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BEST PRACTICES FOR RESCUING TRAFFICKING VICTIMS

DECEMBER 2, 2015

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The Commission consists of nine members from the United States Senate, nine members from the House of Representatives, and one member each from the Departments of State, Defense and Commerce. The positions of Chair and Co-Chair rotate between the Senate and House every two years, when a new Congress convenes. A professional staff assists the Commissioners in their work.

In fulfilling its mandate, the Commission gathers and disseminates relevant information to the U.S. Congress and the public by convening hearings, issuing reports that reflect the views of Members of the Commission and/or its staff, and providing details about the activities of the Helsinki process and developments in OSCE participating States.

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Commission on Security and Cooperation in Europe
Washington, DC

The briefing was held at 2 p.m. in room 2255, Rayburn House Office Building, Washington, DC, Hon. Christopher H. Smith, Chairman, Commission on Security and Cooperation in Europe, moderating.

Commissioners present: Hon. Steve Cohen, Commissioner, Commission on Security and Cooperation in Europe; and Hon. Michael C. Burgess, Commissioner, Commission on Security and Cooperation in Europe.

Panelists present: "Roxana," Foreign-born Female Survivor of Sex Trafficking in the United States; "Celena," Foreign-born Female Survivor of Sex Trafficking in the United States; Dr. Kimberly Chang, Asian Health Services Community Health Clinic; Yaroslaba Garcia, Clinical Director, President, ACT; Southwest Florida Regional Human Trafficking Coalition; Dr. Jordan Greenbaum, Stephanie Blank Center for Safe and Healthy Children, Children's Healthcare of Atlanta; Laura J. Lederer, Adjunct Professor of Law, Georgetown University Law School; and Allison Hollabaugh, Counsel, Commission on Security and Cooperation in Europe.

Mr. SMITH. Good afternoon. And, first of all, let me apologize for being late. We did have a series of votes on the floor of the House, so when they were over I high-tailed it over here. But thank you so very, very much for being here to this Helsinki Commission briefing, which will lead to further action by our Commission, and I would predict by the Congress. So what you convey to us today, and by extension to other members of the Congress, will make a huge difference. So thank you for making the trip and being a part of this important undertaking.

I also want to thank Laura Lederer, whom I have worked with forever on combating human trafficking, going back to the very beginning when we were trying to craft a legislative response to the scourge of modern-day slavery. The Trafficking Victims Protection Act, while it shouldn't have been, was a huge lift. It took three years to get enacted. There was all kinds of opposition to core elements of it. But in the end, at the end of the day, it was nose up. And thank God that landmark legislation was enacted, as well as subsequent reauthorizations that expanded and strengthened the effort.

The estimates, as we all know, is that there are some 14,000 to 17,000 foreign human trafficking victims each year, and yet we found or rescued only 750 victims. In 2013, the

number was 520. So we are missing by a very, very large extent, foreign trafficking victims.

And then when you factor in the hundreds of thousands of young girls and women in our own country who have been trafficked interstate or even within their own states, it just underscores that need—these are victims that are hidden in stealth, if you will. And as Laura Lederer has done so extraordinarily well in her reporting, very often these victims are actually at health care facilities. Well over 60 percent visit an emergency room. That ought to be—a light bulb ought to go off among our LPNs, doctors and nurses working in those. And yet somehow, for whatever reason, they leave that emergency room in the hands of the pimp or the exploiter, only to be further hurt and traumatized.

We've tried—as chairman of the Helsinki Commission, and also of a committee that deals with human rights, we have tried to promote the idea—and again, a lot of it did come from Dr. Lederer—of making people aware, situational awareness, wherever they might be.

Some years ago I chaired a number of briefings just like this on the airline industry and the hotels. And best practices were forthcoming. Homeland Security stepped up to the plate and did a wonderful job, in my opinion, with their efforts. We've taken it internationally. We're trying to get more countries to recognize this situational-awareness solution. And frankly, many have; not enough, but many have. Delta Airlines continues to be one of the leaders. But it ought to be every airline across the board, and that ought to be global.

When it comes to health care professionals, who better to recognize and then take corrective action, quietly and in a way that does not exacerbate the situation? We all know that there have been meetings at HHS over the years which have produced, I think, a good start. But frankly, the one that was held in 2009 laid out all of the issues in very, very good detail, but still we're not there in terms of answers.

Congress did pass a bill this year. Cornyn was the prime sponsor of the Senate version that was actually signed into law that has an entire section dealing with this and a grant and a study that hopefully will lead to best practices. So it's a work in progress. And I think the people that are here today are really to be commended; first of all, those who have been victimized, thank you for your willingness to come out and tell your story and share with all of us, what you have been through; and then, of course, those who are on the other side, who have been leaders, who will tell us what we need to be doing. So everything you say will help us to do a better job in the U.S. House and in the U.S. Senate.

So I'd like to yield to my friend and colleague, Mr. Cohen, for any comments he might have.

Mr. COHEN. Thank you, Mr. Chairman.

Mr. SMITH. Appreciate it.

Mr. COHEN. Thank you, Mr. Chairman. I really just thank you for the lead on this. And I join with you in trying to do what we can to help the problem, which is great, trafficking, and look forward to the testimony and seeing if we can't find any solutions.

Mr. SMITH. Thank you very much.

I'd like to now introduce our distinguished witnesses, beginning first with Roxana, who is originally from Nicaragua and was lured into sex trafficking in the United States at the age of 19. She is currently a T visa holder, a student, and an employee at a

cleaning service. She's proud to be free and have the privilege of loving her children. We have changed her name to protect her identity.

We'll then hear from Celena, who is originally from Mexico and was also lured into sex trafficking in the United States when she was 19 years old. She has a T visa and has worked with law enforcement in the prosecution of her trafficker. In her free time she advocates for trafficking victims and is devoted to her young daughter. We have again also changed her name to protect her identity.

We'll then hear from Dr. Kimberly Chang, who is a physician at Asian Health Services, a federally qualified community health center, which provides primary health care for over 24,000 primarily low-income, limited-English-speaking patients annually, including services such as case management, behavioral health care services, outreach, community health care workers, including a youth program.

Asian Health Services also has a specific program for minor patients who have been or are at risk of being sex trafficked called the Banteay Srei, or Citadel of the Women. For the past 12 years Dr. Chang has provided health care to domestic minor victims of sex trafficking and helped to develop protocols to identify affected patients in the primary care in a community health care setting.

We'll then hear from Ms. Yaro Garcia, who is the clinical director at Abuse Counseling and Treatment, or ACT, and president as well as co-founder of the Southwest Florida Regional Human Trafficking Coalition, for which she received the 2014 Human Trafficking Awareness Partner award in light of her exemplary work in identifying and treating victims of human trafficking. She also assisted in founding Points of Contact Rescue, a new program to involve health care facilities, businesses, hotlines and law enforcement in the identification and rescue of trafficking victims in the southwest Florida community.

She has her master's degree in clinical psychology, is a licensed mental health counselor, and is currently working on her Ph.D. in cognitive psychology. She is also a certified advocate of victims of domestic violence with the Florida Coalition Against Domestic Violence and a certified advocate of victims of sexual abuse with the Florida Council Against Sexual Assault. She was awarded the Purple Heart Advocacy Award in 2012 by the Florida Network of Victim Services for her work with human trafficking victims and for advocating for victims of abuse.

And finally we'll hear from Dr. Jordan Greenbaum, who has been the medical director of the Child Protection Center at Children's Health Care of Atlanta since February 2006. She previously served as medical director for three children's advocacy centers at the Children's Hospital of Wisconsin from 2001 to 2006.

Dr. Greenbaum has helped to launch a number of child abuse prevention programs, including projects to prevent shaken baby syndrome and to train health care workers to recognize and report abuse and neglect. She also has presented information at national and regional workshops. She is a pioneer in developing medical screening tools for the identification of trafficking victims, as well as in developing a multidisciplinary approach to meet victims' needs. She is the current president of the American Professional Society of the Abuse of Children, and she recently served on the Wisconsin attorney general's task force on children in need.

Before going first to Roxana, I'd like to yield to Dr. Burgess, a member of the Energy and Commerce Committee, a medical doctor, and a member of our Commission.

Mr. BURGESS. Thank you, Chairman.

I really don't have any prepared remarks, but I was excited to see you have this hearing today. I think it is important. I had a great deal of frustration last year. About a year and a half ago we had all the problems with unaccompanied minors who were streaming into the State of Texas. Much to my dismay, the question was never even asked to these youngsters when they arrived in our country for screening if they had been the victim of sexual assault. It was only if the child offered the information.

And the frustrating thing for me, as a physician, I know that when I was in practice, if I suspected child abuse, if I suspected that type of child abuse, I was required to notify authorities. No one in our federal agency, the Office of Refugee Resettlement, was notifying the state authorities that there was suspicion that these activities could have occurred. And moreover, they weren't even asking the question.

So I don't even know how to tell you how many people may have gone through that center in McAllen, Texas, and Mission, Texas, been the victims of abuse or traffic on the way through Central America and Mexico. We didn't know because we never asked. And to me that was wrong. And to the extent that I can, I intend to continue to pursue that and do something about it.

But I thank you for holding this hearing today. And again, I apologize. I won't be able to stay with you the whole time. I've got a conflict with the Rules Committee, and you know how that is. But thank you for holding the hearing.

Mr. SMITH. Thank you, Dr. Burgess. Roxana.

ROXANA. [Through interpreter.] [Off mic]—God, who also allowed me to be here as well. I want all of you to understand that I am going to tell you my story, or a little bit of my story, and mainly because I'm hoping that all of you will get a little bit more of awareness and understanding that I'm not just a number, that I'm a real person.

I am the victim of a web of traffickers in the state where I was trafficked. I was initially recruited and brought to the U.S. for this by a family member. And I am going to specifically focus on the neglect, on the health care industry, where I ended up many times as a result of what was being done to me.

Shortly after I got here, after being sold repeatedly, like you sell merchandise on a street, I started having health issues. I was taken to a clinic where the people who were handling me at the time filled out all of my paperwork. They answered most of the questions for me. And they gave me a rehearsed story that I had to tell the doctor once I went in the room, to the result of no one asking a single question about what was happening to me.

The doctor noticed that I had lacerations, that I was severely bleeding, and that I had a severe urinary tract infection, for which she asked what was going on that I had all these symptoms. And because I had been told to rehearse the story, I answered what I was told, which was—I was told to say that I had a partner, a romantic partner, who was very large and who was the cause of all these symptoms that I had. And the doctor believed it.

Looking back now, there were so many abnormalities with what was happening to me. These people were answering questions for me. They never left me alone. They filled out my paperwork. Still I was discharged back to these people. And she says the concerning thing here is the neglect, but also that responsibilities were delegated from every-

one who came into the room and interviewed me and spoke to me. No one made the effort to make a phone call to get me help.

Like that occasion, there were many other occasions where I ended up in the health care industry. I'm going to tell you about the most powerful one. I ended up pregnant by one of the handlers. The second time that I ended up at a health care center, by then I was seven months pregnant. And as you can imagine, I had no previous care at all because I was being trafficked the whole entire time that I was pregnant. With four months of pregnancy, I was still being forced to serve between 40, sometimes 50 johns a day. One day I saw 59.

I was taken to a family health care center that had access to all of my medical records. They could see that I had been experiencing these lacerations and these infections. I had infections in my kidneys. I had all kinds of symptoms related to the amount of sexual activity that I was being exposed to. And once again no one asked a single question. No one asked if I needed any help. No one asked if they could do anything to help me in any way. They accepted the same stupid, ridiculous answer that I was taught to say, that I had had a very large partner.

I ended up at the hospital one more time to give birth, and it ended up being a C-section. Once again these people never left me alone. The two handlers that I had at the time took turns staying with me in the room at all times. Once again no one saw this as a red flag. We talk so much in the health care industry about privacy. What happened to my privacy? I had none. And all of the people that came into the room could notice that no one was leaving me alone at any time.

This to me is still incredible. Every woman spends time choosing a name for their child. You start looking for suggestions. You start thinking of this. I didn't have that opportunity, and it happened right in front of the health care professionals. I did not get to name my child.

The social worker was the only person at the hospital that realized that something was wrong; once again, did nothing. She realized that I did not choose the name on the birth certificate. And instead of asking for help, she simply came up to me and said I know this is not the name that you chose, so I'm just going to white out the first three letters, and then you can have this name instead. That's how she helped me—did not call anyone for anything else. That was all I received.

That social worker asked me why I was afraid of changing the name, and I said because they are going to get mad at me. That was my response. She still did nothing. Eventually I was discharged with my daughter, who was kidnapped from me at nine months old and taken out of the United States.

Mr. SMITH. Roxana, thank you. Please.

INTERPRETER. She says can I have one more minute?

Mr. SMITH. [Off mic.]

INTERPRETER. I hope I can translate everything. She says that during the three-year process that I was being trafficked, I saw other girls, of course, going through the same thing that I was going through, being repeatedly exploited, repeatedly beaten, and sometimes even killed. She says it's my understanding that this is a $152 billion industry a year. And it is crazy that we like to think that all we need to be is aware. That's not all. We need to get involved. We need to take action. Things need to keep changing, and

we need to keep going. She thanked all of you many times. She said God bless you all. And she says during that process what kept me going was the thought of my kids.

Mr. SMITH. Roxana, thank you so very much for that very moving and very disturbing testimony, because it does motivate. And I and others will have questions for you later. But the idea that the handlers were with you even during your time of birth, just as if you were property and they owned you—shame on all of us, and in this case perhaps health care professionals, who did not recognize what should have been obvious.

INTERPRETER. May I translate it to her?

Mr. SMITH. Yes. [The interpreter provides translation to Roxana.]

ROXANA. [Through interpreter.] Thank you for listening.

Mr. SMITH. Thank you. Celena.

CELENA. [Through interpreter.] She says my name is Celena. Thank you for being here. Thank you for listening. And as well, I'm going to tell you just a tiny bit about my story.

At the age of 19 I was brought to the United States by the man who from there on trafficked me for years. My initiation into this process was being taken to a house, where I was forced to serve initially 30 to 50 men for a long process that lasted weeks. And then I ended up in another state, where they moved me, and this continued.

Shortly after this started happening to me, as you can imagine, I was crying constantly. I was not behaving according to how they wanted me to. I was crying. I was sad constantly. I was not performing to how they wanted me to. I felt very ashamed. And I felt this little from what was being forced onto me.

So here is my first interaction with the health care industry. They wanted to stop me from crying so that I could perform better so they could make more money. So they took me to a clinic in New York. The doctor walked in, asked me what were my symptoms, and I explained that I felt very anxious and very sad and I felt like I wanted to cry all the time. She asked no more questions and told me that I was depressed and prescribed me medication for depression.

The second time I was experiencing a lot of pain from all of the activity that I had to perform every single day. The pain was so excessive that the trafficker finally decided to take me back to the clinic now to remedy this issue. I ended up in the same clinic, with the same nurse, with the same doctor—same people. She walked into the room, asked me what was wrong. I explained that I was experiencing pain. She didn't examine me, did not ask me any more questions, and gave me painkillers to take the pain away.

In 2009 this was the worst episode for me. I began bleeding excessively. And by now I had been bleeding for six months straight nonstop while I was still being trafficked every single day. The trafficker forced me to wear makeup sponges inside my vagina so that this could stop the excessive bleeding that was going on every day so that I could keep working for him.

I couldn't take it anymore, and he finally realized that and took me to the doctor. And he told me to say this. He told me to say that I had no family in the United States, that I didn't know anyone, and that I had a boyfriend who was very sexually active. And I had been experiencing these bleedings ever since I had started interacting with him.

That occasion I was at the hospital from 11:00 in the morning until 4:00 a.m. the next day with several people doing exams and tests on me and looking at my interiors. And no one asked a single question. I was not even prescribed medication. They didn't

provide me any treatment because all I had was excessive bleeding and lacerations. So they said just go home and drink a lot of Gatorade so you can hydrate, and you should not have any sexual activity.

I know that I don't have a lot of time, so I want to thank you. And I'm thanking you mainly because I'm hoping that somehow this will go somewhere else where all of the young girls and the young adults that are going through this could be rescued easier or better or that we find other ways to do this for them.

I wish that I could be the person in power to be doing this for the girls. But I also understand that people who are in power, like doctors and police officers and people that may be in this room, are the ones who could possibly make this happen.

Thank you.

Mr. SMITH. Thank you, Celena, for that equally moving testimony. Both of you said no one asked a single question. That is beyond troubling—two different situations, similar exploitation, and yet no one asked a single question. So that should propel us to further action as well as to why this huge gap in interest by health care professionals.

For this second portion, just so we don't want to be videoing you two——

INTERPRETER. Yes, please.

Mr. SMITH. ——victims, survivors——

INTERPRETER. Yes.

Mr. SMITH. ——if they wouldn't mind sitting down at the front. And then we'll video the second part.

INTERPRETER. Yes.

Dr. CHANG. Chairman Smith and esteemed commissioners, thank you so much. Thank you so much for holding this hearing and inviting me to speak about the importance of the health care system and its professionals in rescuing victims from human trafficking.

I'm going to start off with a story as well. One night in 2008, "Christina," a patient of mine, came to the clinic very sick. She was young. She was about 15 years old and had been seeing us at the clinic for three years. Although she never disclosed any sexual exploitation, we suspected that she was being sex-trafficked.

That night she had a high fever, rashes all over her body, swollen joints everywhere, painful. She couldn't walk. She had a racing heartbeat and weighed less than 90 pounds. She was anxious and depressed. She had delayed seeking care despite feeling ill for three months.

She needed to go to the hospital. When I told her this, she absolutely refused, saying to me, "I'd rather die than go back to jail." I didn't quite understand the connection between her going to the hospital and her being sent to jail. Later I learned that on a previous hospitalization Christina was discharged to jail because a bench warrant for her arrest was issued when she failed to appear in court on solicitation charges.

Christina did not go to the hospital that night. I feared she was going to die that night and we had failed our patient. Or had we? Later that night our care did not end when Christina left our clinic walls. Our health center's youth program outreach workers and the case manager of Banteay Srei, our program working with sex-trafficked minors, worked their community connections all night, eventually locating her the next morning. The Banteay Srei case manager went to her, went to Christina, convinced her to go to

the hospital, and personally drove her there. She was hospitalized for almost two months, treated, and she survived.

For Christina, our team-based approach and assistance enabling her to access care, our public health perspective, extending outside of the clinic walls, and our community health care model, was a success. This model can be a success for many more victims across the country.

My work with human trafficking victims as a frontline physician has focused mostly on the role of the community health centers. And so my comments will carry that perspective today. I hope to answer the questions, what is the responsibility of the health care system in addressing human trafficking? What are the unique opportunities and advantages of community health centers in preventing, intervening in, and ending human trafficking? And third, what can government and Congress do to interrupt and intervene in and to enable community health centers to effectively care for trafficked patients?

Christina's story highlights the health care system as a critical access point for reaching victims because of the very nature of human trafficking. You've heard from Celena and Roxana. Victims experience severe physical, mental health and social harms in the short and long term.

So Christina suffered from all three types of harms that night—a possible sexually transmitted infection, depression, anxiety and criminalization, so physical harms, mental health harms and social harms. And here she was in my health center, severely ill, a trafficked patient, refusing to go to the hospital. Her fear of being jailed for the very victimization causing her illness placed her at risk of dying.

Overall, our response as a society to victims is simply inadequate and flawed. When I think about those trafficked, I think about how underground and hidden victims engage with systems of care and protection in an above-ground functioning society. The focus of the criminal justice strategies to reach victims and to end labor and sex trafficking is limited, reaching only a select few.

In 2006, Asian Health Services conducted an internal survey of the Banteay Srei youth development program for the sex-trafficked minors. And we learned that out of the 40 girls participating in the program that year, only three of them had a law enforcement interaction. This means that 93 percent, almost 93 percent, of the patients who were being sex trafficked participating in our program were not being reached within the criminal justice sector. Yet they were engaged with the health care system.

So relying on a justice framework to identify and reach victims means that we miss many others who don't receive, don't qualify for, don't want to use or are excluded from criminal justice services. And like Christina, many of the victims are treated like criminals.

So this call for a robust public health and health care system response to human trafficking has been echoed by justice and law enforcement leadership. The foremost priority of the criminal justice system is to uphold the laws of the state. In best cases, the state interests overlap with victims' needs. But sometimes those interests are at odds. When victims feel too scared or hopeless to participate in the prosecution of their traffickers or when they don't have a strong case for prosecution, does that mean they won't get the services and the healing care that they need?

Separating the priorities of the state in prosecution of traffickers from the priorities of the victims in healing may yield better results in ending trafficking by allowing victims

the time to heal and regain agency over their lives, with one possible outcome being that eventually they'll be strong enough to participate in the prosecution.

Compared to other sectors in a functional society, the health care system provides opportunities for interaction and engagement throughout the entire life span, from pregnancy to childhood to adulthood, from acute emergency care to long-term chronic care, from public health outreach to hospitalizations. So all points of care are opportunities to prevent and start the process to end human trafficking. It's like a long-term process of rescue.

So when I think about the health care system, I think about the whole team of professionals who provide care. Christina's engagement began outside of the clinic walls when the youth program told her about our services and educated her about the harms of commercial sexual exploitation and sex trafficking. That outreach enabled her to access the clinic. And the Banteay Srei case manager enabled her to go to the hospital. She actually went and provided that transportation, enabling her to access care, to get the life-saving treatment that she needed.

So Christina is not alone. Studies showed—and one of them was Dr. Lederer's—that between 28 to 87 percent of trafficking victims had seen a health provider or clinic.

I think that community health centers are the best health care response to human trafficking. Like Christina, untold numbers of trafficked people are accessing care at health centers and their many community programs. A study I published this year shows that trafficked minors can be identified in the community health center setting when they're asked those questions.

Although there's no single profile of the human trafficking victim, people vulnerable to trafficking include runaway youth, foreign nationals with a different language or culture, poverty, and those with a history of trauma or violence. There's significant overlap between the trafficked and at-risk trafficking victims with patients who are seen at community health centers. At the community health centers we see a disproportionate share of the nation's poor and uninsured. Most are members of racial and ethnic minorities. And millions of health center patients are served in a language other than English.

Asian Health Services is not the only clinic doing this work. There's other models that are developing to provide integrative care for trafficking victims. There's a partnership in Honolulu between Kokua Kalihi Valley Community Health Center and the Pacific Survivors Center. We provide this care despite scarce resources.

So health centers are also unique because they provide these enabling services. You heard Roxana and Celena talking about how their handlers were answering all their questions and they were providing the interpretation for them. So in community health centers, we provide special non-clinical help, enabling vulnerable patients access to care, including things like interpretation. At Asian Health Services, we have interpreters in 12 different Asian languages.

So, finally, community health centers serve more than 24 million patients in over 9,000 sites across the United States. This equals millions of clinical and non-clinical opportunities in that system to reach out to, identify, and help trafficked patients.

So with all this in mind, I have some recommendations to help shift the care for victims from the criminal justice sector to the health care and public health system.

One, create wrap-around care teams in community health centers across the nation. Focus on reaching out to and providing care to victims of human trafficking.

Two, create human trafficking-specific programs, like Banteay Srei, within health centers to address the physical, mental health, and social harms that result from being trafficked, through all the stages of trafficking, from prevention to long-term care.

Three, ensure language accessibility for victims and cultural competence by professionals throughout all systems that engage with human trafficking victims.

Four, ensure that non-clinical assistance enabling victims to access care is provided throughout the health care system.

Five, incorporate trauma-informed care training throughout all systems that engage with human trafficking victims.

And finally, please direct the federal agencies to consider health impacts—physical, mental, and social—of anti-trafficking policies on victims and survivors.

So in conclusion, let's get back to Christina. So our team that night was successful in getting her treated at the hospital. After two months, her physical health improved. She was ready to be discharged. But guess where she was discharged to. She was discharged directly to the county jail. So we can and we must do better.

Thank you.

Mr. SMITH. Thank you so very much for those not only insights, but the recommendations, which I think will help all of us come up with a better plan. Thank you, Dr. Chang. Ms. Garcia.

Ms. GARCIA. Thank you. First, thank you so much for the opportunity to speak in front of everyone here. I really appreciate the opportunity to do this. Thank you.

I work with survivor victims of sex trafficking and labor trafficking every single day. I'm here to tell you some of the recommendations that I would like to see, but also to tell you about some of the issues that we're still experiencing.

The average sex-trafficking victim, as you heard from Celena and from Roxana, could be serving 30, 40, 50 johns a day. Take, for example, the story of who I will call "Adele," who was found on a Sunday. And on Saturday, the day before, she reported serving 70 johns in one day. As you can imagine, the repeated exploitation that happens to these victims creates many, many health issues that, of course, also end up being chronic.

I would like to explain some of the physical abuse that these victims sustained over time while being handled. These include punching, slapping, hair pulling, ear pulling, being beaten up with sticks and belts and shoes, choking, smothering, and, of course, also being repeatedly sexually assaulted by the handler as well.

I'll give you another example. This person I will call "A.T." She was recruited at age 17. And whenever she complained or whined or made remarks about stopping, she was locked in a room with no food while the trafficker continued to sexually assault her. In her case, she was trafficked for five years; also had contact with the health care industry. No one asked a single question. Every single time she was discharged back to the trafficker.

Here's my second point. Minor and adult victims of sex trafficking may appear to be junkies or addicted to illegal or prescription drugs when they show up in the health care industry. It is part of the traffickers' control method to create even more vulnerability for the victim by keeping them addicted to drugs. Because they have been forced to use drugs from the time of recruitment, by the time that they show up in a health care facility, they're drug users and addicted to something.

For example, in the case of a person who I will call "B.T." She was 14 when she was recruited and forced to use drugs on the second day with the trafficker, and every day after that. In her particular case, the trafficker would decide what drug he would force her to use, whether it was injected or by mouth. Sometimes she was given drugs that would make her hyper and active because she was expected to serve dozens of buyers, sometimes in parking lots. Other times she was given drugs that would create unconsciousness because she had a certain buyer who wanted to perform certain paraphilic behaviors that she was not OK with performing. So while she was unconscious, these things were done to her. She was recruited at age 14, trafficked for five years.

Because of the repeated sexual exploitation, physical abuse, the drug use, the victims end up having at least one or reported encounters with the health care providers in our system. Here are my points for the health care providers.

First off, we need to understand that more time needs to be spent assessing the difference between perceived prostitution and self-voluntary prostitution. Victims are still being treated with confusion regarding the symptoms they present and the stories that they tell as to whether or not it may be prostitution, even when they're minors.

We are not asking intake staff, nurses, doctors and health social workers to become investigators or experts. We need them to understand the unique aspects of complex trauma, the bonding that happens between the victim and the perpetrator as it happens in human trafficking, and that there is a process of incremental disclosure where, unless you spend time talking to this person, they are not going to disclose what's happening to them.

Second, health care departments everywhere in the United States, in every state, need to have appropriate protocols in place that must be strictly followed, even when a patient is denying being forced or coerced, but the medical personnel is suspicious that something is going on.

Assuming that it's just prostitution increases the risk of a victim not being helped and being discharged back to the perpetrator, as we saw in the case of Roxana and Celena. Signs, symptoms and self-disclosures of prostitution-related activity should be treated all the same by medical professionals. Even when someone is saying I'm prostituting and I'm doing it on my own, the protocols still need to be followed.

Any of the previously mentioned signs—physical, psychological, the signs that Roxana and Celena talked about—all of these need to be considered by medical personnel as enough to make an additional phone call to the appropriate state, local or federal law enforcement or nongovernmental organization in the area the facility is located in.

In most cases, especially in the case of adults, likely the first person that should be called is an NGO rather than law enforcement. That NGO could lead to law enforcement. That NGO could be the person that they trust first.

Third point: All hospital personnel that come in contact with patients have to understand human trafficking. There should be at least one individual in each department that has been uniquely trained to be able to interview and talk to a potential victim.

Specific ways of interviewing have been found to be more successful than others. For example, we have found that utilizing the word "help" is a trigger to the victims because they have already been forewarned by traffickers that they are not to accept any help, that they are not to act in any way that's going to cause someone to think that they need

help. So utilizing the word "help" by medical personnel is going to automatically trigger them to say, no, I'm fine.

What needs to be said is something like, there is this person that's going to come and talk to you; this is part of our protocol. And that person needs to be uniquely trained to learn how to gain their trust and to be able to maintain that trust with that victim.

Next point: All personnel must have appropriate access to numbers and know who to call, whether it's services for minor or adult victims, which many times are different from state to state; the services that are provided to minors and the ones that are provided to adult victims are different in many states, and the medical personnel should know the differences on who to call.

It is no longer OK for medical personnel not to respond correctly due to lack of knowledge or not being able to understand what's going on. They must know who to call and how to respond so that the process of helping the victim goes through. It's no longer OK for medical personnel to discharge patients without creating some type of connection or providing additional assistance outside of the medical facility for the victim.

The victim should at least leave with some form of information on how they can get help if they decide to do so eventually. Many times we have seen cases where when they make contact initially with a health care provider, they may not be ready to talk, but two or three days later, because they're upset or they got a beating or they had an opportunity to make a call, they will call. But what happens when they're discharged and they have no one to call, no information, no number? Now we have nothing.

Interagency—and by this I mean law enforcement cooperation and NGOs—is critical. There has to be a relationship. Because of this process of incremental disclosure, which may take a long period of time, it is essential that health care facilities develop relationships with all of the agencies that are going to be involved.

Last—I'm going to leave you with this—I have personally seen this: When protection procedures for these victims in the health care facilities are consistent, honest, and reliable, the victim can feel supported and encouraged throughout the internal disclosure process and maybe will agree to receive help at the moment or later on. This can surmount current difficulties in supporting survivors over time and through the physical and psychological difficulties of stepping out of the trafficking environment and the post-trafficking process of restoration and rehabilitation.

Thank you.

Mr. SMITH. Yaro Garcia, thank you as well for, again, your very specific recommendations and the insights that you have provided. They will all be used, I can assure you, very effectively by this Commission and by other members of Congress, so thank you.

I'd like to now—Dr. Greenbaum—yield.

Dr. GREENBAUM. Thank you. Good afternoon, Chairman Smith, distinguished Commission members and members of the audience. I'm grateful for the opportunity to testify before you today.

In addition to my oral testimony, I would like to submit written testimony into the record.

My name is Jordan Greenbaum. I'm a child abuse physician at the Children's Healthcare of Atlanta Stephanie Blank Center for Safe and Healthy Children. I'm also a consultant for the International Center for Missing and Exploited Children.

The Blank Center provides medical and behavioral health services to suspected victims of abuse and their families. The International Center for Missing and Exploited Children is a nongovernmental organization that combats child trafficking and child exploitation globally.

I'd like to provide testimony today on sex and labor trafficking, especially involving minors.

As you know and has been said a few times, reliable estimates of the incidence and prevalence of human trafficking throughout the world are not available. But the best estimates indicate that millions of adults and children worldwide are involved in trafficking. Victims of human trafficking may experience a plethora of physical and emotional adverse consequences, including traumatic injury from physical assault and sexual assault, work-related injury, sexually transmitted infections, post-traumatic stress disorder, major depression with suicidality, and anxiety disorder.

Despite the criminal nature of human trafficking and the desire of traffickers to elude detection, we do know that victims come into contact with health care providers. We also know that victims rarely self identify and may even deny victimization, as we've seen very eloquently. Therefore, it is incumbent on the health care provider to recognize signs of at-risk youth and adults, to ask questions appropriately, and to provide trauma-informed care to identified victims.

The problem is, how does a health care provider recognize a potential victim if they don't identify themselves as such? This is a real quandary.

At Children's Healthcare of Atlanta, we recently conducted a pilot study to describe characteristics of sex trafficking victims. Based on that data, we designed a six-item screening tool, and a cutoff score of two positive answers was determined to have a 92 percent sensitivity for identifying child trafficking victims. A child with a negative screen had a 97 percent likelihood of not being a victim. Now, our study results need to be validated with other adolescent populations outside Atlanta, and currently, we're conducting a multisite study.

Beyond knowing what questions to ask and when to worry, health care providers need to know how to interact with potential victims in a way that does not re-traumatize them, that encourages trust and honesty. A trauma-informed approach is absolutely essential.

This approach to patient care involves the medical provider recognizing the real possibility that patients they're interacting with have experienced some sort of trauma, and that this trauma may influence how the patient responds to questions, how they respond to interactions, their behavior with health care providers and others.

Victims of human trafficking have almost certainly experienced complex, repeated severe trauma. And this, combined with their additional distrust of authorities, their fear, their shame, their humiliation, makes it very difficult for health care providers to interact with them in a way that's appropriate.

It's quite a challenge. It's not easy for a health care provider to consistently respond with support and understanding if a patient appears hostile, disinterested in receiving help or protective of the trafficker. But these reactions may be all related to trauma. The victim is responding to their trauma, and it's imperative that health care providers understand that and not respond inappropriately. But again, a calm, nonjudgmental, supportive approach may be the only way to convince a victim to disclose their victimization. But

that's not an easy thing, and health care providers are not necessarily trained to do that. In medical school, we are not trained to do that. In nursing school, they are not either. So this is something that has to be learned, and we have to set about training professionals on doing that.

The problem is that many curricula had been designed and implemented throughout the United States training health care providers—lots of webinars, lots of training scenarios—but almost none of these have been formally evaluated to see if they're really effective. And this is extremely important: Before we invest thousands, hundreds of thousands of dollars trying to teach hundreds of thousands of health care providers how to respond, we need to know whether these curricula are effective.

There are some exceptions to this. At Children's Health Care of Atlanta, we developed a six-part webinar series on child sex trafficking designed for health care professionals. Results from the post-webinar survey documented significant changes in beliefs about trafficking. And in a six-month follow-up survey, we found a significant increase in the percentage of webinar participants who are now asking adolescents questions about risk factors related to sex trafficking. And that represents an important persistent behavior change.

In general, health care providers are not trained to actively seek relationships with non-medical outside organizations. We're just not good at that. We don't feel comfortable doing that. And so that's another thing that has to be learned. We have to have a paradigm shift. Health care providers tend to work within the health care system: We're very good at interacting with each other but not so good with interacting with other people and other agencies, and that has to change. It's a critical step in the process of caring for patients who are trafficked victims because we need to be able to bridge the gap between the medical world and the community agencies that can provide the services to victims.

The HEAL Trafficking organization is developing a protocol that will provide step-by-step assistance to health care providers who want to work with their community to develop an anti-trafficking multidisciplinary team. Such a tool will help providers bridge that gap between the medical clinic and the community services that are so important for survivors.

And finally, I want to discuss the World Health Organization's International Classification of Diseases. This is a system used by health care providers worldwide to code all symptoms, diagnoses, and procedures related to health care. The ICD codes are very important because they're used to monitor incidence and prevalence of health problems and provide critical data for monitoring world health. Currently, there are no specific codes for human trafficking. This makes it extremely difficult to obtain epidemiologic data about human trafficking and to study health complications related to human trafficking.

In December 2014 the International Center for Missing and Exploited Children initiated a proposal to the World Health Organization to adopt specific ICD codes for child sexual exploitation and adult sexual exploitation. In early 2015 the HEAL Trafficking organization initiated a similar proposal to the World Health Organization asking for codes for labor trafficking. These codes will support the initiative of the SOAR to Health and Wellness Act by providing, quote, a reliable methodology for collecting and reporting data on a number of human trafficking victims identified and served in health care settings, end quote. The International Center and HEAL Trafficking are eager to see the proposals accepted and are seeking support from other stakeholders.

In conclusion, human trafficking is a public and private health issue, and health care providers play a critical role in identifying victims. They need training to know how to recognize victims and how to respond appropriately. And specifically, this includes trauma-informed care—how to respond, how to ask questions, how to do that in an empathic way that doesn't discourage victims from coming forth. They need to be able to work with community providers, to reach outside the medical system, to help bridge that gap so that survivors have somewhere to go. Then we need to train them on how to do that. This training needs to occur in the United States but also overseas, because trafficking is a transnational problem and requires a transnational solution.

Thank you for the opportunity to speak to you today.

Mr. SMITH. Thank you so very much, Dr. Greenbaum.

I'll begin with a few questions and then ask our two ladies if they would want to come back up to answer any questions for me, either myself or anybody in the audience.

First, Dr. Chang, you mentioned 93 percent of the victims didn't have any contact with law enforcement. Did any percentage of those victims, as they went through your program, decide at some point—and how long was that lag between when they had enough confidence—to bring a case or to identify the perpetrator of the crime? And what were the outcomes? And did that give them any sense of empowerment, that the person that had done such horrific things to them has now been held accountable, or at least is not able to do it to others?

Dr. CHANG. Well, actually, you bring up a very good point, Chairman. We actually have a protocol in place now where we will—if as a health care provider we suspect any sex trafficking of minors, we will make a report to the child abuse professionals. We also make a same-time report to the police department. However, what happens is the systems, these two systems were not built necessarily to address this problem. So the child welfare department says that it's not abuse committed by a caregiver, so refer to the police. The police say, is your victim willing to make a report? And no, they're not. So we do make these reports in the hopes that the data is being collected so that it can show down the line that this is a very big issue in our community, but as of yet, there are no systems responses that are coming in to intervene within our clinical setting.

Mr. SMITH. Does it at least add to the surveillance of a potential trafficking area? We just had a case in my own district where we got some, what I think was, actionable information. We got it right to the FBI and to local law enforcement in that order. And they are now looking into that matter very aggressively. Do they at least follow it up in that way?

Dr. CHANG. I think they do follow it up that way. And in fact, in California, they did just a couple years ago change the reporting requirements for child abuse to include suspected sex trafficking.

Mr. SMITH. And in terms of the community health centers, has the national association at all looked into this as a protocol to follow?

Dr. CHANG. I hope they are. And in fact, they did invite me to speak on a human trafficking panel last year. So we're getting on that with the Association of Asian-Pacific Community Health Organizations, which is a member of NACHC as well.

Mr. SMITH. You know, we recently had a huge bust in Lakewood, New Jersey, which is in my district, of a number of Mexican traffickers and women who were liberated who lived in Lakewood. We do have a community health center. And frankly, I've been working

on this since 1995, and while I've been to the community health center, we are checking now to see what it is that they do. I think you inspire all of us to look into our own—I have three in my district. They serve a very, very compelling need for health care. And they do have trauma because that is, as you've all said, a very important component of all of this. So thank you for that insight as to part of the remedy to helping.

In terms of faith based, do you find, all of you, that you seek to integrate the faith-based community? I've been in shelters all over the world, as well as in the United States. I can tell you that at least in my view, where there has been some connection to faith, the healing process—you know, mental health, opens up doors, helps diagnose the problem. Psychologists, psychiatrists do wonderful work. But when it's done in companion with a faith-based approach, the deeper healing often can occur.

I was recently in two shelters, one in Lima, Peru, the other one in La Paz, Bolivia. And both were supported by the governments. And, you know, to have the Bolivian Government support something, given Evo Morales' viewpoint towards the church, which is not a good one—and yet that government does support this faith-based initiative in La Paz. But I met many women, young women especially, who were there. And the key was longevity, or a key. There weren't there for two weeks. It wasn't a shelter just to get out of the—they were there in some cases for two years or longer. But they learned life skills. They were learning computer skills as well. But they had a joy that was just remarkable.

In like manner, I was in Goma in the Democratic Republic of Congo, where several women, many women, had been subjected to sexual abuse and rape based on war. And again, in HEAL Africa, another faith-based group, they were having incredible results, not only treating the physical side as best they can but also the mental health side, but the spiritual side as well. And I'm just wondering if you find in your work that that's a component that you embrace and feel should be a part of this?

Dr. GREENBAUM. We certainly see a strong faith-based interest in our—and I'm from Georgia, and a lot of faith-based organizations are very interested in anti-human trafficking efforts, so they put a major effort into creating homes and safe houses and putting forth a lot of volunteers. So it's extremely helpful.

Ms. GARCIA. As well here in the same format as well, providing places that are safe. One of the things that I have noticed with the Point of Contact/Point of Rescue program that it's mentioned there, with this program it's like a triangle effect where we teach the health care personnel, law enforcement, and the hotline all to respond to calls and work together in this way. Where the faith based I find has helped is through the process once they have established some type of connection or relationship with the health care provider. Whether it is the psychologists or a counselor, whoever it may be, I find that having a neutral person that they maintain contact with really helps through the process of that incremental disclosure that eventually may lead to prosecution—or successful prosecution, I should say. So having that neutral contact that's consistent is essential. And in my case, in most successful cases, it has been a neutral party. It's not a law enforcement person, it's not the pastor of the church, and it's not the doctor. It's someone else who the child or the adult is seeing outside of the system.

Mr. SMITH. You did say call the NGO rather than law enforcement or at least first—

Ms. GARCIA. Especially for adults.

Mr. SMITH. Are there enough NGOs in your opinion?

Ms. GARCIA. No. And this is one of the suggestions—they're probably both shaking their heads no—this is one of the suggestions that needs to be made that in every county, in every state, there has to be an identified NGO that can respond to these calls, outside of the Department of Children and Families.

Mr. SMITH. Yes, please.

Dr. CHANG. Thanks. I wanted to address the spiritual—the faith-based response. I think it is essential. And in fact, sometimes traffickers use a deeply held faith by a victim as a form of abuse. For example, I did some work in the Western Pacific and in the Pacific jurisdictions, and there was a young girl who had been sex trafficked and raped and kidnapped forcibly. And the traffickers repeatedly told her that her God no longer loved her because she had been defiled. And so I think the healing component for spiritual aspects is very important.

Mr. SMITH. Ms. Yaro Garcia, you mentioned—upon leaving an emergency room or health venue, they need to know who to call. How do you convey that if the handler, as was said earlier, even to the point of being with her during the birth of her child, how do you get that information? Do you look for—does an especially trained person look for some place where they close the curtain and say, everybody out, and then they just do it like you're doing at a——

Ms. GARCIA. Correct. That's exactly what we are training the hospital personnel to do through Point of Contact/Point of Rescue is first off, you must get everyone to leave the room—and medical personnel, by the way, have that authority, in every state; they can ask everyone to leave the room—and then conversate with the potential victim about, I'm going to give you this information; where can you put it? How could I help you memorize it? Take it with you. I know you don't want it right now, but if you do later, I want you to have it.

Mr. SMITH. Are there many instances where the trafficker or the pimp found a card, business card, something with a phone number on, and then——

Ms. GARCIA. Yes, I have had those cases, especially with minor victims. However, it's few compared to the cases where it hasn't happened.

Mr. SMITH. Right.

Dr. GREENBAUM. Can I just add something to that? I do a lot of training of health care providers, and two of the questions they almost inevitably have are, how do we get the person out of the room so we can talk to the child alone? And what do I do if the child refuses to stay and I need to make a report and they want to leave?

And the answer to the first one is that we usually say it's our policy here at Children's or the clinic or wherever you are, it's our policy here to interview all adolescents alone, so I'm going to need to have to ask you to step out, and there's a waiting room down the hall; can you just step this way? You're not really asking them; you're sort of telling them. But you're saying, this is a policy; we do it for all parents. And so the person usually goes. If they don't, if they refuse to leave the side of the victim, like in your case, what I would suggest is that the health care provider come up with a different scenario saying, you know, we need to get this child a chest X-ray, and we're going to need to take her to radiology. We need to draw some labs. We're going to have to take her to the laboratory. And so you escort the child or whoever the patient is, you escort them out and leave the trafficker in the room.

The other thing that I think refers to what you were getting at as to how do you give information to a patient in a safe way. And that is I think very difficult, and we have to be very careful because no one knows more than the patient how safe they are and what will put them into danger. And so I agree, we have to be very, very discreet about that and say, can I give you these resources? And if not, if they say, absolutely not, then we don't, but we can leave the door open and say, this is a safe place to come; if you decide to come back, come here, we can offer you services. That's all we can do, but——

Mr. SMITH. Dr. Chang, you talked about the fear of jail. And I'm just wondering, you know, when we—and I was the prime author of the Trafficking Victims Protection Act. One of the areas that we had a great deal of headwind to overcome was the T visa and providing safe haven and really doing a sea change in terms of saying, these are not perpetrators of crimes; these women are victims—or men, but most, obviously, in sex trafficking are women. And, you know, that is the law. Matter of fact, the definition to anyone that has not attained the age of 18 by definition is a trafficking victim if just one commercial sex act is committed, and then forceful coercion for anybody after they have attained the age of 18. So the fear of jail—is it that law enforcement is not sufficiently aware? Is it the local or state laws that are the problem? I mean, federal law I think is clear. But your thoughts on that, Dr. Chang.

Dr. CHANG. Thank you for asking. That's a wonderful question. And you're right, it's—federal law has clearly defined my patients as victims. I think it takes—it's taking time for the state laws to catch up—and also the application of state laws by the different counties and the different prosecuting attorneys, depending on the states and how they divide up their law enforcement and criminal justice system. So in California, there are still counties that are able to arrest minors for solicitation.

Dr. GREENBAUM. I think it's also that traffickers will threaten the child or the patient with saying, you'll get arrested, and I won't. If you go to law enforcement, they'll arrest you and throw you in jail or deport you.

Ms. GARCIA. In the case of Celena, she was held in state federal prison for three months when she was found, for three months. And again, this goes back to not utilizing the appropriate services that are available and law enforcement not understanding that other services also have to be provided, that it's not just you interviewing and prosecuting a case; this individual has to be allowed to become a—to have a process where they go through that process of incrementally disclosing what they want to disclose. Sometimes law enforcement has an idea that because they're victims, they should be ready to talk; because they're victims, they should be ready to be rescued or be helped. This is not what we see with human trafficking. We're talking about very, very complex trauma, bonding that happens between the victim and the perpetrator.

Mr. SMITH. Roxana earlier had spoken about the handler staying with her even as the baby was being born. And my question is, are these handlers, these pimps that good of actors that they can deceive a group of very highly competent—medically speaking, certainly—people? Emergency rooms are tough places to work. Are they that pressed for time? Or is it the sense of, don't ask questions, just be indifferent, just handle the patient and don't judge, or some nonsense like that where you're not judging, you're ascertaining the nature of the situation? But it seems to me that there would have to be giveaways at all times.

Dr. CHANG. Go ahead.

Dr. GREENBAUM. I think there are a number of factors, and it probably differs with different physicians. I think certainly time and requirements for productivity drive a lot of behavior for medical care. They have to see a number of patients, and they have to keep going. There are 16 patients waiting to be seen. I think there is also discomfort: I'm not sure how to ask these questions, I don't know what to do, I don't know—what if they say yes, there are a victim? I don't know who to call, so if I don't ask, I won't have to respond.

Mr. SMITH. Let me ask you on that, is the American Hospital Association, are they promulgating recommendations for their own hospitals? Because they are a huge network.

Dr. GREENBAUM. I think that's a very good point. I don't know that they are. We are working very hard with individual medical organizations to try to get policy statements. For example, the AMA has issued a policy statement saying physicians need to be trained on how to recognize and identify victims. And so a number of these medical organizations are working. But I think your suggestion of the American Hospital Association is a very good one.

Mr. SMITH. I will offer, if you want to work with us, we'll write a letter to the AMA——

Dr. GREENBAUM. Yes. Sign me up.

Mr. SMITH. ——AMA is already doing it—American Hospital Association and others asking them specifically as the Helsinki Commission what are they doing, will they do it, and help us tell them or convey to them what a best practice would be for the hospitals—what you're doing. But, I mean, we'll work on that immediately.

Dr. GREENBAUM. I think the whole thing having to do with trauma—

Mr. SMITH. Maybe we'll invite them to a hearing. Find out what they're doing.

Dr. GREENBAUM. The whole idea of trauma-informed care is such a sea change for the medical world for people to really take the time to ask people about possible trauma and to interpret their behaviors as possibly reflecting their traumatic experiences. And to take it into account is so different than what we've been told and taught in medical school, in nursing school. It's a hard thing. But it's absolutely essential that we do that.

Ms. GARCIA. I think we're also looking at an understanding of an issue of loyalty. Many of the victims have a sense of loyalty to the trafficker because of that bond that I keep talking about. And if medical personnel doesn't understand that there is that loyalty, they get confused by, well, they don't want to talk about anything happening to them and they don't want to say what's happening to them, so therefore what can I do? What they can do is understand that there may be that loyalty and approach the issue in a different way. Sometimes it's as simple as saying—in the case of Roxana, she has told me before, she says, I wish that they would have just said to me, you can come back here the next time that you have a fight with your partner. As simple as that. Treat it with some normalcy to her, and it would've felt safer.

Mr. SMITH. Let me ask you, what time of day and what part of the week is there any sense that trafficking victims are brought in? Like late Saturday night after they have been abused to the point where they break down and are unconscious or—because I remember I traveled with the proactive unit of the Trenton Police, second term, so it was, like, 32 years ago. And they brought in a woman who had been raped who was unconscious. And she was so badly beaten it was—I mean, I was crying, I just had to hold back—I felt so bad for her. But there was a matter-of-fact attitude towards her that—

and again, trauma people see it all the time, and for them it must be—you know, they just steel their emotions. But I kept looking at this poor woman who was just battered and wondered, did they catch the guy? Did they—and so do you find there is a certain time of the week, certain hours of the day that traffickers bring their victims in?

Dr. GREENBAUM. I think that since victims have to work 24 hours a day, seven days a week, that they can be beaten at any time and be brought in at any time. That's my thought on it. I'm interested to hear what the other——

Ms. GARCIA. Same here. I have not found a specific pattern on times. I know in the state of Florida the busiest days for the brothel activity is Mondays and Saturdays. However, in my cases that I have worked, no specific pattern on when they're taken in. It just basically happens when it gets to that point where it just—there is nothing else the trafficker can be pushing for.

Mr. SMITH. Could I—I'm sorry—Dr. Chang—the WHO—you know, part of my subcommittee, it's called Africa, Global Health, Global Human Rights and International Organizations, so the U.N. does come under. And, you know, I have followed with great interest. I have been up to the U.N. I'm the special representative for the U.N. this term; it's the third time I have done it over the years, over 35 years, as a member of Congress. But the WHO comes under—we deal with them all the time. I have a big hearing, for example, next week on tuberculosis, particularly multidrug resistant TB, and the WHO has just sounded the alarm for just how dangerous—and I know some of the trafficking victims do suffer from that, as well as HIV/AIDS and other diseases.

But I'd like to follow up on the WHO side with the codes that you spoke about. So again, anything specific you can provide with the post-2015 sustainable development goals. We tried very hard to get more explicit language on combating human trafficking for the global effort, which will be in effect for the next 15 years. So specifically on WHO, I'd love to follow up with you on that, all of you, if you'd like, because I think that's something that needs to be done.

Dr. GREENBAUM. We could really use the help. We have submitted the proposals, and the ICD 11 is the new coding edition. And that is in its beta phase through 2017, and that means that people can provide proposals for change, and people review them during this time. And so if we could have your support in saying these are good, this is a good idea, or this is a good idea, but I suggest you change the wording—we're open to suggestions. But we really need support to make it go through. So I would love to be able to talk to you a little bit more about that in specific details.

Mr. SMITH. Very good. Thank you. We'll do that.

You know, we did check with two community health centers in my district. And while they're interested, they don't have something, so I'd like to follow up with you on that and try to get that going in our area. Thank you.

Just a couple of final questions, and maybe we can turn that off and just ask one or two final questions of our two other witnesses. But the Federal Strategic Action Plan, your thoughts on that? Obviously, it began in 2013. Are you encouraged as it's taking shape?

Dr. CHANG. I am actually very encouraged by it. I think there has been a great push for victims and its services. Department of Health and Human Services is involved now. And I think the health resources and services administration side is involved as well.

Ms. GARCIA. I'm also very encouraged by it. And the only thing that I would suggest at this point that I would like to see with it eventually in the future is that more specific on protocols and what to do, especially with the health care system, a little bit more of that.

Dr. GREENBAUM. I'm very encouraged by it as well in the sense that it very strongly advocates for a victim-centered approach and increased victim services. I do also appreciate the idea that whatever we do, we need to make sure that we look at outcomes measures and test the efficacy of these various strategies. It's not enough to come up with great ideas that feel good and start implementing all these programs. We need to measure the outcomes and make sure that they're actually working and helping victims.

Ms. GARCIA. I agree with that.

Mr. SMITH. Roxana had talked about the rehearsed story. Is that common as well?

Ms. GARCIA. Yes, almost every single time.

Mr. SMITH. And the pimp or person that is accompanying her knows very well what she has to say, and if she doesn't say it, there is retaliation?

Ms. GARCIA. Yes. In all the cases that I've worked, there is a rehearsed story. It's a little different every time, but it always appears to be a very normal story.

Mr. SMITH. And finally, the national symposium in 2009 on the health needs of human trafficking victims had a number of important points, including cultural competency or the lack of it, the illiteracy issue. I mean, how often, particularly in an emergency room, does that present itself, where the attending or the LPN or nurse just doesn't get it because they don't understand the language or the nuances? They did say the consequences of human trafficking on mental health cannot be overstated, and I think that is a huge issue that's gone unfocused upon. And we know more about PTSD and other trauma consequences than we've ever known. Is it being applied effectively to these trafficking victims?

I wrote a law called the Torture Victims Relief Act—three of them, as a matter of fact—which provides torture centers and best practices for dealing with torture victims. And we have about 500,000 in the U.S., mostly came here, obtained asylum from a country that was a dictatorship—Africa, Latin America, Europe, Russia, China. And what I've learned from all of that, because we've had witnesses tell their stories, is that the trauma continues for decades—not years but decades, unless dealt with. And I'm wondering if we're doing enough on the mental health side to address that, because that can be disguised. Antidepressants can cloak it. Maybe they're needed. I'm not saying they're not. But getting to core issues is—so maybe you might want to speak to that.

And then that leads to the other issue of re-victimization, which they also discussed at length at the symposium. You know, they just give up, or they're coerced back into it, but sometimes it's a matter of such utter brokenness that they give up.

Dr. GREENBAUM. I think that you make an excellent point. We can treat the gonorrhea. We can treat the closed head injury. We can treat the fractures and the burns. But it's extremely hard to treat the post-traumatic stress disorder, the suicidality. In one study of child survivors, 47 percent had attempted suicide in the past year. That's a very large percentage of adolescents.

And I think that there are some promising actions. The trauma-focused cognitive behavioral therapy is a very effective evidence-based therapy that's very good for sexual assault victims and sexual abuse victims. And they're working hard on tweaking it so it

is appropriate for human trafficking victims. Now, it's in its early stages, but there is some promising evidence on that.

But again, everything has to be evidence based. And so I think people are really aware of that. They're saying, OK, we're going to tweak this strategy, but we've got to see if it really works. But it is promising.

Mr. SMITH. Yes. Dr. Chang.

Dr. CHANG. So one of the promising things about the community health centers is that there is the push for the integration between primary care and behavior health services. So we are trying in our human trafficking or commercially sexually exploited, my own program at Asian Health Services, to include the behavior health side to that.

Ms. GARCIA. I think it's essential. I think that we could still make more progress with it. As previously mentioned, evidence-based services should be the key—and, of course, outcomes; we do need to start obtaining some types of outcomes on what best practices are, what works, what doesn't. Yes, I think all of this——

Mr. SMITH. Is there anything you'd like to add as we near the end?

Dr. GREENBAUM. I'd just like to thank you so much for focusing so much attention on this issue because it is something that is desperately needed, and thank you very much for your efforts.

Ms. GARCIA. Same thing. Thank you so much. And on behalf of all of the victims that I have personally worked with, thank you.

Mr. SMITH. Would you want to come back up, ladies, just for a moment?

[Note: The briefing proceeded to an off-the-record session, then returned to on-the-record.]

Mr. SMITH. I mentioned that I sponsored the Trafficking Victims Protection Act. I always meet with traveling TIP people from different countries. As a matter of fact, they often go over to the TIP office. And I encourage them—when I know they're coming, and very often they ask, we do have meetings in my office with my staff.

Eight years ago I was meeting with the trafficking personnel from Thailand— which is a Tier 3 country today, worst offender, but at the time they weren't— and I asked them, if you knew a convicted pedophile was traveling to Thailand, what would you do? And they said, we wouldn't allow them in, and if they got in we'd watch them very, very carefully.

That day we began working on a new idea called the International Megan's Law. We passed a law—states, that is, although there is a federal overlay, but it is primarily state law. A little girl in my hometown, Megan Kanka, was brutally raped and then murdered by a convicted pedophile who lived across the street and nobody knew it. So information would have helped all parents in that area, including the Kankas, to take precautionary efforts to make sure that no one goes in that house or even near this individual.

The Megan's Laws work, to some extent. I think they work well. They keep these individuals from being coaches on soccer teams, baseball, softball, whatever it might be. And there's gradations of threat—one, two and three.

Long story short, the International Megan's Law passed three times in the House. NCMEC has been a very good supporter, and I'm eternally grateful for that, in supporting it. But it is now over on the Senate side again. The Foreign Relations Committee has approved it. They're hotlining it, maybe, today. Our hopes and fingers are crossed. But

it seems to me that the more we break the impunity and the ability to travel in secret, to aid and abet people who exploit women and children, boys and girls, the quicker we'll get to a society where those people are behind bars, and certainly not going on these sex tourism trips in secrecy, because you know when they come back they're not just ending that. It continues, and they—as you mentioned, Ms. Garcia, they—you know, as they rotate the, quote, "merchandise"—the victims—they then abuse the women and young girls in their locale.

So just for the record, we are trying very hard to get this passed. Please keep it in your prayers, because I think it will have a chilling effect. And we also are trying to get the other countries to look at adopting their own Megan's Law so that they, too, know where they are, what they're doing, and when they do travel to the United States our hope would be that we get noticed in a timely fashion, the way we want to be noticed when they make their way here, because we will deny visas to those individuals, just like they do. In visa-free countries, or Visa Waiver countries, it presents some additional problems. But I think knowing where they are can have a chilling effect. And so that becomes part of the rubric of law and policy that helps victims, or tries to, and does a prevention strategy so it doesn't happen at all, or to the greatest extent possible.

Ms. GARCIA. Thank you.

Mr. SMITH. Laura, would you like to say something?

Ms. LEDERER. No.

Mr. SMITH. Please. [Laughter.] Laura Lederer has been a——

Ms. LEDERER. I just want to thank you very much for your continued leadership on this. And one thought I had is, as I've been hearing particularly from the survivors that I've been working with Yaro, is that we had that hearing in 1998–1999 with the Cadena brothers, and 15 years—17 years have passed, and the stories we heard when we were in Yaro's clinic were just so similar. It's almost as if the progress that needs to be made, particularly on these very young victims from Central America and Mexico into the United States—we just need to work harder on it. And I appreciate the work on the victims, but on the front end we need to continue to do that, too. And that's why it's so important for health providers to get over their fear of working with law enforcement and figure out how to do that. And so thank you all for being here. I really appreciate your participation.

Mr. SMITH. Thank you very much.

Ms. LEDERER. Thanks.

Ms. GARCIA. I agree with you fully that the international aspect of this is also very important, where not just international awareness but international policies also need to keep increasing and changing and improving.

Mr. SMITH. I do serve as special representative to the Organization for Security and Cooperation Parliamentary Assembly. It's 57 countries, parliamentarians. We meet three times a year. The big meeting is in—during the summer months, usually around July 4th. And I have offered one resolution after another for years, going back to when we first did our Trafficking Victims Protection Act of 2000, to try to get the other nations to share their best practices, everybody get on the same page—at least from a European perspective, the OSCE. And we've been bringing many of these ideas.

This hearing really does help us, coupled with all of your written testimonies—take this to the other countries as well—because we're laggards in some things, others are laggards. We want to get ahead of the curve rather than at it or behind it.

Again, what you've conveyed to the Helsinki Commission isn't just for the United States and follow up here, like with the Hospitals Association and all the other things we hope to do, but also, as special representative, I get to bring it to the others. And hopefully it's listened to. And we also try to work with the OAS, the African Union, because, again, there are areas where, if you get critical policymakers to really understand the issue and to do something, it has huge consequences in the positive direction.

I thank you so much for your time, for your efforts, for your courage, for being here. You're in our prayers, believe me, because we in my office—and we're not unique—we do pray through these issues, believing very strongly that we are up against an evil that is otherworldly, to exploit people in such a horrific fashion. But thank you so much.

We're adjourned.

Ms. GARCIA. Thank you. [Applause.]

Mr. SMITH. I'd just add, Allison Hollabaugh, I just want to point out, does yeoman's work on the issue of human trafficking and has, as you know, helped put this all together. And I want to thank her publicly for her work. She is a tremendous asset to the Commission.

Ms. HOLLABAUGH. Thank you.

Mr. SMITH. And so thank you, Allison. [Applause.]

[Whereupon, at 4:15 p.m., the briefing ended.]

APPENDIX

PREPARED STATEMENT OF "CELENA"

My name is Celena. Thank you for being here. Thank you for listening. And as well, I'm going to tell you just a tiny bit about my story.

At the age of 19 I was brought to the United States by the man who from there on trafficked me for years. My initiation into this process was being taken to a house, where I was forced to serve initially 30 to 50 men for a long process that lasted weeks. And then I ended up in another state, where they moved me, and this continued.

Shortly after this started happening to me, as you can imagine, I was crying constantly. I was not behaving according to how they wanted me to. I was crying. I was sad constantly. I was not performing to how they wanted me to. I felt very ashamed. And I felt this little from what was being forced onto me.

So here is my first interaction with the health care industry. They wanted to stop me from crying so that I could perform better so they could make more money. So they took me to a clinic in New York. The doctor walked in, asked me what were my symptoms, and I explained that I felt very anxious and very sad and I felt like I wanted to cry all the time. She asked no more questions and told me that I was depressed and prescribed me medication for depression.

The second time I was experiencing a lot of pain from all of the activity that I had to perform every single day. The pain was so excessive that the trafficker finally decided to take me back to the clinic now to remedy this issue. I ended up in the same clinic, with the same nurse, with the same doctor—same people. She walked into the room, asked me what was wrong. I explained that I was experiencing pain. She didn't examine me, did not ask me any more questions, and gave me painkillers to take the pain away.

In 2009, this was the worst episode for me. I began bleeding excessively. And by now I had been bleeding for six months straight nonstop while I was still being trafficked every single day. The trafficker forced me to wear makeup sponges inside my vagina so that this could stop the excessive bleeding that was going on every day so that I could keep working for him.

I couldn't take it anymore, and he finally realized that and took me to the doctor. He told me to say that I had no family in the United States, that I didn't know anyone, and that I had a boyfriend who was very sexually active. And I had been experiencing these bleedings ever since I had started interacting with him.

That occasion I was at the hospital from 11:00 in the morning until 4:00 a.m. the next day with several people doing exams and tests on me and looking at my interiors. And no one asked a single question. I was not even prescribed medication. They didn't provide me any treatment because all I had was excessive bleeding and lacerations. So they said just go home and drink a lot of Gatorade so you can hydrate, and you should not have any sexual activity.

All of the times I was taken to the hospital or a treatment facility by the traffickers no one helped me despite of the many signs that something was wrong with my body and with the symptoms that I had. I was bleeding excessively and there was swelling and lacerations. I was too quiet, afraid to make eye contact and barely talked. How could the doctors believe that I simply had a partner who was so active that he was hurting me sexually? This makes no sense. The medical staff could have asked me about my situation or simply just called law enforcement to get me out of it. Inside I was screaming for help I had just lost the ability to ask for help, or to desire it or even understand that I wanted help. The medical professionals had many opportunities to assist me but instead I was just discharged back to the people who were exploiting me.

I know that I don't have a lot of time, so I want to thank you. And I'm thanking you mainly because I'm hoping that somehow this will go somewhere else where all of the young girls and the young adults going through the same thing I did could be rescued easier or better or that we would find other ways to do this for them.

I wish that I could be the person in power to be doing this for the girls. But I also understand that people who are in power, like doctors and police officers and people that may be in this room, are the ones who could possibly make this happen.

Thank you.

PREPARED STATEMENT OF DR. KIMBERLY CHANG

Chairmen Smith and Wicker, and esteemed Commissioners:

Thank you for inviting me to address the important issue of the role of the healthcare system and healthcare professionals in rescuing victims from human trafficking.

Introduction

One night in 2008, Christina, a patient of mine, came to the clinic very sick. She was young, about 15 years old, and had been seeing us at the clinic on and off for three years. Although Christina never disclosed any sexual exploitation, we suspected that she was being sex trafficked. That night, Christina had a high fever, rashes all over her body, swollen painful joints, a racing heartbeat, and weighed less than 90 pounds. She was anxious and depressed over her condition. She had delayed seeking health care despite feeling ill for three months. She needed to go to the hospital. When I told her this, she absolutely refused, stating, "I'd rather die than go back to jail!" I didn't understand the connection between her going to the hospital and being sent to jail. Later I learned that on a previous hospitalization, Christina was discharged to jail because a bench warrant for her arrest was issued when she failed to appear in court on solicitation charges. Christina did not go to the hospital that night. When I found out she didn't go, I feared she was going to die. We had failed our patient. Or, did we?

Our care did not end when Christina left the clinic's four walls. Our health center's youth program outreach workers and Banteay Srei case manager contacted their community connections all night, eventually locating Christina the next morning. The Banteay Srei case manager went to Christina, convinced her to go to the hospital, and personally drove her there. Christina was hospitalized for almost two months. She was treated, and survived. For Christina, our team-based approach, our assistance enabling her to access care, our public health perspective, and our community health center model was a success.

This model can be a success for many more victims across the country.

My name is Kimberly Chang. I am a physician at Asian Health Services. Asian Health Services is a Federally Qualified Health Center, which provides primary health care for over 24,000 primarily low-income, limited-English speaking patients annually; including such as case management, behavioral healthcare, community health outreach including a youth program, and on-site culturally and linguistically appropriate care, including interpretation in twelve Asian languages.[1] As a result of caring for patients like Christina, we also have a specific program for minor patients who have been or are at risk of being sex trafficked or commercially sexually exploited, called Banteay Srei ("Citadel of the Women").[2] For the past twelve years, I provided health care to domestic minor victims of sex trafficking, and helped develop protocols to identify affected patients in the primary care and community health settings. I am a co-founder of HEAL Trafficking,[3] a network of interdisciplinary health professionals committed to preventing and ending human trafficking, and healing patients who have been trafficked. I consulted and advised anti-human trafficking task forces in the Western Pacific Compact of Free Association nations, and other Pacific jurisdictions, in building and strengthening the capacity of the public health, community health, and medical sector's response to human

[1] Asian Health Services. Retrieved November 25, 2015, from http://www.asianhealthservices.org
[2] Banteay Srei. Retrieved November 25, 2015, from http://www.banteaysrei.org/
[3] HEAL Trafficking. Retrieved November 29, 2015, from http://healtrafficking.org/

trafficking. Additionally, I have trained thousands of front-line multidisciplinary professionals on the healthcare intersect with human trafficking. I spent the past year as a Commonwealth Fund Mongan Minority Health Policy Fellow at Harvard Medical School[4] and the Harvard T.H. Chan School of Public Health, working with the Association of Asian Pacific Community Health Organizations[5] to address the role of community health centers in caring for victims of human trafficking.

My work with human trafficking victims has focused mostly on the function of primary care and public health, particularly the role of community health centers, and so my comments will carry that perspective today. As a front-line physician, I also see these issues through the lens of my affected patients. I hope to provide some context for the role of the healthcare system and healthcare professionals by answering: What is the responsibility of the healthcare system in addressing the issue of human trafficking? What are the unique opportunities and advantages of government-funded health centers in preventing, intervening in, interrupting, and stopping the victimization of patients who have been or are at risk of being trafficked? And, what can government and Congress do to enable community health centers to help end human trafficking and effectively care for trafficked patients?

Human Trafficking is a Healthcare Issue

Christina's story highlights the position of the healthcare system as a critical access point for identifying and reaching out to victims. Because of the very nature of human trafficking, victims experience severe physical, mental health, and social harms, and visits to any health care provider are opportunities to intervene in and interrupt the exploitation. [6] Think about the conditions of human trafficking and the way people are controlled for labor or sex, and you get an idea of the health harms to victims in the short and long-term. In captivity, victims are deprived of health care and food, are socially restricted, and are coerced into drug and alcohol use and addiction. They are forced into dangerous, dirty and degrading living and working conditions; and they are subject to all forms of abuse (physical, sexual, psychological, emotional, behavioral, and spiritual).[7] The health harms fall into three categories:

- physical harms such as sexually transmitted infections, injuries, malnutrition;
- mental health harms, such as trauma, depression, anxiety; and
- social harms, such as criminalization and stigmatization.[8,9,10,11,12,13,14,15]

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[4] Commonwealth Fund Mongan Fellowship in Minority Health Policy. Retrieved November 25, 2015, from https://mfdp.med.harvard.edu/cfmf/

[5] Association of Asian Pacific Community Health Organization. Retrieved November 25, 2015, from http://www.aapcho.org/

[6] Institute of Medicine; National Research Council. (2013). Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States. Washington, DC: The National Academies Press.

[7] Baldwin, S., Eisenman, D., Sayles, J., Ryan, G., & Chuang, K. (2011). Identification of Human Trafficking Victims in Health Care Settings. Health and Human Rights, 13(1), E36–49.

[8] Institute of Medicine; National Research Council. (2013). Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States. Washington, DC: The National Academies Press.

[9] Zimmerman, C., Yun, K., Shvab, I., Watts, C., Trappolin, L., Treppete, M., . . . Regan, L. (2003). The Health Risks and Consequences of Trafficking in Women and Adolescents. Findings from a European Study. London: London School of Hygiene and Tropical Medicine.

[10] Felitti, V., Anda, R., Nordenberg, D., Williamson, M., Spitz, A., Edwards, V., . . . Marks, J. (1998, May). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245–258. Retrieved from Centers for Disease Control and Prevention:http://www.cdc.gov/violenceprevention/acestudy/index.html

Christina suffered from all three types of harms that night—malnutrition, a possible sexually transmitted disease, depression, anxiety, and criminalization. And here she was in my health center, severely ill—a trafficked patient refusing to go to the hospital. Her fear of being jailed for the very victimization causing her illness placed her at risk of death. Overall, our response to victims is simply inadequate and flawed.

A Robust Healthcare System Response is Critical to Victim Support

When I think about people who are being trafficked, I think about how underground and hidden victims engage with the systems of care and protection in an aboveground functioning society. The focus on criminal justice strategies to reach trafficking victims, and to end labor and sex trafficking is limited, reaching only a select few. In 2006, Asian Health Services' Banteay Srei youth development program for commercially sexually exploited minors conducted an internal survey of patients—we learned that out of the 40 girls participating in the program, only three had an interaction with law enforcement. This means almost 93% of these victims were not identified within the justice system! Yet, they were engaged with the healthcare system. Relying on a justice framework to identify and reach victims means that we miss many others who don't receive, don't qualify for, don't want to use, or are excluded from criminal justice services.[16] And, like Christina, there are many victims who are treated as criminals.

The call for a robust public health and healthcare system response to human trafficking has been echoed by justice and law enforcement leadership.[17,18] It is understood that the foremost priority of the criminal justice system is to uphold the laws of the state. In best cases, these state interests overlap with victims' needs. Sometimes, however, they are at odds. When victims feel too scared or hopeless to participate in the prosecution of their traffickers or they don't have a strong case for prosecution, does that mean the victim doesn't deserve and won't receive the support he or she needs to heal? The call for a robust public health and healthcare system response means we can create solutions whose foremost priority is that victims will undergo a healing process or obtain the educational and economic opportunities they so urgently need. Separating the priorities of the state in prosecuting traffickers, from the priorities of victim healing can yield better

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[11] Dovydaitis, T. (2010). Human Trafficking: The Role of the Health Care Provider. J Midwifery Womens Health, 55(5), 482–487. doi:10.1016/j.jmwh.2009.12.017

[12] Isaac, R., Solak, J., & Giardino, A. (2011). Health Care Providers' Training Needs Related to Human Trafficking: Maximizing the Opportunity to Effectively Screen and Intervene. Journal of Applied Research on Children, 2(1), 1-33.

[13] Baldwin, S., Eisenman, D., Sayles, J., Ryan, G., & Chuang, K. (2011). Identification of Human Trafficking Victims in Health Care Settings. Health and Human Rights, 13(1), E36–49.

[14] Crane, P., & Moreno, M. (2011). Human Trafficking: What is the Role of the Heatlh Care Provider? Journal of Applied Research on Children, 2(1), 1–27. Retrieved November 25, 2015, fromhttp://digitalcommons.library.tmc.edu/childrenatrisk/vol2/iss1/7

[15] Willis, B., & Levy, B. (2002). Child Prostitution: Global Health Burden, Research Needs. and Interventions. The Lancet, 359, 1417–22.

[16] Chang, K., & Littenberg, N. (2015, July 29). Veto of SB 265 doesn't end need to help victims of sex trafficking. Honolulu Star-Advertiser.

[17] Holder, E. (2012, April 24). Justice News. Retrieved November 29, 2015, from The United States Department of Justice: http://www.justice.gov/opa/speech/attorney-general-eric-holder-speakson-human-trafficking-thefrank-and-kula-kumpuris

[18] Tiapula, S. (2010, September 15). Hearing on: Domestic Minor Sex Trafficking. Retrieved November 29, 2015, from The United States House of Representatives Judiciary Committee. http://judiciary.house.gov/-files/hearings/pdf/Tiapula100915.pdf

results in ending trafficking, by allowing victims the time to heal and regain agency over their lives.

The Healthcare System: Multiple Opportunities for Intervention through a Team of Professionals

Compared to other sectors in a functional society, the health care system provides opportunities for interaction and engagement throughout the entire lifespan—from pregnancy, to childhood, through adulthood; from acute emergency care, to long-term, chronic care; from public health community outreach, to hospitalizations. All of these points of care are opportunities to prevent, intervene in and start the process to end the exploitation of trafficked patients, a long-term process of rescue. And when I think about the health care system, I think not only of doctors or nurses, I think of the whole team of professionals who provide care and service. Christina's engagement with the healthcare system began outside the clinic walls when she learned about the health harms of commercial sexual exploitation, and the care our health center could provide. The outreach work of Asian Health Services' youth program community health workers, who taught health education to various community groups and schools, enabled Christina to access the clinic. And the Banteay Srei case manager enabled Christina to get life-saving treatment at the hospital. Christina is not alone: studies of victims revealed a wide range of encounters with health care professionals and clinics while being trafficked—between 28–87% had seen any type of health care professional or clinic.[19,20,21]

Community Health Centers are the Best Healthcare Response to Human Trafficking

Like Christina, untold numbers of trafficked people are accessing care at community health centers and their many community programs. Community health centers are key components of the healthcare system serving people at risk for being trafficked. A study that I published with colleagues this year shows that trafficked minors can be identified in a community health center.[22] They offer unique opportunities and advantages in preventing, intervening in, and stopping the victimization of patients who have been or are at risk of being trafficked. Although there is no single profile of a human trafficking victim, vulnerabilities that indicate a higher susceptibility to being victimized and trafficked include runaway youth, foreign nationals with a different language or culture, poverty, and those with a history of trauma or violence. These vulnerabilities make them targets for predators seeking to exploit them.[23] There is significant overlap between people who are vulnerable to being trafficked, and patients of community health centers. Community health centers serve a disproportionate share of the nation's poor and uninsured. Most are members of racial or ethnic minorities, and millions of health center

[19] Lederer, L., & Wetzel, C. (2014). The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. Annals of Health Law, 23(1), 61–91.

[20] Family Violence Prevention Fund. (2005). Turning Pain Into Power: Trafficking Survivors' Perspectives on Early Intervention Strategies. San Francisco: Family Violence Prevention Fund.

[21] Baldwin, S., Eisenman, D., Sayles, J., Ryan, G., & Chuang, K. (2011). Identification of Human Trafficking Victims in Health Care Settings. Health and Human Rights, 13(1), E36–49.

[22] Chang, K., Lee, K., Park, T., Sy, E., & Quach, T. (2015). Using a Clinic-based Screening Tool for Primary Care Providers to Identify Commercially Sexually Exploited Children. Journal of Applied Research on Children, 6(1), Article 6.

[23] NHTRC: National Human Trafficking Resource Center. (2015, November 25). Retrieved from The Victims: https://www.traffickingresourcecenter.org/what-human-trafficking/human-trafficking/victims

patients are served in a language other than English.[24] Asian Health Services is not the only clinic doing this work—many others are developing models of care, like the partnership in Honolulu, Hawaii, between the Kokua Kalihi Valley community health center and the Pacific Survivor Center, providing integrated care to trafficking victims. Community health centers provide this care, despite scarce resources.[25]

Health centers are also unique in that they provide special non-clinical help enabling and facilitating vulnerable patients' access to care, such as outreach, case management, translation/interpretation, referrals, transportation, eligibility assistance, health education, environmental health risk reduction, and health literacy.[26]

And finally, community health centers serve more than 24 million patients in over 9000 sites located across the United States.[27] This equals millions of clinical and non-clinical opportunities in the community health center system to reach out to, identify, and help trafficked patients.

Organizing our Interventions: A Public Health Prevention Model

A useful framework to help organize the healthcare system interface and response to human trafficking victims is through a public health prevention model. If we think about human trafficking as a disease, and the very real health harms as the symptoms of the patient, we can craft specific solutions to prevent and intervene during different stages of the exploitation.[28]

- Primary prevention aims to reach people who are not being trafficked, but are at risk. Interventions include issue awareness in communities, such as media campaigns, about human trafficking.
- Secondary prevention tries to reach victims in early stages of trafficking, before many health harms may have occurred. Interventions include early identification in various settings, like clinics or schools.
- Tertiary prevention occurs when a victim is being trafficked and is also experiencing physical, mental health or social harms. This prevention level is late stage and patients usually present in crisis—like Christina did that night. Interventions include acute medical visits to the Emergency Department, and are the most obvious opportunities for an immediate physical rescue.
- And finally, healthcare presents a unique opportunity to assist and enable long-term recovery for survivors who are no longer being trafficked, or sex trafficked minors who reach 18 years of age—but they may have serious health consequences

[24] National Association of Community Health Centers. (2014). A Sketch of Community Health Centers Chartbook 2014. Washington, DC. Retrieved November 25, 2015, from http://www.nachc.com/client/Chartbook-2014.pdf

[25] Association of Asian Pacific Community Health Organizations. (2015, October 30). Establishing Policies and Building Capacity of Community Health Centers to Address Human Trafficking Education Brief 2015. Retrieved November 25, 2015, from AAPCHO: http://www.aapcho.org/wp/wp-content/uploads/2015/10/AAPCHO-Human-Trafficking-Education-Brief-103015.pdf

[26] US Department of Health and Human Services Health Resources and Services Administration. (2015). Health Center Program Terms and Definitions. Retrieved November 25, 2015, from HRSA: http://www.hrsa.gov/grants/apply/assistance/Buckets/definitions.pdf

[27] National Association of Community Health Centers. About Our Health Centers. Retrieved November 25, 2015, from National Association of Community Health Centers: http://www.nachc.com/about-our-health-centers.cfm

[28] Chang, K., Sy, E., Vo, T., Nguyen, S., Thaing, M., Lee, J., & Quach, T. (2014, January/February). Reframing our Response: A New Approach to Care for Commercially Sexually Exploited Children. San Francisco Medicine, pp. 21-22.

from their exploitation. This stage is vital to healing, and to preventing revictimization; yet, it is often overlooked in policy and program development.

Table 1: Public Health Model—Prevention Levels [29]

Prevention Levels			Healthcare Professional Side	
			Disease: Human Trafficking	
			Absent	Present
Patient Side	Illnesses, Injuries, Impairments: Health Effects / Harms	Absent	Primary Prevention *Illness Absent* *Disease Absent*	Secondary Prevention *Illness Absent* *Disease Present*
		Present	Long-Term Care *Illness Present* *Disease Absent*	Tertiary Prevention *Illness Present* *Disease Present*

Recommendations for Shifting the System of Care for Victims to the Healthcare and Public Health System

I have discussed ways in which our current criminal justice based response to victims is suboptimal in providing the care they need, shown that the healthcare system is a crucial component in promoting the long-term rescue process of trafficked people, and highlighted the unique advantages of Federally Qualified Health Centers in a robust healthcare response to end human trafficking and support victims. As such, I offer several recommendations to help shift the system of care for victims from the criminal justice sector to the healthcare and public health system.

1. Create wrap-around care teams in community health centers across the nation focused on reaching out to and providing care for victims of human trafficking.
   a. Care teams include outreach workers, peer educators, social workers, therapists, case managers, interpreters, and clinical staff like doctors, nurses, medical assistants.
   b. A point person on the care team can be a victim advocate to law enforcement teams.
   c. Behavioral health and oral health should be included in care.
2. Create human trafficking specific programs within health centers to address the physical, mental health and social harms that result from being trafficked.
   a. Programs such as Banteay Srei should be created for victims of different types of human trafficking, with an emphasis on culturally relevant strategies to help those affected heal and fulfill their human potential.
   b. Programming should address all stages of human trafficking, from primary, secondary, and tertiary prevention, to long-term care.
3. Ensure that there is language accessibility for victims and cultural competence by professionals throughout all systems that engage with human trafficking victims, including community health centers.

[29] Chang, K. (2015, August 23). Integration of Primary Care and Behavioral Health for Human Trafficking Survivors in Patient-Centered Medical Homes. Institute of Violence, Abuse & Trauma: 20th International Summit & Training on Violence, Abuse & Trauma Across the Lifespan. San Diego, CA.

a. Community health centers provide a model for how to care for vulnerable populations. Their emphasis and priority on language access and cultural competency in care serves as a model that should be emulated across all sectors that work with human trafficking victims.

b. Language access is critically important for criminal justice teams in communicating with victims.

4. Ensure that non-clinical assistance enabling patients to access care is provided throughout community health centers.

a. Enabling services, according to the Health Resources and Service Administration's Bureau of Primary Health Care, are defined as non-clinical services that do not include direct patient services to increase a patient's access to health care, and should be part of a holistic healthcare response and model.

b. This type of enabling assistance is central to the community health center model and should be included in their reimbursements. Without this assistance, trafficked patients may never realize that help may be just around the corner at their neighborhood clinic. They may not be able to access case management needed to help them navigate reenrolling into school, finding safe housing, or making a police report against a trafficker.

5. Incorporate trauma-informed care training throughout all systems that engage with human trafficking victims, such as justice, law enforcement, and immigration. The healthcare system is no exception, and must approach patients from a trauma-informed perspective.

a. A robust healthcare response lies not only in the healthcare system—professionals from other sectors engaging with victims must be knowledgeable and aware of the physical, mental, emotional, and psychological effects of human trafficking, and how to work with and engage with victims. All victims have experienced some type of trauma. Understanding this is crucial.

b. When professionals understand how to partner with those affected, by approaching victims from a trauma-informed perspective, those victims will be better supported, more likely to begin a healing process and ultimately transitioned out of the control of the trafficker and dangerous situations.

6. Direct federal agencies to consider the health impacts (physical, mental, and social) of anti- trafficking policies on victims and survivors.

a. Develop a framework and methodology to evaluate the health impacts of anti-human trafficking policies across different agencies.

b. Create guidelines on minimizing harmful health impacts in federal agency policies.

Conclusion

Let's get back to Christina: Our team was successful in getting her treated at the hospital. After two months, her physical health in better shape, she was ready to be discharged. But guess where she was discharged to? She was discharged directly to the county jail.

We can and must do better.

In conclusion, currently labor and sex trafficking victims are accessing the healthcare system. There is a great opportunity to provide better care for victims. The criminal justice based response to victims in inadequate and the healthcare system is better suited to provide the healing care needed. Looking at human trafficking through a health lens

will allow us to better identify, treat, and follow-up with victims. Federally Qualified Health Centers are in the best position to deliver this care across the U.S. To do so, they need the resources to create prevention, early identification, and acute and long-term care models.

Let's not let another Christina suffer at the hands of traffickers, or our response.

Prepared Statement of Yaraslaba Garcia

Mr. Chairman and Members of the Commission. Thank you for this opportunity to testify at the United States Commission on Security and Cooperation in Europe. My name is Yaro Garcia. I am a Clinical Therapist at Abuse Counseling and Treatment Center in Fort Myers, Florida. I am also a member of the South West Florida (SWFL) Regional Human Trafficking Coalition. In my work I treat victims of both labor and sex trafficking who have been trafficked from other countries into the United States.

These men, women, and children are victims of serious abuse over a period of months, and many times years, during which they are held against their will. For example, in our practice we have encountered young women and girls who have been sold as many as 20 to 30 times a day to men who buy and use them for 15 to 20 minutes before they are sold to someone else. These repeated physical and sexual assaults day in and day out are the cause of severe physical and psychological health symptoms, many of which become chronic health issues.

This physical abuse (with and without objects) includes: punching, slapping, pushing, smothering, kicking, hair and ear pulling, biting, strangulation, choking, and sexual assault by the trafficker. The victims endure this abuse from both the traffickers and the buyers. Take the case of A*T, who was recruited at age 17. She was locked in a room without food to force her to continue "working." Whenever she complained, she was assaulted by the trafficker to get her to understand that this is what would happen to her if she complained again. She was trafficked for over 6 years.

Minor and adult victims of sex trafficking may also appear to be junkies or addicted to illegal and/or prescription drugs. This is part of the trafficker's method of control, creating even more vulnerability by keeping the victims using drugs. Because they have been forced to use from the time of recruitment, the victims may present in a health care facility as a drug user/abuser/addict and not a victim of sex trafficking. For example, in the case of B*T, who was 14 when she was recruited, was forced to use drugs the 2nd day with the trafficker, and every day after. The trafficker decided which drugs to give her and sometimes injected her with drugs at the request of the buyers. Sometimes she was given drugs to make her hyper and active because she was expected to serve dozens of buyers. Other times, when a buyer wanted something out of the ordinary, such as intercourse with a beer bottle or other forms of paraphilic behavior, she was given drugs that would numb her and make her unconscious while the buyers repeated assaulted her. She was trafficked for 5 years.

Because of repeated sexual exploitation, physical abuse and forced drug use the victims end up having at least one or repeated encounters with health providers while being handled by traffickers.

It is important to know that in these encounters, when seeking health care, minors and adult victims of sex trafficking are taught to rehearse a story that they present to medical staff. By the time they end up in the health care system they might have formed a complex bond with the trafficker. In many cases, the victim is afraid of the trafficker and what he will do to her if she doesn't follow his instructions to the letter. In other cases, this bond leads to the victim wanting to protect, be afraid, and/or be obedient enough, to follow the directions given by the trafficker, saying that they are prostituting on their own, that they have been careless about their sexual activities, or, simply, that they are in a relationship and don't understand why they are having these symptoms.

It is essential that healthcare providers are educated to understand that trafficking victims may claim voluntary self-prostitution in order to explain the symptoms of abuse. Because of the complexity of the trauma, the victims may protect the trafficker and rehearse what they have been told to say.

We are not asking the intake staff, nurses, doctors, and health social workers to become investigators or even experts. We need them to understand the unique aspects of complex trauma, bonding between victim and perpetrator as it happens in human trafficking, and the incremental disclosure process unique to victims of trafficking. This understanding MUST lead to the medical personnel seeking appropriate help for the victims.

To seek appropriate help, what is needed is protocols in place that must be strictly follow even when a patient is denying being forced, or coerced.

Assuming it is just prostitution increases the risk of a victim not being helped and being discharged to perpetrator. Signs, symptoms and self-disclosures of prostitution-related activity should all be treated the same by the medial professionals. Any of the previously mentioned signs should be considered by medical personnel enough to make an additional phone call to the appropriate state, local, and/or federal law enforcement or Non-Governmental Organization in the nearby area that can respond. In the case of adults, the call should most likely be made to an NGO first, as law enforcement may be perceived as a physical and mental threat rather than as a protective service.

All hospital personnel that come in contact with patients should understand human trafficking. There should be at least one individual in each department that has been uniquely trained to be able to interview and talk to a potential victim.

Specific ways of interviewing have been found to be more successful than others when helping trafficking victims disclose. Using the word "help" may trigger the victim's fear. It has been more effective to say that "other medical personnel are coming in to talk" as part of their "regular protocol." It is essential that this appointed individual understands that human trafficking victims go through an incremental disclosure process and asking direct questions about their situation may not reveal any information about being trafficked.

Protection services include partnerships with other agencies. Here are some examples:

- Human trafficking services need to be survivor-centered in all aspects. Survivor security must be safeguarded as the needs they may present are addressed.
- All personnel must have access to appropriate national, state, or local hotline that can connect hospital personnel to services for minors and adult victims. In most states there is a difference in who will respond to a minor or adult victim. These differences must be clarified to the personnel in every health care facility.
- Medical personnel need to be able to answer victim questions about the process. It is no longer ok for medical staff to not respond correctly due to ignorance. They must know who to call and how the response process goes to be able to explain to victims.
- It is no longer ok for medical staff to discharge without creating for the victim some form of connection, and/or providing additional assistance outside of medical care. The potential victim must at least leave with some form of information regarding services or help available.

- Survivors may do better when being visited by an advocate/counselor/therapist at the emergency room and/or hospital rather than law enforcement. Law enforcement should be involved once the victim has developed some type of trust or has accepted support and is ready to talk about what happened in the trafficking environment. The process of getting law enforcement involved may take hours, days, or months.
- Sound protection starts with proper attitude training for first responders. Coordinated training sets the basis for how the victim may react and feel about future law enforcement and in some instances their experience with an NGO, local police, state and federal jurisdiction.
- Also, as previously discussed, protection efforts need to include a best practice, survivor-centered interview process which takes complex trauma into account.
- Inter-agency and law enforcement cooperation is critical because the process of internal disclosure, which includes development of trust over a long period of time, conflicts with many law enforcement and agency protocols and resources. Each law enforcement entity needs to have someone available who is trained to talk to trafficking victims.
- Victim interviewing techniques should be directed towards the comfort of the victim and collaterals with which the victim has developed some beginning level of trust.

When protection procedures in the health care system are consistent, honest, and reliable, the victim can feel supported and encouraged throughout the internal disclosure process, and agree to receive help at that moment or later on. This can surmount current difficulties in supporting survivors over time and through the physical and psychological difficulties of stepping out of the trafficking environment, and the post-trafficking process of getting well.

PREPARED STATEMENT OF DR. JORDAN GREENBAUM

Good afternoon, Chairman Smith, co-chairman Wicker and distinguished Commission members. I am grateful for the opportunity to testify before you today. In addition to my oral testimony I would like to submit written testimony into the record.

My name is Jordan Greenbaum. I am a child abuse physician at the Stephanie Blank Center for Safe and Healthy Children at Children's Healthcare of Atlanta, and a consultant for the International Center for Missing and Exploited Children. The Blank Center is a hospital-based child protection program that provides medical and behavioral health services to suspected victims of abuse and their families. The International Centre for Missing and Exploited Children is a non-governmental organization that works to combat child abduction and child sexual exploitation globally. As the protection of children from victimization requires a coordinated, comprehensive, and global approach, the International Centre assists countries in creating national solutions through public-private partnerships; establishing a global resource to prevent child-sexual exploitation; creating national centers and affiliates worldwide; and providing training to professionals working on child sexual exploitation. Through its Global Health Initiative, the Centre seeks to apply a public health model to child sexual exploitation, to promote changes in medical education regarding exploitation, to facilitate research on the health of victims and the long term impact of victimization, and to assess current treatment modalities for victims. I would like to provide testimony today on the health consequences of sex and labor trafficking, especially involving minors.

As you know, reliable estimates of the incidence and prevalence of human trafficking are lacking, but the best existing estimates suggest that millions of adults and children are involved worldwide.[1] Child trafficking is truly a global phenomenon. According to a recent study by the United Nations Office on Drugs and Crime,[2] 33% of the 40,000 cases of human trafficking identified in 128 countries involved children. As emphasized by the International Centre for Missing and Exploited Children, a missing child is a vulnerable child. Consider the massive numbers of children who run away from home, who become separated from parents while fleeing turbulence in their home country, who leave home to seek a job in the United States so they can feed their impoverished family. These children are easy prey for traffickers, who offer them a place to stay, a free meal, or a ride to the next city. Victims of human trafficking may experience a plethora of adverse physical and behavioral health sequelae, including traumatic injury from sexual and physical assault, work-related injury, sexually transmitted infections, non-sexually transmitted infections, chronic untreated medical conditions, pregnancy and related complications, chronic pain syndromes, complications of substance abuse, and malnutrition and exhaus-

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[1] International Labour Organization (2012). ILO 2012 Global estimate of forced labour: Executive summary. Available at: http://www.ilo. org/wcmsp5 /groups/public/-ed-norm/- declaration/documents/ publication /wcms-181953 .pdf Accessed Dec 23, 2014.

[2] UNODC, Global Report on Trafficking in Persons 2012. (United Nations publication, Sales No. E.13.IV.1) (2012) Accessed Nov. 22, 2013. Available at: http://www.unodc.org/ documents/data-and- analysis/ glotip /Trafficking -in-Persons-2012-web.pdf.

[3] Willis BM LB. Child prostitution: Global health burden, research needs, and interventions. Lancet. 1996;359:1417–1422.

[4] Estes RJ, Weiner NA. The commercial sexual exploitation of children in the U.S., Canada and Mexico. Center for the Study of Youth Policy, University of Pennsylvania, Accessed at http://www.sp2.upenn.edu/ restes/CSEC-Files/Complete-CSEC-020220.pdf on 7/7/122002.

tion. [3,4,5,6] Mental health consequences include depression with suicide attempts, flashbacks, nightmares, insomnia and other sleep problems, anxiety disorder, hypervigilance, self-blame, helplessness, anger and rage control problems, dissociative disorders, post-traumatic stress disorder, and other co-morbid conditions.[7,8]

Despite the criminal nature of human trafficking and the desire of traffickers to elude detection, research consistently shows that victims do have contact with medical professionals. In a study of adult and adolescent female sex trafficking survivors, 87.8% had seen health care providers (HCP) during their period of exploitation.[9] In another study of runaway and homeless youth involved in commercial sexual exploitation, over 75% had seen a provider within the past 6 months.[10] But we also know that victims rarely self-identify when seeking medical care and may even deny victimization out of fear of the trafficker, lack of perception of their victim status, shame, humiliation, and other reasons.[11] Therefore, it is incumbent on the HCP to recognize signs of at-risk youth and adults, ask questions appropriately and provide trauma-sensitive care to identified victims.

Arguably, all adolescents are at risk for human trafficking simply by virtue of their age and developmental status. This is a period of risk-taking and impulsive behavior, when the part of the brain responsible for thoughtful consideration of risks and benefits, of delaying gratification, of comparing current possible outcomes with past consequences is still relatively immature. In contrast, that part of the brain that craves rewards and immediate satisfaction is quite active. Adolescents want to break away from parents, gain peer acceptance, and begin to form sexual relationships. All of these factors increase their vulnerability to manipulation and exploitation.

While quantitative, peer-reviewed research on child trafficking is relatively scant, available evidence tells us that certain youth in the U.S. and around the world face additional risk factors. Homelessness, physical abuse and family dysfunction, sexual abuse,

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[5] AAP Clinical Guidelines: Greenbaum J, Crawford-Jakubiak JE, Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: Health care needs of victims. Pediatrics, 2015;135(3):566-574.

[6] Smith L, Vardaman S, Snow M. The national report on domestic minor sex trafficking: America's prostituted children. In: International SH, ed. Accessed at http://sharedhope.org/ wp- content/uploads /2012/09/ SHI_National __Report __on__DMST __2009 .pdf on 7/7/132009.

[7] Zimmerman C. Stolen smiles: A summary report on the physical and psychological consequences of women and adolescents trafficked in Europe. London School of Hygiene and Tropical Medicine; 2006.

[8] Choi H, Klein C, Shin MS, Lee HJ. Posttraumatic stress disorder (PTSD) and disorders of extreme stress (DESNOS) symptoms following prostitution and child abuse. Vio Against Women. 2009;15(8):933–951.

[9] Lederer L, Wetzel C. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Annals of Health Law. 2014;23:61–91.

[10] Curtis, R., Terry, K., Dank, M., Dombrowski, K. and Khan, B. (2008) The Commercial Sexual Exploitation of Children in New York City, Volume One, The CSEC Population in New York City: Size, Characteristics, and Needs Final report submitted to the National Institute of Justice. New York, NY: Center for Court Innovation and John Jay College of Criminal Justice.

[11] AAP Clinical Guidelines: Greenbaum J, Crawford-Jakubiak JE, Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: Health care needs of victims. Pediatrics, 2015;135(3):566-574.

[12] Estes RJ, Weiner NA. The commercial sexual exploitation of children in the U.S., Canada and Mexico. Center for the Study of Youth Policy, University of Pennsylvania, Accessed at http://www.sp2.upenn.edu/ restes/CSEC__Files/Complete__CSEC__020220.pdf on 7/7/122002.

poverty, child neglect, substance abuse, social upheaval, gender bias and minority status increase the risk of child exploitation.[12,13,14]

Information on risk factors may be very useful in identifying potential victims and additional quantitative research may assist in creating brief screening tools to be used in the health care setting. At Children's Healthcare of Atlanta we recently conducted a study to describe characteristics of child sex trafficking victims and to develop a screening tool to identify victims among a high risk adolescent population. We evaluated female youth aged 12–18 years who presented to one of three metropolitan pediatric emergency departments or one child protection clinic, and who were identified as victims of sex trafficking. We compared them to similar-aged patients with allegations of sexual assault/sexual abuse (ASA) without evidence of trafficking. The two groups differed significantly on 16 variables involving reproductive history, high-risk behavior, sexually transmitted infections, and prior experience with violence. A 6-item screen was constructed and a cut-off score of 2 positive answers was determined to have a 92% sensitivity for identifying trafficking victims. A child with a negative screen had a 97% likelihood of NOT being a victim. Thus, a short, 6-item questionnaire effectively distinguished victims of alleged sex trafficking from those with reported sexual assault/abuse and no evidence of trafficking. Our study results need to be validated with other adolescent populations from outside the Atlanta metropolitan region, as regional differences may exist. Currently we are conducting a multi-site study of youth presenting to a variety of medical settings, with and without previous documentation of sex trafficking activity.

However, health care providers need more than a screening tool. They need to know when to use it, when to consider the possibility of human trafficking. Several months ago I was asked to evaluate an infant with a leg fracture because there were concerns the child had been physically abused. Initially the child was the sole focus of my concern. But as the evaluation progressed I realized that the child was not the only potential victim. The mother was young, homeless, without job skills, and was almost certainly being trafficked by her boyfriend. I only realized this as we discussed her living situation and her tumultuous past history. Thus, one evaluation for victimization turned into two. It was every bit as important to assess the mother's safety as it was to ensure the child's. Human trafficking may involve a child, the child's parents, or the entire family. The HCP needs to consider these possibilities in all patient interactions.

Beyond knowing when to worry and what questions to ask, HCPs need to know how to interact with potential victims in a way that does not re-traumatize them, a manner that encourages honesty and trust. Trauma-informed care is essential. This approach to patient care involves the medical provider recognizing the real possibility that a patient has experienced significant trauma, that this trauma may influence how the patient thinks, acts and responds to others, and that questioning of the patient needs to be culturally appropriate and very sensitive in order to minimize the likelihood of triggering additional anxiety and fear. Victims of human trafficking have almost certainly experienced repetitive, severe, complex trauma and this, combined with their potential distrust of authorities, feelings of humiliation and shame, as well as significant cultural and lan-

[13] Walls NE, Bell S. Correlates of engaging in survival sex among homeless youth and young adults. J Sex Res,2011;48(5):423–436.

[14] Konstantopoulos WM AR, Alpert EJ, Cafferty E, McGahan A, et al. An international comparative public health analysis of sex trafficking of women and girls in eight cities: Achieving a more effective health sector response. J Urban Health: Bulletin of the NY Aca Med. 2013;90(6):1194–1204.

guage barriers, may make interviews of patients quite challenging. It may not be easy for a health care provider to respond consistently with support and understanding when a patient appears hostile, disinterested in receiving help, protective of the trafficker, or unwilling to engage. A medical provider may not understand that these behaviors are related to the patient's fear, anxiety and trauma, and may react negatively. Yet, a calm, nonjudgmental, supportive approach is critical and may be the only way to build the trust needed for patient disclosure and the possibility of intervention. But such a trauma-informed approach must be learned and is not in the repertoire of many medical providers. This needs to change.

Multiple studies have demonstrated convincingly that many HCPs lack the knowledge and skills to identify and assess victims. In one study 63% of medical providers reported never having received training on how to identify human trafficking victims. Those who had training were significantly more likely to have confidence in their ability to do so and to have encountered a victim in the past.[15] Health care providers who participated in the study indicated that the greatest barriers to victim identification were a lack of training (34%) and lack of awareness of sex trafficking (22%). Further, a study of trafficking survivors demonstrated that the failure of HCPs to identify victims was often accompanied by behavior that hurt and humiliated victims, making it clear that a trauma-informed approach is not uniformly practiced.[16]

More and more training modules are being designed and implemented across the country. But health professional training must overcome several challenges. First, HCPs are constantly faced with the need to learn about new conditions, new procedures, and new research, from new drugs to combat human immunodeficiency virus, to the epidemiology of domestic violence, to the latest developments in medications for diabetes mellitus and heart disease. Human trafficking is one of many critical topics that must compete for the attention of professionals. Second, the vast majority of training curricula on human trafficking have not undergone formal evaluation to show that they effectively increase knowledge, influence beliefs and change provider behavior. Such evaluation is critical before we invest heavily in efforts to train hundreds of thousands of health professionals. Resources are too scarce to be used on unproven strategies.

There are some exceptions to this. One group randomized controlled trial of emergency department providers involved delivering focused education on human trafficking to physicians, nurses, social workers and other emergency department personnel. Results demonstrated significant increases in knowledge about trafficking, knowledge about who to call for victim services and an increase in the proportion of participants suspecting they had encountered a victim, relative to the group of providers who had not yet received the training.[17] At Children's Healthcare of Atlanta, we developed a 6-part webinar series for health care professionals across the country addressing child sex trafficking. The series was delivered repeatedly during 2014. Participants attending one or more webinars were asked to complete a post-test survey and a 6-month follow up survey, which elicited information about knowledge, beliefs and practices related to child trafficking. While the

[15] Beck ME, Lineer MM, Melzer-Lange M, et al. Medical providers' understanding of sex trafficking and their experiences with at-risk patients. Peds, 2015;135(4):e895.

[16] Miller C. Child sex trafficking in the health care setting: Recommendations for practice. Paper presented at 25th International Nursing Research Congress;July 27, 2014;Hong Kong. From, Stoklosa H, Grace aM, Littenberg N. Medical education on human trafficking. Am Med Assoc J Ethics,2015;17(10):914–921.

[17] Grace AM, Lippert S, Collins K, et al. Educating health care professionals on human trafficking. Pediatr Emerg Care. 2014;30(12):856–861.

webinar series was advertised as targeting HCPs, we had many professionals outside the medical field attending the sessions, as well. Survey questions comparing pre vs. post-webinar conditions documented significant changes in beliefs about child sex trafficking, including an increase in the proportion of participants strongly agreeing that

- human trafficking is a significant problem in their community,
- the language used to describe commercial sexual exploitation can shape others' beliefs and opinions,
- prostituted children are victims of child abuse and
- sex trafficking is associated with negative health outcomes. Further, in the 6 month follow up survey we found
- a significant increase in the percentage of webinar participants asking adolescents about risk factors related to sex trafficking, representing an important and persistent change in behavior.
- 64% of participants had used information from the webinars when interacting with youth,
- 75% had used it when interacting with the public, and
- 79% had used information from the webinars in their work-related duties.

Thus, the webinars were associated with a significant increase in overall training competencies and the knowledge change was found to be sustainable in a 6-month follow up period. There was measurable change around screening, referrals and knowledge-sharing after webinar participation.

An important finding in our study highlights yet another challenge to educating busy medical professionals. The vast majority of providers we reached with our webinars were nurses; very few physicians participated. This is almost certainly due to the timing of the webinars: few physicians have time during the day to attend a webinar, and targeting a national audience means that any webinar may or may not be scheduled at a convenient time, given the multiple U.S. time zones. We have addressed this challenge by converting 5 of the 6 webinars into online, self-paced modules. These are proving much more effective in reaching the physician audience, especially as free continuing medical education credits are offered.

An important finding in our study highlights yet another challenge to educating busy medical professionals. The vast majority of providers we reached with our webinars were nurses; very few physicians participated. This is almost certainly due to the timing of the webinars: few physicians have time during the day to attend a webinar, and targeting a national audience means that any webinar may or may not be scheduled at a convenient time, given the multiple U.S. time zones. We have addressed this challenge by converting 5 of the 6 webinars into online, self-paced modules. These are proving much more effective in reaching the physician audience, especially as free continuing medical education credits are offered.

However, webinars and online modules cannot substitute for in-person training with role playing and mentoring. Didactic teaching, especially if supplemented with toolkits containing lists and algorithms are very helpful but HCPs need to feel comfortable with patient interactions if they are to fundamentally change their behavior and actively screen for human trafficking victims. Reaching large numbers of providers in this manner is challenging. Ultimately, it may best be accomplished by integrating a trauma-informed care model into medical and nursing student training, to be implemented when students

are learning basic medical history and physical exam skills. Alternatively, residents could receive training during their required didactic teaching conferences.[18] Such training would be extremely useful to all practitioners when they interact with patients who may have experienced any kind of significant trauma, be it a major medical procedure, a motor vehicle crash or any sort of recent violent event. That is, the skills needed to interact with a traumatized trafficking victim are also useful when interacting with victims of other major trauma, and are an essential part of the arsenal of clinical tools used by effective HCPs.

The role of any HCP extends beyond recognizing and treating illness and injury. We are tasked with working with patients and families to prevent illness and injury and to provide anticipatory guidance to those at high risk. In the area of human trafficking, health care professionals need to be educated about risk factors and early signs, then take that knowledge and use it to counsel children, parents and adult patients to avoid situations that increase vulnerability. Discussing internet safety may save a child from sexual exploitation; discussing common recruitment techniques involving false advertising for jobs may save an adult from labor trafficking. In addition, medical professionals need to use their knowledge to help families obtain resources that address current vulnerabilities such as homelessness, substance abuse, domestic violence, and poverty. They need to look beyond the confines of their offices and clinics to identify community resources that may help patients and families.

In general, HCPs are not trained to actively seek relationships with outside, nonmedical organizations and agencies, nor do many providers feel comfortable in this role. Yet this is a critical step in the process of caring for patients and families involved in human trafficking. We must assist HCPs in adopting this change in behavior.

We need to encourage them to identify community agencies and organizations, and build relationships with governmental and nongovernmental investigators and service providers so that victims may obtain the help they need. The HEAL Trafficking organization (Health Professional Education, Advocacy, and Linkage) is an international organization of professionals that addresses human trafficking through a health care lens, serving as a resource on health for the broader anti-trafficking community. Currently HEAL is developing a protocol that will provide step-by-step assistance to HCPs who want to work with their community to build a multidisciplinary anti-trafficking team. Such a tool will help HCPs bridge the gap between medical clinics/hospitals and critical community services that may provide for the long term needs of trafficking survivors.

There are other ways HCPs can, and should, work to prevent human trafficking. Once again moving beyond the confines of clinic and hospital, HCPs can actively support community efforts to end trafficking. They can serve on the advisory boards of trafficking organizations or programs that address risk factors for exploitation. They can support faith-based organizations in their anti-trafficking initiatives, publicly support victim-serving organizations, and refer patients and families to these programs. They can work with the media to increase public awareness regarding human trafficking and available community and national programs to combat exploitation. They can encourage their own

[18] H-65.966: Physicians response to victims of human trafficking. Policy of American Medical Association. No date given. Accessed at https://www. ama-assn.org/ssl3/ ecomm/PolicyFinderForm. pl?site=www.ama-assn.org&uri =%2Fresources%2Fhtml%2FPolicyFinder %2Fpolicyfiles%2FHnE%2FH- 65.966.HTM on July 14, 2015.

professional organizations to advocate for anti-trafficking policies and initiatives. And of course, they can vote.

Several national medical organizations have recognized the potentially powerful role of the medical provider in victim service, advocacy and prevention, and have published policy statements and reports calling on health care professionals to raise their awareness of human trafficking issues, and obtain resources for patients. The American Medical Women's Association further advocates for patient access to coordinated medical care and other support services, appropriate medical treatment, as well as advocating for anti-trafficking measures in the community.[19] Such policy statements and clinical reports by the American Medical Association, American Medical Women's Association, American College of Obstetrics and Gynecology, the American Academy of Pediatrics[20,21,22] and others are laudable but efforts should not stop here. These and other professional medical organizations need to continue to advocate for recognition of international and domestic sex and labor trafficking as serious threats to the health and development of adults and children in the United States and around the globe. That is, human trafficking is not only a criminal issue, not only a social issue, it is a public and private health issue. The physical and emotional health consequences experienced by victims have far-reaching ramifications for the general population. Medical organizations need to advocate for public policy that recognizes human trafficking as a gross violation of human rights and a violation of the Convention on the Rights of the Child.[23] They need to encourage government efforts to increase availability and use of victim services, including T- and U-visas by victims and their families. They need to support public policy and legislation that recognizes exploited adults and children as victims rather than offenders, as all too often victims are charged with prostitution, petty theft, immigration violations and other crimes associated with their exploitation. Professional medical organizations need to advocate for provider education on adult and child, sex and labor trafficking, including both domestic and international trafficking. Such advocacy should include recommendations that HCPs working in the United States and overseas use a victim-centered, age- and culturally appropriate and trauma-informed approach to patient care, and that they become actively engaged in supportive referral networks for trafficking survivors. Healthcare providers need to be aware of processes available for immigration assistance, including T- and U-visas, and other federal programs. Finally, medical organizations need to support and encourage research on domestic and international human trafficking, so that screening methods, assessment tools, treatment protocols (especially rigorously tested mental health interven-

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[19] Position paper on the sex trafficking of women and girls in the United States. American Medical Women's Association, May 2014. Accessed at https://www.amwa-doc.org/ wp-content/uploads/2013/12/AMWA- Position-Paper-on-Human-Sex-Trafficking—May-20141.pdf on July 16, 2015.

[20] 5. AAP Clinical Guidelines: Greenbaum J, Crawford-Jakubiak JE, Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: Health care needs of victims. Pediatrics, 2015;135(3):566-574.

[21] H-65.966: Physicians response to victims of human trafficking. Policy of American Medical Association. No date given. Accessed at https://www.ama-assn.org/ssl3 /ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2 Fresources%2Fhtml%2FPolicyFinder%2 Fpolicyfiles%2FHnE%2 FH-65.966.HTM on July 14,2015.

[22] Human Trafficking. Committee opinion of the Committee on Health Care for Underserved Women of the American College of Obstetricians and Gynecologists, Sept 2011. Accessed at http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for- Underserved-Women/Human-Trafficking on July 17, 2015.

[23] United Nations Human Rights, Office of the High Commissioner for Human Rights. Convention on the Rights of the Child. Available at: http://wwwohchrorg/en/ professionalinterest/pages/crcaspx 1990

tions), and prevention efforts may be effective and evidence-based. We do not have the time or the financial resources to support myriad ideas and strategies that lack reliable evidence of effectiveness.

ICD Codes for Human Trafficking

The World Health Organization's (WHO) International Classification of Diseases (ICD) is a system used by HCPs to code all symptoms, diagnoses and procedures related to health care. The ICD codes are important because they are used to monitor incidence and prevalence of health problems and provide critical data for monitoring world health. Currently, the ICD-10 (International Classification of Diseases-10th Edition) provides diagnostic codes for sexual assault of adults and minors, domestic violence and several types of child maltreatment, including neglect, physical abuse, psychological abuse and sexual abuse. It lacks codes for human trafficking/commercial exploitation.

As discussed above, victims of human trafficking may experience myriad adverse physical and behavioral health sequelae. These effects have been demonstrated in victims from diverse geographic regions, reflecting the global nature of exploitation and the similarity of harsh experiences jeopardizing the health and well-being of victims everywhere. [24] [25]At present, the incidence of the sequelae for each type of trafficking/exploitation, the risk factors for the sequelae, and the cost of treatment are unknown. There is little more than anecdotal data on the relationships between the types of exploitation or how sequelae may vary with the relationship of victim with exploiter. With specific ICD codes for sexual exploitation/trafficking these important questions and others may be answered. Codes will help quantify how many exploited persons are identified in healthcare settings and facilitate chart reviews for additional research information. New ICD codes would allow access to critical knowledge that could drive global health efforts and prevention strategies to address these severe human rights violations.

Currently, the World Health Organization (WHO) is developing the new ICD-11 coding system and this effort is in its beta phase until 2017. During this period proposals for code revisions and new codes are accepted and reviewed by stakeholders. In Dec 2014, the International Centre for Missing and Exploited Children initiated a proposal to the WHO to adopt specific ICD-11 codes for sexual exploitation of adults and minors. A similar proposal was submitted to the National Center for Health Statistics to update ICD-10. These codes specifically distinguish various types of sexual exploitation (e.g. exchanging a sex act for something of value; prostitution controlled by a 3rd person; child pornography; cyber enticement for sexual purposes; and exploitation through a sex-oriented business, not prostitution), and types of perpetrators (spouse/partner, parent, unrelated caregiver, etc.). Such detail will allow comparison of the incidence of various types of exploitation, the health-related complications associated with the various types, and the potential impact of various perpetrator-victim relationships on health complications and treatment outcomes. It will also provide data on the health-related cost of human trafficking in the United States and elsewhere. Specific ICD codes for human trafficking will support the initiative of the SOAR to Health and Wellness Act by providing "a reliable

[24] Konstantopoulos WM AR, Alpert EJ, Cafferty E, McGahan A, et al. An international comparative public health analysis of sex trafficking of women and girls in eight cities: Achieving a more effective health sector response. J Urban Health: Bulletin of the NY Aca Med. 2013;90(6):1194–1204.

[25] Oram S SH, Busza J, Howard LM, Zimmerman C. Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: A systematic review. PLoS Med. 2012;9(5):e1001224.

methodology for collecting and reporting data on the number of human trafficking victims identified and served in health care settings."

In early 2015, HEAL Trafficking initiated a similar proposal to the WHO to adopt specific ICD-11 codes for labor trafficking of adults and minors. These codes distinguish among several forms of labor trafficking (e.g. agriculture, mining/logging; food processing/packaging industry, etc.) and various types of perpetrators (e.g. spouse; parent; unrelated caregiver; stranger, etc.). The International Centre and HEAL Trafficking are eager to see the two proposals for sex and labor trafficking accepted and are seeking support from other stakeholders.

In conclusion, new information makes it clear that human trafficking is a public and private health issue, that trafficking victims are at risk for multiple physical and mental health problems, and that health providers play a critical role in identifying trafficking victims. Health care providers need training to understand human trafficking and recognize potential victims when they encounter them. They need to know how to respond appropriately, including using a trauma-informed approach, and making critical reports and referrals to service providers. And they need contribute to data collection and research. This training needs to take place here in the United States, but also in other countries, for trafficking is a transnational problem and will require transnational solutions.

Recommendations:

1. Develop curricula on human trafficking to be delivered to practicing health care providers in the form of online modules, on-site training and webinars. Obtain outcomes studies measuring efficacy of curricula in impacting participant beliefs, attitudes, knowledge and behavior related to human trafficking. Training should include

- Definitions of human trafficking, risk factors and possible indicators of victimizationA trauma-informed approach to interacting with potential victims
- Appropriate referrals for victims, including common immediate and long term needs of survivors (domestic and transnational victims)
- Appropriate reporting procedures (including discussion of mandated vs. voluntary reporting)
- Specific information on federal programs such as T- and U-visas
- A discussion of HIPPA as it applies in the context of suspected human trafficking

2. Incorporate education on human trafficking into curricula of health professionals-in-training (including but not limited to future physicians, nurses, physician assistants, advance practice nurses, medical social workers and mental health professionals). Conduct formal outcomes evaluations on training curricula.

3. Support research that provides an evidence base for development of screening tools, effective interview techniques, and successful treatment interventions for victims/survivors, with a special focus on mental health treatment.

4. Support acceptance by the World Health Organization of ICD-11 codes for sexual exploitation and forced labour exploitation.

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