I could spend forever kind of commenting on, but I am going to get to the "what do you do in that moment." And this gets to that kind of "then what" question.

I am going to speak as a clinician in Massachusetts at the moment. But it depends on age, first of all. So if they are under the age of 18, there are mandated reporting requirements.

And I should say before I even get into the age thing the most important consideration is to meet the victim or the survivor where they are at in that moment.

So while -- for an under-age-18 individual, I am -- I am ultimately going to do -- need to initiate a mandated reporting pathway. If -- if the patient in front of me feels like I am all about rescuing them and doing X, Y and Z and I am not there in the moment assessing their needs for food, maybe for water, for just having that human interaction, I am -- all is lost, really.

But -- so under the age of 18, mandated reporting, and that would initiate child protective services. There is also -- in Massachusetts, we are lucky enough to have the SEEN Coalition, which is a wrap-around set of services for those that are victims of sexual

exploitation under the age of 18, which includes legal services, mental health services.

And we try to limit the number of even health providers that are asking them about their traumatic experience to make sure that it is not re-traumatizing for them in that situation and then referral to services. Obviously, we take care of their medical needs as well.

If they are over the age of 18, it is finding out where they are at and what they -- you know, what they want. Maybe it really is just a sandwich. Maybe they are not ready to get out of that situation.

It is very akin, in many ways, to what we have seen with intimate partner violence. They ultimately have agency in that situation. As it -- and as hard as it is to let them go back out, in some cases, that -- that is the choice that is made.

I see it as a spectrum, that their interaction with caring individuals, whether it be interaction with the healthcare setting or other providers -- ultimately, they may get to that point where they are able to say that, "I want to be out of this situation."

We have to recognize that sometimes it is actually less safe for them to -- to disclose that information. They may be -- they may know that, if some information gets back to their pimp, that they are going to be beaten that evening if they were to disclose.

They may have extreme levels of blackmail that are kind of wielded

over their heads either against their family, told that their family's going to be murdered or that pictures are going to be shown to those that love them and care for them.

So we have no idea what -- what is actually going on in their minds, and that is a really important thing for providers to realize. And it is really about meeting them where they are at.

And then, just in terms of the barriers, barriers of judgment on behalf of healthcare providers, as you are saying, they may just be, like, "Oh, this is a prostitute. She is choosing it." A lot of these victims present with substance abuse issues. And what I tell health providers is that those are opportunities for us.

There -- there was a case in New England last year where a health provider asked someone who had come in with a heroine overdose, "You know, I see you have been here a number of times with us. Like how did you get hooked on heroin?"

And then she reported that it was her pimp. And, from there, they were able to uncover this entire trafficking ring. So it is being aware of the signs and symptoms and being -- and really coming at it with that trauma-informed approach.

And then further barriers are on the referral side. So, like, "What then?" You know?

Mrs. Ellmers. Right.

Dr. Stoklasa. Have them call the National Human Trafficking Hot Line. They are -- they are a great resource both -- for the survivor to talk to. Or if the survivor is not in that position yet, I can speak in a way that is HIPAA-compliant with the National Human Trafficking Hot Line. So that is also a great resource.

But there have to be resources under that -- there have to be roots to that system. If there is no infrastructure for me to refer to, maybe he or she is in some ways better off being in the hands of their exploiter. I mean, it really is a tough state of affairs.

Mrs. Ellmers. Would anyone else like to comment on this situation of, again, even talking about barriers that exist right now and -- and what we are doing today that in the future we can improve upon?

Okay. Dr. Stoklasa, you covered that very well.

I think we are at a point where we can close our meeting. We will have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly.

I would imagine and -- that many of the members who could not be here for the subcommittee because of ongoing things that are happening today -- that you will probably receive some -- some written questions.

And then members should submit their questions by the close of business day on Thursday, September 25th.

Before I adjourn, I just want to thank you again for coming, testifying on this incredibly emotional and vitally important issue. This is something that we can all work on. This is -- this is definitely a bipartisan issue that everyone has input on, and we will be able to come together.

And I just feel so strongly that -- that we need to be doing everything we can to make this happen, and I look forward to working with all of you.

Please know that my door is open. The committee is, you know, more than happy to take more of your input. And let's work together on the solutions that we need to find.

With that -- with that and, without objection, the subcommittee is adjourned.

[Whereupon, at 11:25 a.m., the subcommittee was adjourned.]