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To cite this article: Holly G. Atkinson, Kevin J. Curnin & Nicole C. Hanson (2016) U.S. State Laws Addressing Human Trafficking: Education of and Mandatory Reporting by Health Care Providers and Other Professionals, Journal of Human Trafficking, 2:2, 111-138, DOI: 10.1080/23322705.2016.1175885

To link to this article: http://dx.doi.org/10.1080/23322705.2016.1175885

Published online: 31 May 2016.

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U.S. State Laws Addressing Human Trafficking: Education of and Mandatory Reporting by Health Care Providers and Other Professionals

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ABSTRACT

Human trafficking is a global problem and constitutes a grave human rights violation, affecting more than 20 million individuals worldwide. This brutal crime often results in both short- and long-term physical and psychological harm to its victims. We provide a systematic review of U.S. laws that address education about human trafficking and/or mandatory reporting requirements that affect healthcare providers and other professionals across the United States. Thirteen U.S. states now have laws that address education about human trafficking, while seven specifically require mandatory reporting of minors who are victims of trafficking. The findings are instructive to not only practicing physicians and other professionals, who are now mandated reporters of trafficking victims in some states, but also to regulatory and legislative bodies contemplating enacting such laws in an effort to address trafficking.

KEYWORDS

Child sexual abuse; labor trafficking; legislative review; mandatory education; mandatory reporting; sex trafficking

Background

Human trafficking, the act of causing a person to be controlled and exploited for sex or labor or services through fraud, force, or coercion, is a grave human rights violation affecting an estimated 20.9 million or more individuals worldwide (International Labor Organization, 2015). Due to the hidden nature of human trafficking and the difficulty in collecting reliable data, accurate statistics on the incidence and prevalence of trafficking currently do not exist. Nevertheless, estimates indicate that, worldwide, women and girls account for the majority of labor-trafficked victims, with 11.4 million (55%) compared with 9.5 million (45%) men and boys. Women and girls also account for upwards of 85–90% of victims of sex trafficking (International Labor Organization, 2015).

In the United States, trafficking has been reported in cities, suburbs, and rural areas in all 50 states and in Washington, DC (National Human Trafficking Resource Center, 2015). Approximately half of trafficking victims in the United States are believed to be minors (U.S. Department of State, 2007). One study found that the average age of entry into the commercial sex industry for girls is around 12 to 14 years old, while for boys it is younger at 11 to 13 years old (Estes & Weiner, 2001). Another more recent study found the age of entry for young people’s initial sex trade experience ranged from 10 to 17 years of age, with a median age of 15 (Gibbs, Walters, & Lutnick et al., 2014). Many victims have suffered abuse and neglect as children and are runaways or homeless, or have a history of involvement in the juvenile or criminal justice system (Institute of Medicine [IOM] and National Research Council [NRC], 2013). Many victims also have
histories of past sexual abuse (Smith et al., 2009). Investigations have revealed that the majority of identified trafficked victims have also had some interaction with child protective services.\(^1\)

Today, human trafficking is a multibillion-dollar global criminal enterprise. According to the U.S. Department of Justice, it is one of the world’s fastest growing crimes (Bureau of Justice Assistance, U.S. Department of Justice, 2015). It is a complex problem tied to social, cultural, and economic issues. Factors fueling trafficking include men’s demand for paid sex, traffickers’ ability to generate recurring revenues and to reap high profits, and law enforcement’s failure to arrest and prosecute perpetrators. Perpetrators can be as close to their victims as family members or as distant as heads of international criminal organizations. They exploit persons already made vulnerable by an array of social, cultural, economic, and political issues, including gender and ethnic discrimination, a history of abuse or neglect, poverty, globalization, social instability, corruption, lawlessness, and military conflict. All of these factors can, in turn, hamper law enforcement (Kara, 2009).

Trafficking is a particularly brutal and dehumanizing crime. Victims of trafficking are often deprived of their most basic human rights: life, liberty, and security of person; freedom from slavery or servitude; freedom from torture and/or cruel, inhuman, or degrading treatment; a standard of living adequate for health and well-being; medical care; freedom of movement; and freedom of expression.\(^2\) The range of abuses and traumas they endure result in multiple acute and long-term physical and psychological problems. Adverse physical outcomes include injuries from violence (bruises, concussions, fractures, lacerations, perforations of vagina and rectal walls), infections (sexually transmitted diseases (STDs), pelvic inflammatory disease (PID), and HIV/AIDS), gynecologic issues (repeat unintended pregnancies/abortions, lacerations, hemorrhaging), untreated chronic conditions (diabetes), malnourishment, and poor dental care (Kiss et al., 2015; Lederer & Wetzel, 2014; Oram, Stöckl, Busza, Howard, & Zimmerman, 2012). Adverse psychological outcomes include complex trauma-related posttraumatic stress disorder (PTSD), anxiety disorder, major depressive disorder, suicidal ideation, psychosomatic illness, trauma-bonding and Stockholm syndrome, drug/alcohol addictions, and eating disorders (Oram, Khondoker, Abas, Broadbent, & Howard, 2015; Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008; Zimmerman et al., 2008).

Beyond the individual human cost, human trafficking is also a serious public health issue, placing a greater demand on the health care system and thereby increasing the financial costs associated with its numerous sequelae (U.S. Department of Health and Human Services, Administration for Children and Families, 2015). Other societal costs include increased utilization of law enforcement and the legal system, as well as greater demands for resources provided by the federal and state governments and numerous nongovernmental organizations.

Traffickers look upon their victims as “product” and thus want to prolong their product’s value. When a trafficked person is ill or injured, as so often happens given the day-to-day deprivations, the trafficker might take the individual to a hospital or clinic for treatment. Studies conducted with both domestic and foreign survivors of trafficking in the United States suggest that 28–88% of survivors were seen by a health care provider at least once during the time they were trafficked (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Lederer & Wetzel, 2014). But trafficking victims are often unable or unwilling to self-identify—physical, emotional, and/or psychological abuse and deep fear and shame prevent it. Social, cultural, and language barriers, as well as mistrust of authority figures also hinder self-identification (Baldwin et al., 2011). Furthermore, trafficking victims often do not recognize their victim status due to a variety of reasons, including the development of trauma bonding between victim and exploiter (Smith et al., 2009).

Health care providers and other professionals have important roles to play in identifying and caring for victims, as well as in referring them to additional support services for assistance with their various needs, including shelter, food, clothing, job training, and legal and educational services (American Professional Society on the Abuse of Children, 2013). However, even among health care providers, most have not been trained and thus are unprepared to make appropriate interventions and referrals on behalf of trafficking victims (Beck et al., 2015; Viergever, West, Borland, & Zimmerman, 2015).
**Brief legal history**

In 2000, the United Nations General Assembly adopted the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (“The Palermo Protocol”). The Palermo Protocol commits signatory countries, of which there are now 166, to undertake initiatives to prevent and combat human trafficking, to protect and assist victims, and to cooperate with other states. In the United States over the past 15 years, the federal government and all 50 states have enacted anti-trafficking laws. The federal Trafficking Victims Protection Act (TVPA) of 2000, reauthorized most recently in 2013, seeks to punish traffickers, to protect victims, and to coordinate anti-trafficking initiatives. The law defines “severe forms of trafficking” as (a) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age and (b) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. Specifically, the William Wilberforce Reauthorization Act classified trafficking as a Part I Crime in the Federal Bureau of Investigation’s (FBI) Uniform Crime Report, mandating the collection of data about two newly created categories: commercial sex acts and involuntary servitude.

Since the State of Washington enacted the first state human-trafficking criminal statute in 2002, all 50 states and the District of Columbia have passed legislation making human trafficking a felony offense. In response to the evolving awareness of the problem of trafficking, states are now increasingly passing legislation that specifically addresses physicians’ and other health care providers’ roles in addressing human trafficking, especially the problem of trafficking of minors for commercial sexual exploitation.

**Focus: New state laws**

This article focuses on a still-evolving and underexamined legal development: state laws that address human trafficking by providing education and/or imposing reporting obligations on a wide range of health care providers (e.g., doctors, nurses, physician’s assistants, nurse practitioners, dentists, psychologists, counselors, etc.) and other professionals (e.g., teachers, coaches, social workers, public employees). Our purpose is to provide a systematic review of legislation creating educational initiatives and mandating the reporting of trafficking victims by physicians and other professionals with a particular focus on the health care field. (For ease of reading and to reflect what seems to be the predominant legislative intent, this article most often uses the term “health care provider.”) To date, we are not aware that any such analysis has been conducted. The comparison of the legislative strategies and the key elements of the laws reveals significant differences and raises important issues. The findings should be helpful not only to health care providers who are now mandated reporters of trafficking in some states but also to state legislatures considering similar laws and regulatory agencies charged with their enforcement.

**Methodology**

An initial search was conducted using standard web search engines for background information, news reports, and articles to identify commonly used terms and identifiers. Broad legal database searches were then formulated and undertaken. Twenty-one separate legal searches of federal and state law databases were conducted from October 2014 through November 2015. Searches were conducted using both Westlaw (“WestlawNext”) and Lexis (“Lexis Advance”). There were no date restrictions.

WestlawNext filters were used to narrow the results. Searches were not limited by content, meaning searches spanned all of the databases’ categories, including but not limited to statutes, regulations, administrative decisions, proposed legislation, enacted legislation, case law, court orders, and secondary materials. Geographically, database searches were limited to the United States, all states and territories. Jurisdictionally, the searches were run at the federal and state levels.

Searches were conducted in the English language using typical legal database techniques such as key terms, expanders and proximity in both Boolean and natural-language methods. The Boolean method of
search uses the words AND, OR, NOT (known as Boolean operators) to combine keywords and phrases to limit, broaden, or define the search. Natural-language methods employ every day, plain language written out in phrases to retrieve relevant documents “about” the subject/theme under review.

Broader searches for “human trafficking” were filtered for “train! or educat! and physician or health or doctor or medic! or nurse” and “report!” Separate searches were conducted for education and reporting laws. Education law searches included “train! educat! /s hospital medical teach! school educat!” /s “human trafficking” and “human trafficking” /407 “training.” Reporting law searches included (a) “mandatory reporters,” (b) mandat! report! “human trafficking,” (c) “professionally mandatory reporters,” (d) trafficking “mandat! report!,” (e) “human trafficking” report! Physicians doctors medical, (f) “child abuse” mandat! report!, (g) report! /s traffick!, and (h) medical board, continu! educat!. Filters were then applied within the reporting searches for specific instances of “physician or health, must, mandatory, child abuse or neglect.”

Results generated for any particular state were reviewed for relevance and further refined, including a review of cross-code section references and statutory annotations. Concurrently, independent weekly alerts were set up to search automatically for news or updates regarding pending federal and state legislation, administrative codes, and regulations, as well as a news search for articles about human trafficking, particularly with regard to training, education, reporting, and health care.

In analyzing state education laws, we asked five primary questions: Who receives the education? Is it mandatory or voluntary for the trainee? Who oversees the education? What is the curriculum? Does the law require data collection and assessment?

Our analysis of mandatory reporting laws focused on six primary questions: Who reports, when, and under what circumstances? What gets reported and to whom? Is data collection required?

Results
In total, 17 states have enacted legislation that either specifically addresses the education of health care providers and other professionals about human trafficking (13 states), requires mandatory reporting of trafficking of minors (seven states), or compels both (three states). None of these statutes has appropriated funds to support these endeavors.

**State education laws**

In total, 13 states have education laws related to human trafficking\(^8\) (see Table 1). Ten of these states have only education laws,\(^9\) while three (CO, MA, NC) have both education and reporting laws.\(^10\) All of the education laws address both labor and sex trafficking, except for Minnesota, which addresses child sex trafficking only.\(^11\) Including Minnesota’s law that only calls for education on child-trafficking victims, three states in total limit their education and training programs to awareness or identification of minors (under age 18) only (LA, MA, MN). Louisiana’s human-trafficking-victim services plan restricts the development and dissemination of educational and training programs to child-trafficking victims,\(^12\) and Massachusetts requires training for child abuse and neglect that includes human trafficking as a covered abuse.\(^13\)

**Who receives the education**

Washington is the only state that has a standalone physician education provision regarding trafficking, although in Washington, other professionals (mental health counselors, marriage and family therapists, social workers, and psychologists) are covered by other provisions.\(^14\) The remaining 12 state laws cover education for a variety of health care providers, grouping them with a range of other professionals, such as educators, law-enforcement personnel, clergy, and social workers in a single provision (see Table 2). Even more broadly, some states include “employers” (KS, VT),\(^15\) “local departments of social services,” “public and private agencies,” “service providers,” and the “general public” (LA, NC) and state agency “officials and employees” (MO).\(^16\) Two states (CO, MO) also call for education of persons who are more likely to encounter trafficking victims, namely those working
**Table 1. State Human Trafficking Education Laws.**

<table>
<thead>
<tr>
<th>State</th>
<th>Relevant Statutes</th>
<th>Trafficking Education Provision</th>
<th>Mandatory or Voluntary Training for Trainee</th>
<th>Trafficking Type</th>
<th>Trafficking of Minors Only or All Victims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>COLO. REV. STAT. § 18–3-505 (2014)</td>
<td>The Human Trafficking Council is tasked with developing training standards and curricula.</td>
<td>Voluntary</td>
<td>Both</td>
<td>All victims</td>
</tr>
<tr>
<td>Kansas</td>
<td>KAN. STAT. ANN. § 75–759 (2013)</td>
<td>The State Secretary of Labor and Attorney General are tasked with developing and implementing an education plan to raise awareness among Kansas employers about the problem of human trafficking, the national human trafficking resource center hotline, and any other resources or services that might be available to employers, employees, and victims of trafficking.</td>
<td>Voluntary</td>
<td>Both</td>
<td>All victims</td>
</tr>
<tr>
<td>Louisiana</td>
<td>LA. REV. STAT. ANN. § 46:2161 (2014)</td>
<td>The State Department of Children and Family Services, in conjunction with the Department of Health and Hospitals, is tasked with developing a plan for the delivery of services to victims of human trafficking, including preparing and disseminating educational and training programs and materials to increase awareness of human trafficking and services available to victims of human trafficking.</td>
<td>Voluntary</td>
<td>Both</td>
<td>Minors only</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>MASS. GEN. LAWS ch. 119, § 51A (2008)</td>
<td>The law requires that a mandated reporter who is professionally licensed by the Commonwealth will complete training to recognize and report suspected child abuse or neglect, which includes the abuse of human trafficking.</td>
<td>Mandatory</td>
<td>Both</td>
<td>Minors only</td>
</tr>
<tr>
<td>Minnesota</td>
<td>MINN. STAT. § 145.4716 (2013)</td>
<td>The Director of Child Sex Trafficking Prevention is tasked with the following: training, collecting, and disseminating information on services; applying for federal funding for anti-trafficking efforts; managing grant programs and managing grant proposal requests; identifying best practices for serving victims; providing oversight; conducting evaluations of statewide programs for victims; and developing policy for sharing data among agencies/advocates regarding sexually exploited youth.</td>
<td>Voluntary</td>
<td>Sex</td>
<td>Minors only</td>
</tr>
<tr>
<td>Missouri</td>
<td>MO. REV. STAT. § 566.223 (2004)</td>
<td>The Department of Public Safety may establish training programs as well as standard protocols for appropriate agencies to educate officials and employees on state statutes and federal laws regulating human trafficking and the identification and assistance of victims of human trafficking.</td>
<td>Voluntary</td>
<td>Both</td>
<td>All victims</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>State</th>
<th>Relevant Statutes</th>
<th>Trafficking Education Provision</th>
<th>Mandatory or Voluntary Training for Trainee</th>
<th>Trafficking Type Labor and/or Sex</th>
<th>Trafficking of Minors Only or All Victims</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Jersey</td>
<td>N.J. STAT. ANN. §§ 2 C:13–12, 26:2 H-2 (2013)</td>
<td>The law requires certain employees of every licensed health care facility to complete a one-time training course on the handling and response procedures of suspected human-trafficking activities.</td>
<td>Mandatory</td>
<td>Both</td>
<td>All victims</td>
</tr>
<tr>
<td>Tennessee</td>
<td>TENN. CODE ANN. § 71–1–135 (2012)</td>
<td>The Commissioner of Human Services must develop a plan with other departments to prepare and disseminate educational materials and to provide training programs to increase awareness of human trafficking and the services available to victims.</td>
<td>Voluntary</td>
<td>Both</td>
<td>All victims</td>
</tr>
<tr>
<td>Vermont</td>
<td>VT. STAT. ANN. tit. 13, § 2661. (2011)</td>
<td>The State Department of Labor must develop and implement an education plan to raise awareness among Vermont employers about the problem of human trafficking, the national human-trafficking resource center hotline, and any other resources or services that might be available to employers, employees, and victims of trafficking.</td>
<td>Voluntary</td>
<td>Both</td>
<td>All victims</td>
</tr>
<tr>
<td>Washington</td>
<td>WASH. REV. CODE § 18.71.080 (2009); § 18.83.090 (2009); § 18.225.040 (2009)</td>
<td>The State Medical Quality Assurance Commission, Mental Health Counselors, Marriage and Family Therapists, and Social Workers Advisory Committee, and Board of Psychology must disseminate information on trafficking to their respective licensees (based on information from the State Office of Crime Victims Advocacy).</td>
<td>Voluntary</td>
<td>Both</td>
<td>All victims</td>
</tr>
</tbody>
</table>
Rather than dictating which persons or groups should receive the education, Tennessee broadly directs the Commissioner of Human Services to develop a plan to “prepare and disseminate educational materials and provide training programs to increase awareness of human trafficking.”

Voluntary or mandatory
In most states (10 of 13), education is voluntary for the targeted trainees (see Table 1). Most of the laws in these states generally call for a program to be established, an oversight position to be created, and education to be provided. But they do not mandate trainee attendance. Education is mandatory for the designated trainees in Massachusetts, Michigan, and New Jersey. Florida’s legislative approach is a work in progress and is illustrative of a continuing medical education approach.
Massachusetts’ education requirement is subsumed within its child abuse reporting laws, as mandatory reporters of child abuse must undergo training to identify and report child abuse victims, which statutorily includes children who are trafficked.\(^2\) Michigan has further refined its approach with additional, more targeted legislation. It has passed a general law under which a Human Trafficking Commission must provide information and training on human trafficking to police, prosecutors, court personnel, social services personnel, health care providers, and any other group the commission deems appropriate.\(^2\) Participation by these trainees is voluntary. However, a separate provision directs a joint task force for health profession subfields to create standards for the mandatory education and training of physician’s assistants to identify human-trafficking victims.\(^2\) The new standards will apply to both licensing and registration renewal.\(^2\) Other states may follow this model, tailoring mandates to specific cadres of health care providers.

New Jersey’s approach is more direct and comprehensive. In a standalone single provision, the state lists all the categories of professions and employees who must be trained by taking a single mandatory course at their place of employment. Verifiable completion of the training course by the required employees is a condition of issuance, maintenance, or renewal of any license, permit, certificate, or approval required or issued to licensed health care facilities. This contrasts with the more common approach of most legislatures, which is to direct that a commission create a training curriculum and decide for itself who, when, and what is required. New Jersey’s law covers not only all employees of a health care facility but law-enforcement personnel, hotel and motel owners, and court personnel.\(^2\)

Who oversees the education

Four states (CO, MI, TX, NC) adopted a task-force approach to develop and oversee education.\(^2\) Minnesota has mandated a different approach by appointing a single director rather than a group of appointees or individuals, who must perform similar duties of developing training, collecting information, and overall management of trafficking programs and practices.\(^2\) In New Jersey, the Department of Health, in consultation with the Commission on Human Trafficking, is tasked with developing, approving, and providing, through an approved nonprofit course provider if it so chooses, its one-time training course. Four other states (KS, MA, MO, VT) provide no specifics other than naming the state agency authorized to establish a program.\(^2\) In Washington, the law requires that the Washington State Medical Quality Assurance Commission disseminate information on trafficking to physicians.\(^2\) Regarding who specifically leads the trainings, the statutes offer limited guidance.

Content of curriculum

The statutes offer only minimal guidance for creating the educational curricula. A few statutes provide that the education must be created or approved by that state’s task force or commission on trafficking or child abuse or dictate what agencies must be consulted to develop the curriculum.\(^2\) Others simply call for the dissemination of educational materials and programs to increase awareness of trafficking and services.\(^2\)

From this general framework, three approaches merit closer consideration. New Jersey’s standalone human-trafficking statute offers the most concrete guidance.\(^2\) For all employees of “a licensed health care facility,” education is mandatory. “Licensed health care facility” is comprehensively defined, including entities such as general hospitals, mental hospitals, public health centers, diagnostic centers, rehabilitation centers, extended-care facilities, nursing homes, intermediate-care facilities, maternity hospitals, outpatient clinics, dispensaries, and home health care agencies.\(^2\) All such persons employed by a health care facility were required to participate in a one-time training course within one year of the law’s enactment (May 6, 2013). The training must cover “the handling and response procedures of suspected human trafficking activities.” The Department of Health is responsible for ensuring that all required employees of licensed health care facilities attend the training course; new employees must take the course within six months of employment.

Florida is utilizing a continuing medical education (CME)-based approach. Currently, physicians can, but do not have to, satisfy their two-hour domestic violence (DV) CME requirement by taking a
Looking ahead, two new bills would move Florida to a mandatory education model. At their broadest, the bills would apply to physicians, midwives, nurses, dentists, and psychologists, among others. The content of the training, on both sex and labor trafficking, would include information on the types and extent of trafficking, risk factors and patient identification, patient safety and security, management of patient records, and resources and referral procedures for legal and social services.

A federal bill, the Trafficking Awareness Training for Health Care Act of 2015, which became an official session law on May 29, 2015, requires the Administrator of the Agency for Healthcare Research and Quality to award one grant to “an accredited school of medicine or nursing with experience in the study or treatment of victims of a severe form of trafficking” to determine best practices for health care professionals to recognize and respond appropriately to victims of severe forms of human trafficking. The bill seeks to have the grantee then make subgrants to one entity located near an established anti-human-trafficking task-force initiative in each of the 10 administrative regions of the Department of Health and Human Services to develop pilot programs to test best practices for trainings and to collect and analyze data. Health and Human Services will disseminate the evidence-based best practices on its Web site and to health care professional schools.

State reporting laws

Seven states (CA, CO, FL, IL, MD, MA, NC) now have specific mandatory reporting laws regarding human trafficking (see Table 3). Four of these states (FL, IL, MA, NC) address both sex and labor trafficking, whereas California, Colorado, and Maryland require reporting of sex trafficking only. All seven states with reporting laws limit their mandate to minors only. Illinois, however, extends the requirement to residents of state facilities aged 18–22.

Of course, every state in the United States already has child abuse and neglect (CAN) laws (Mandatory Reporters of Child Abuse and Neglect, 2013); however, these older laws as written do not always cover all trafficking situations. The new human trafficking reporting laws discussed herein establish that trafficking, in its various manifestations, is a distinct reportable offense. Just as states diverge in the particulars of their education requirements, so too have they adopted different definitions of what constitutes the crime of human trafficking (see Table 3). As a legislative matter, these laws effectively add trafficking specifically to the types of abuse covered under the child abuse and neglect reporting laws, which were drafted long before legislators became aware of human trafficking.

Who reports, when, and under what circumstances

Five states (CA, CO, IL, MD, MA) define “reporter” broadly, including not only a range of health care providers but also law-enforcement and court personnel, social service workers, school personnel, and clergy. Florida and North Carolina go further: All residents are mandatory reporters (see Table 4).

In all seven states, the failure to report is subject to escalating penalties, starting with fines, proceeding to a criminal misdemeanor, and, for repeat offenders, a felony. In Massachusetts, the maximum fine is $1,000, but a reporter who knows of abuse or neglect of a child that results in serious bodily injury or death and who willfully fails to report is subject to a $5,000 fine and up to 2½ years imprisonment. California similarly punishes a mandated reporter who fails to report known or reasonably suspected child abuse or neglect with a $1,000 fine, up to 6 months imprisonment, or both.

Five states (CA, CO, IL, FL, MD) require reporting to take place “immediately or as soon as possible,” while Massachusetts extends to 48 hours. Only Massachusetts mandates a written report only, while the rest mandate oral reporting with a written report to follow.

Course “Domestic Violence with a Special Focus on Human Trafficking.” Looking ahead, two new bills would move Florida to a mandatory education model. At their broadest, the bills would apply to physicians, midwives, nurses, dentists, and psychologists, among others. The content of the training, on both sex and labor trafficking, would include information on the types and extent of trafficking, risk factors and patient identification, patient safety and security, management of patient records, and resources and referral procedures for legal and social services.
Table 3. State Human Trafficking Reporting Laws.

<table>
<thead>
<tr>
<th>State</th>
<th>Statutes</th>
<th>Trafficking Type</th>
<th>What to Report</th>
<th>To Whom and How to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td><strong>CAL. PENAL CODE</strong> § 11165.9 (West 2007), § 11165.6 (West 2008), § 11167 (West 2011), §§ 11165.1, 11166 (West 2016)</td>
<td><strong>Sex</strong></td>
<td>Name, business address, and telephone number of the mandated reporter; The capacity that makes the person a mandated reporter; The information that gave rise to the reasonable suspicion of child abuse or neglect and the source or sources of that information; Child’s name, the child’s address, present location, and, if applicable, school, grade, and class; The names, addresses, and telephone numbers of the child’s parents or guardians; The name, address, telephone number, and other relevant personal information about the person or persons who might have abused or neglected the child.</td>
<td>Reporter must, within his or her professional capacity or within the scope of his or her employment, have knowledge of or observe a child whom the reporter knows or reasonably suspects has been the victim of child abuse or neglect. Reporter must report to any police or sheriff’s department or county welfare department immediately or as soon as practicably possible, with a written report to follow within 36 hours of receiving the information of the abuse or neglect. Reports must be made even if the child has died, regardless of whether the abuse or neglect was a contributing factor to the death, and even if the suspected abuse was discovered during an autopsy. If a reporter is unable to submit an initial report by telephone, they shall make a one-time automated written report on the Department of Justice’s form. Such automated form reports shall be submitted to the counties and the Legislature by the State Department for data collection.</td>
</tr>
<tr>
<td>Colorado</td>
<td><strong>COLO. REV. STAT. §§ 16–22-102 (2002), 19–3-304 (1993), 19–3-307</strong></td>
<td><strong>Sex</strong></td>
<td>Name, address, age, sex, and race of child; The name and address of the person responsible for the abuse; The nature and extent of the child’s injuries, including any evidence of previous cases of known or suspected abuse or neglect of the child or the child’s siblings; The names and addresses of the persons responsible for the suspected abuse or neglect, if known; The family composition; The source of the report and the name, address, and occupation of the person making the report; Any action taken by the reporting source.</td>
<td>Reporter must have reasonable cause to know or suspect abuse or neglect. Reporter must notify the county department, the local law-enforcement agency, or the child abuse reporting hotline system. Reporter must report immediately and then follow up with a written report. The county department must send a report to the district attorney’s office and to the local law-enforcement agency. County department, law enforcement, and hotline must then submit a report to the state department within 60 days.</td>
</tr>
</tbody>
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(Continued)
Table 3. (Continued).

<table>
<thead>
<tr>
<th>State</th>
<th>Statutes</th>
<th>Trafficking Type</th>
<th>What to Report</th>
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</thead>
<tbody>
<tr>
<td>Florida</td>
<td>FLA. STAT. §§ 39.01 (2014), 39.201 (1994)</td>
<td>Sex and/or Labor</td>
<td>Professionals must provide their name when reporting to the hotline.</td>
<td>Reporter must have reasonable cause to suspect that child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative. Reports shall be made immediately to the Department of Children and Families’ central abuse hotline (by toll-free telephone number or via fax, Web-based chat, or Web-based report). Personnel at the department’s central abuse hotline shall determine if the report warrants protective investigation.</td>
</tr>
<tr>
<td>Illinois</td>
<td>325 ILL. COMP. STAT. 5/3 (2012), 5/4</td>
<td>Sex and/or Labor</td>
<td>Names and addresses of child and child’s parents or persons responsible for child’s welfare; Name and address of the school that the child attends or last attended, and the name of the school district; Child’s age, sex, and race; Nature and extent of the child’s abuse or neglect, including any evidence of prior injuries, abuse, or neglect of the child or his (or her) siblings; Names of the persons apparently responsible for the abuse or neglect; Family composition, including names, ages, sexes, and races of other children in the home; Name of the person making the report, occupation and contact information; Actions taken by the reporting source, including taking photographs and x-rays, placing the child in temporary protective custody, or notifying the medical examiner or coroner.</td>
<td>As soon as there is reasonable cause to believe there has been abuse or neglect, the reporter must immediately report to the Department of Children and Family Services.</td>
</tr>
</tbody>
</table>
### Table 3. (Continued).

<table>
<thead>
<tr>
<th>State</th>
<th>Statutes</th>
<th>Trafficking Type</th>
<th>What to Report</th>
<th>To Whom and How to Report</th>
</tr>
</thead>
</table>
| **Maryland**| **MD. CODE ANN. FAM. LAW §§ 5–701 (2012), 5–704**                       | **Sex**                           | Name, age, and home address of the child and the child’s parent or other person who is responsible for the child’s care; Whereabouts of the child; Nature and extent of the abuse or neglect of the child, including any evidence or information available to the reporter concerning possible previous instances of abuse or neglect. | Reporter must have reason to believe that a child has been subjected to abuse or neglect. Reporter must notify the local department or law-enforcement agency.  
If the reporter is only a staff member in a hospital, public health agency, childcare institution, juvenile detention center, school, or similar institution, then they must report to the head of the institution or the designee of the head.  
The report shall be made orally by phone or direct communication as soon as possible and follow up with a written report no later than 48 hours after the contact with the abused/neglected child. |
| **Massachusetts** | **MASS. GEN. LAWS ch. 119, §§ 21 (2013), 51A (2008)**                  | **Sex and/or Labor**              | Names and addresses of child and child’s parents or caretakers; Child’s age and sex; Nature and extent of child’s injuries, including evidence of any previous injuries; Circumstances under which the person required to report first became aware of the child’s injuries; Whatever action was taken to treat, shelter or assist the child; Name of the person making the report; The identity of the person or persons responsible for the neglect or injuries; Photographs of the child’s injuries can be taken as evidence without permission of child’s parent or guardian, and such will be sent to the department with the report. If hospital personnel collect physical evidence of abuse or neglect of the child, the local district attorney, local law-enforcement authorities, and the department shall be immediately notified. | Reporter must have reasonable cause to believe that a child is suffering physical or emotional injury resulting from being a sexually exploited child or being a human-trafficking victim (among other abuses and neglect).  
Reporter must file written report with the Department of Children and Families within 48 hours.  
Reporter may also notify the person or designated agent in charge of such institution and have them report instead.  
Reporter may contact local law-enforcement authorities or the child advocate about the suspected abuse or neglect.  
Within 30 days of receiving a report from a mandated reporter, the department shall notify the mandated reporter, in writing, of its determination of the nature, extent, and cause or causes of the injuries to the child and the services that the department intends to provide to the child or the child’s family. |
<table>
<thead>
<tr>
<th>State</th>
<th>Statutes</th>
<th>Trafficking Type</th>
<th>What to Report</th>
<th>To Whom and How to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>N.C. Gen. Stat. §§ 7B-101 (2013), 7B-301 (2013)</td>
<td>Sex and/or Labor</td>
<td>Definition: Reporters must report victims of human trafficking, meaning anyone subjected to a person who knowingly or in reckless disregard of the consequences of the action recruits, entices, harbors, transports, provides, or obtains by any means another person with the intent that the other person be held in involuntary servitude or sexual servitude or willfully or in reckless disregard of the consequences of the action causes a minor to be held in involuntary servitude or sexual servitude. N.C. Gen. Stat. §§ 14-43.11(a), 14-43.12, 14-43.13</td>
<td>Reporter must have cause to suspect that any juvenile is abused, neglected, or dependent or has died as a result of maltreatment. Report may be oral (by telephone) or in writing. Upon receipt of any report of sexual abuse of the juvenile in a child care facility, the director shall notify the State Bureau of Investigation within 24 hours or on the next workday.</td>
</tr>
</tbody>
</table>

Report shall include the name and address of the juvenile; the name and address of the juvenile’s parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information that the person making the report believes might be helpful in establishing the need for protective services or court intervention. If the report is made orally or by telephone, the person making the report shall give the person’s name, address, and telephone number.
<table>
<thead>
<tr>
<th>State</th>
<th>Who Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>A teacher; an instructional aide; a teacher’s aide or teacher’s assistant employed by a public or private school; a classified employee of a public school; an administrative officer or supervisor of child welfare and attendance, or a certified pupil personnel employee of a public or private school; an administrator of a public or private day camp; an administrator or employee of a public or private youth center, youth recreation program, or youth organization; an administrator or employee of a public or private organization whose duties require direct contact and supervision of children; an employee of a county office of education or the State Department of Education whose duties bring the employee into contact with children on a regular basis; a licensed psychologist, psychiatrist, or psychologist employed by a public or private education agency or school, including but not limited to foster parents, group home personnel, and personnel of residential care facilities; a social worker, probation officer, or parole officer; an employee of a school district police or security department; a person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in a public or private school; a district attorney investigator, inspector, or local child support agency caseworker, unless the investigator, inspector, or caseworker is working with an attorney appointed to represent a minor; a peace officer; a firefighter, except for volunteer firefighters; a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker, professional clinical clinical counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code; an emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; a psychological assistant; a marriage and family therapist intern; a state or county public health employee who treats a minor for venereal disease or any other condition; a coroner; a medical examiner or other person who performs autopsies; a commercial film and photographic print processor; a child visitation monitor; an animal control officer or humane society officer; a clergy member; any custodian of records of a clergy member; an employee of any police department, county sheriff’s department, county probation department, or county welfare department; an employee or volunteer of a court-appointed special advocate program; a custodial officer; a person providing services to a minor child; an alcohol and drug counselor; a clinical counselor trainee; a clinical counselor intern; an employee or administrator of a public or private postsecondary educational institution, whose duties bring the administrator or employee into contact with children on a regular basis, or who supervises those whose duties bring the administrator or employee into contact with children on a regular basis, as to child abuse or neglect occurring on that institution’s premises or at an official activity of, or program conducted by, the institution; an athletic coach, athletic administrator, or athletic director employed by any public or private school that provides any combination of instruction for kindergarten, or Grades 1 to 12, inclusive; a commercial computer technician; any athletic coach, including but not limited to an assistant coach or a graduate assistant involved in coaching, at public or private postsecondary educational institutions.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Physician or surgeon, including a physician in training; child health associate; medical examiner or coroner; dentist; osteopath; optometrist; chiropractor; podiatrist; registered nurse or licensed practical nurse; hospital personnel engaged in the admission, care, or treatment of patients; Christian Science practitioner; public or private school official or employee; social worker or worker in any similar facility; mental health professional; dental hygienist; psychologist; physical therapist; veterinarian; peace officer; pharmacist; commercial film and photographic print processor; firefighter; victim’s advocate; licensed professional counselors; licensed marriage and family therapists; registered psychotherapists; clergy member.</td>
</tr>
<tr>
<td>Florida</td>
<td>Any person who knows or has reasonable cause to suspect abuse; physician, osteopathic physician, medical examiner, chiropractic physician, nurse, or hospital personnel engaged in the admission, examination, care, or treatment of persons; other health or mental health professional; practitioner who relies solely on spiritual means for healing; school teacher or other school official or personnel; social worker, day care center worker, or other professional child care, foster care, residential, or institutional worker; law-enforcement officer; or Judge.</td>
</tr>
<tr>
<td>Illinois</td>
<td>Any physician, resident, intern, hospital, hospital administrator and personnel engaged in examination, care and treatment of persons, surgeon, dentist, dentist hygienist, osteopath, chiropractor, podiatric physician, physician assistant, substance-abuse treatment personnel, funeral home director or employee, coroner, medical examiner, emergency medical technician, acupuncturist, crisis line or hotline personnel, school personnel (including administrators and certified and non-certified school employees), higher education personnel, educational advocate, member of a school board or the Chicago Board of Education or the governing body of a private school, student, employee, school personnel, or employee, social worker, social services administrator, domestic violence program personnel, registered nurse, licensed practical nurse, genetic counselor, respiratory care practitioner, advanced practice nurse, home health aide, director or staff assistant of a nursery school or a child day care center, recreational or athletic program or facility personnel, early intervention provider, law-enforcement officer, licensed professional counselor, licensed clinical professional counselor, registered psychologist and assistants working under the direct supervision of a psychologist, psychiatrist, or field personnel of the Department of Healthcare and Family Services, Juvenile Justice, Public Health, Human Services, Corrections, Human Rights, or Children and Family Services, supervisor and administrator of general assistance under the Illinois Public Aid Code, probation officer, animal control officer or Illinois Department of Agriculture Bureau of Animal Health and Welfare field investigator, or any other foster parent, homemaker, or child care worker.</td>
</tr>
</tbody>
</table>
A closer look at two legislative schemes helps illuminate the different approaches to reporting. Colorado’s reporting requirements are found in the Abuse and Neglect section of the Children’s Code, which defines “child abuse and neglect” to cover a child subjected to unlawful sexual behavior. The Children’s Code is cross-referenced to Colorado’s Sex Offender Registration Act to define “unlawful sexual behavior,” which includes “human trafficking of a minor for sexual servitude,” “sexual exploitation of children,” “procurement of a child for sexual exploitation” and “inducement of prostitution.” "Reporters" is broadly defined to include not only physicians but health care workers, school officials and teachers, social workers, licensed counselors and therapists, department of human services workers, coaches, and emergency medical services (EMS) personnel among many others. Colorado makes reporting mandatory when there is “reasonable cause to know or suspect . . . abuse or neglect” of a child under 18. An oral report must be made to the county department, local law enforcement, or the child abuse hotline, followed “promptly” by a written report. The county department must notify law enforcement and the district attorney. The county department must also submit a report to the state department within 60 days.

Massachusetts parallels Colorado’s language insofar as it broadly defines reporters and triggers upon “reasonable cause to believe that a child is suffering physical or emotional injury” resulting from being “sexually exploited” or a “human trafficking victim.” But Massachusetts has two novel provisions. One protects reporters from workplace retaliation for having reported in good faith. The other requires that the Department of Children and Families give written notice to the reporter within 30 days of the outcome of the report and any services provided to the victim.

### What gets reported

States with trafficking reporting laws typically require similar kinds of information from the reporter (see Table 3), such as the following:

- Names and addresses of the child and the child’s parents or caretakers;
- Child’s age;
- Nature and extent of the abuse, including any evidence of previous abuse;
- Name and address of the school that the child attends or last attended;
- Names of the persons apparently responsible for the abuse or neglect;
- Family composition, including names, ages, sexes, and races of other children in the home;
• Actions taken by the reporting source, including taking photographs and x-rays, placing the child in temporary protective custody, or notifying the medical examiner or coroner.

At least five states (CO, FL, IL, MA, NC) expressly call for the name of the reporter. In North Carolina, the reporter must provide a name if reporting orally or by telephone, but declining to state their name will not impede the local department of social services from investigating the report. Massachusetts provides that photographs of the child’s injuries may be taken without permission of the child’s parents or guardians. Massachusetts also provides that if hospital personnel collect physical evidence of abuse or neglect, then law enforcement, the local district attorney, and the Department of Children and Families are to be notified immediately.

Where reports are sent
Most commonly, reports are made to the Department of Children and Family Services or the Department of Human Services. The department or agency receiving the report must usually, in turn, report the suspected abuse to local law enforcement and/or the district attorney. Some states allow for reports to be made directly to law enforcement (see Table 3).

State-mandated data collection
The collection of uniform and high-quality data is essential for assessing whether new laws aimed at health care providers and other professionals are achieving their goals of identifying more victims of trafficking and securing effective services to aid in their rehabilitation. Most, but not all, of the 17 states with education and/or reporting laws related to human trafficking provide for some form of data collection. Six states are silent on the topic (MD, MA, MO, NJ, NC, WA). Of the remaining 11, eight states tie data collection to their education laws and three to their reporting laws (see Table 5). All of the 11 states that legislate data collection assign responsibility to either a human-trafficking council or commission (CO, MI, MN, TX) or a state agency (CA, KS, TN, VT, LA, IL, FL). There is no consensus on what gets collected, how to collect the data, where to keep it, or what to do with it. Illinois calls for a “central register” of all child abuse and neglect cases, kept in such a way as to enable the Department of Children and Family Services (a) to “immediately identify and locate prior reports,” (b) to “continuously monitor” all reports where services were provided, and (c) to "regularly evaluate the effectiveness of existing laws and programs.”

Texas, emphasizing law enforcement and prosecution of traffickers, is particularly detailed in describing the data that should be collected, including the following: (a) number of convictions, arrests, and prosecutions, and even investigations of traffickers and forgery offenses as part of trafficking; (b) demographics of convicted traffickers and the victims; (c) geographic routes of trafficking; (d) means of transportation and methods for trafficking; and (e) social and economic factors creating a demand for trafficking. While lacking the detail of Texas, Florida specifies that record collection is only for law-enforcement and prosecutorial purposes.

As far as to whom these collectors of data then report, the most common audience is the state judiciary committee. Reports, usually on an annual basis, may also be directed to the governor, the legislature, an appointed committee (such as committees on health and welfare, criminal justice, or human services), or some combination thereof. Annual reporting is typically directed to cover victim identification, location and types of services offered, number of persons served, education provided, and costs of implementation. Minnesota’s education law uniquely guides the Director of Child Sex Trafficking Prevention to collect data not for the legislature or government but rather to promote a system for sharing data among regional and community advocates.

Michigan has grappled specifically with the issue of data collection regarding human trafficking. Mandated by law, the human-trafficking commission must file an annual report with the governor, the secretary of the Senate, and the clerk of the House of Representatives regarding trafficking in the
In the Michigan Commission on Human Trafficking’s 2013 Report on Human Trafficking, the Data Collection Subcommittee (DCS) noted that there are four primary obstacles to data collection: “underreporting [of the crime]; lack of uniform data reporting; lack of data sharing; and lack of quality data” (Michigan Commission on Human Trafficking, 2013, p. 20). In its recommendations to the governor and legislature, the human-trafficking commission and DCS called for, among other initiatives, the “implementation” of a standard, comprehensive method for capturing and storing human trafficking data, the development of “data sharing agreements,” and the encouragement of and funding support for more research across academic disciplines (Michigan Commission on Human Trafficking, 2013, p. 20).

Table 5. State Human-Trafficking Laws—Data Collection Requirements*.

<table>
<thead>
<tr>
<th>State</th>
<th>Stipulated by Reporting or Education Law</th>
<th>Collection and Use of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>Education Law</td>
<td>The Human Trafficking Council must collect data relating to the prevalence of and the efforts of law enforcement to combat human trafficking. The Human Trafficking Council must annually report the data to the judiciary committees of the state legislature.</td>
</tr>
<tr>
<td>Florida</td>
<td>Reporting Law</td>
<td>The law requires collection of child abuse reporting records only for law enforcement, state attorney investigating and prosecuting purposes, or for administrative penalties. No data collection is required for human-trafficking victims and the effect of the law.</td>
</tr>
<tr>
<td>Illinois</td>
<td>Reporting Law</td>
<td>The law establishes for the maintenance of a central register of all reported cases of suspected child abuse or neglect. The central register must allow for immediate identification and location of prior reports of child abuse or neglect, continuous monitoring of the current status of all reports of child abuse or neglect and to allow for regular evaluations of the effectiveness of the laws.</td>
</tr>
<tr>
<td>Kansas</td>
<td>Education Law</td>
<td>The State Secretary for Children and Families and Secretary of Labor report to the standing committees on judiciary in the senate and the house of representatives on the progress achieved in developing and implementing the notice requirement for trafficking victims and education plan for trafficking. This requirement is not specific for data collection of the number of trafficking victims or the prevalence of trafficking in the state.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Education Law</td>
<td>The law orders any private entity that provides services to trafficking victims to submit to the State Department of Children and Family Services an annual report on their operations, including information on the services offered, geographic areas served, the number of persons served, and individual status updates on each person served. The Department of Children and Family Services must compile data from all the reports and provide this information to the legislature annually.</td>
</tr>
<tr>
<td>Michigan</td>
<td>Education Law</td>
<td>The Human Trafficking Commission must file an annual report with the governor, the secretary of the Senate, and the clerk of the House of Representatives regarding human trafficking in the state, covering the services provided, extent and nature of trafficking in the state, and training provided.</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Education Law</td>
<td>The State Director of Child Sex Trafficking Prevention must collect and maintain information on trafficking and develop a system for sharing data among regional and community advocates.</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Education Law</td>
<td>The State Department of Human Services must provide a report to the chair of judiciary committee of the Senate and the chair of criminal justice committee of the House of Representatives on victim identification, assistance and services, training, and costs of implementation.</td>
</tr>
<tr>
<td>Texas</td>
<td>Education Law</td>
<td>The Human Trafficking Prevention Task Force must collect statistical data on the nature and extent of human trafficking, including (a) number of convictions, arrests, and prosecutions for traffickers and forgery offenses as part of trafficking, (b) demographics of convicted traffickers, (c) geographic routes of trafficking, (d) means of transportation and methods for trafficking, and (e) social and economic factors creating a demand for trafficking.</td>
</tr>
<tr>
<td>Vermont</td>
<td>Education Law</td>
<td>The State Department of Labor shall report to the House and Senate Committees on Judiciary, the House Committee on Human Services, and the Senate Committee on Health and Welfare on the progress achieved in developing and implementing the notice requirement for trafficking victims and the education plan for trafficking.</td>
</tr>
</tbody>
</table>

*This article discusses data-collection efforts arising from trafficking education and reporting laws only, not from criminal trafficking laws or child abuse and neglect laws.
Discussion

We have systematically reviewed current U.S. state laws that address human-trafficking education and mandatory reporting by health care providers and other professionals. To date, 17 states in total have enacted laws that establish education initiatives about human trafficking and/or stipulate trafficking per se as a reportable event. Thirteen of the 17 states have educational laws, seven of the 17 have mandatory reporting laws, and three have both education and mandatory reporting laws. Because these laws were enacted only within the past few years, and because data collection and analysis, to the extent undertaken, has not been widely shared, it is difficult to assess the laws’ effectiveness and, hence, to determine best practices. However, several salient issues and questions emerge.

Education

With the rise in awareness about the scope of human trafficking in the United States, a number of authoritative medical bodies have recently issued calls for education about human trafficking. The Institute of Medicine and National Research Council, in its 2013 report titled Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States, recommends widespread evidence-informed training of numerous professionals, including physicians and other health care providers. Taking it one step further, the report goes on to say, “A legal mandate to ensure that personnel who come into regular contact with minors have been trained in these issues...would appear to have potential value” (IOM [Institute of Medicine] and NRC [National Research Council], 2013, p. 187).

Within the last three years, at least nine professional medical societies have issued new policy statements on human trafficking and made similar recommendations regarding the need for education and training. The American Public Health Association, in its 2015 statement, acknowledges the severe physical and mental health effects of human trafficking and “calls for professional schools, societies, and certifying bodies to improve training of licensed health professionals and to integrate human trafficking into existing curricula on intimate partner violence, domestic violence, and child and elder abuse (American Public Health Association, 2015, p. 1).

HEAL Trafficking, a nonprofit organization comprised of health care professionals, has stated that training should be grounded in “a patient-centered, culturally relevant, evidence-based, gender-responsive, trauma-informed perspective for identifying and treating victims” and that “trauma-informed care should be integrated into health professional training across specialties, clinical practice and professional titles” (HEAL Trafficking, 2015, p. 1, para. 5).

Medical organizations are calling for education about human trafficking because, although standard medical training covers issues of child abuse and neglect, intimate partner violence, and elder abuse, it does not yet cover human trafficking (Stoklosa, Grace, & Littenberg, 2015). Physicians and other health care providers report that they are poorly prepared and lack the knowledge and skills to effectively engage with suspected trafficking victims and, furthermore, do not know where to turn for resources (Beck et al., 2015; Titchen et al., 2015). Health care providers need to know about the scope of the problem, the risk factors and “red flags” for victimization, and how to identify victims, as well as to be armed with the clinical skills to diagnose, treat and refer victims of trafficking for various services (IOM and NRC, 2013).

While health care providers should keep in mind that this review is limited to state laws and does not consider policies or practice rules enacted by other governing bodies such as medical boards, it is worth noting that several hospitals and other health care facilities across the nation have recently developed protocols for health care providers to follow when presented with a suspected or known case of trafficking. This positive development reflects growing awareness of human trafficking but also the growing need for training on protocol compliance and evaluation of their impact.
Furthermore, mandatory reporters need more detailed training on their reporting obligations within the context of trafficking, and on how to ethically navigate ambiguous, complex situations. They also need to learn more about reporting procedures in their states, how child protective services conducts investigations of reported cases, and the outcomes of such investigations (Flaherty, Jones, & Sege, 2004; Flaherty, Sege, & Hurley, 2008). Such “procedural” training has been shown to enhance the willingness of physicians to report cases of child abuse and neglect (Alvarez et al., 2010).

These new state laws aimed at promoting trafficking awareness and education among health care providers and other professionals, if implemented in an effective manner, have the potential to significantly improve outcomes. But best practices are as yet difficult to discern, without data to draw from this early in the implementation. Lessons can be drawn, however, from the field of domestic violence (DV). While human trafficking differs in important ways from DV, there are many similarities, including the tactics that perpetrators use to establish power and control over their victims, the trauma bond that often develops between victim and abuser, the physical and psychological consequences that result, and the barriers to physicians identifying and intervening on behalf of victims (Williamson, Dutch, & Clawson, 2010). Furthermore, there is, at times, considerable overlap between DV and trafficking victims, in that many adolescents and women are often trafficked by people who are family members and/or intimate partners.

Although current practices and procedures for intervening on behalf of domestic violence are not perfect, three decades of work in this arena have provided a solid foundation of knowledge about training health care providers to identify and offer services to victims of interpersonal violence (Williamson et al., 2010). Research on the effectiveness of domestic violence education in postgraduate and continuing medical education activities suggest that multifaceted educational interventions for health care providers (e.g., interactive workshops, Web-based learning, patient simulations, and experiential training) combined with system support interventions (e.g., general awareness initiatives, workplace reminders about victim identification, improved systemic access to support services) increase health care providers’ knowledge and skills, referrals to resources, and, ultimately, positive outcomes for victims (Bair-Merritt et al., 2014; Harris, Kutob, Surprenant, Maiuro, & Delate, 2002; MacGregor, Wathen, Kothari, Hundal, & Naimi, 2014; Shefet et al., 2007; Zaher, Keogh, & Ratnapalan, 2014).

Given that quality education and training underpin health care providers’ competencies in identifying, treating, and appropriately referring and reporting trafficking victims, it is critical that we determine best practices specifically for human trafficking. A new federal law passed in 2015, which seeks to identify and disseminate best practices for training on human trafficking, is expected to help in this regard. More evidence-based research is needed, but some best practices are already starting to emerge, thanks to many innovative local initiatives that have spread. These include, among others, developing screening tools to help identify trafficking victims, training new clinical employees and urging all clinicians to attend, creating a multipart Webinar, producing online training videos, and forging relationships with law enforcement and social services before the need to refer or report arises (McKinney, 2015). A U.S. Department of Health and Human Services pilot project called Stop Observe Ask Respond (SOAR) has provided training to health care providers in at least six cities, using both a pretraining survey to better gauge participants’ baseline knowledge and a posttraining survey to check their retention of new material (McKinney, 2015). Finally, funding sources must be identified to support these educational and research endeavors; a lack of funding will hamper full implementation and sabotage the best of intentions.

**Mandatory reporting**

*New laws extend reportable offenses to include trafficking situations*

To date, seven states have specifically made trafficking of a minor a reportable offense. It is important to note that some trafficking situations are already covered under current state laws: Mandatory reporters are obliged to treat many sex-trafficking situations involving minors as...
reportable offenses because they constitute “sexual abuse” or “sexual exploitation” (e.g., DE, GA, MI, NM, OR). For example, a situation that entails a stepfather prostituting his minor stepdaughter would be reportable under established CAN laws. Most child abuse laws define “sexual exploitation” as primarily covering the following: acts of prostitution; enticing, preparing, publishing, and distributing sexually exploitative material; or sexual performances by children. But while all CAN laws include variations of “sexual abuse” and some separately define “sexual exploitation” as reportable offenses, the specific forms of abuse, as defined in these older statutes, may not be broad enough to cover all trafficking situations. If a state only has the language of “sexual exploitation” or a vague definition of “sexual abuse” and does not specifically designate “trafficking,” then many incidents of trafficking, including labor trafficking, may not be covered as reportable offenses.

Furthermore, in about one third of states, acts are reportable under the CAN reporting laws only if a parent, guardian, custodian, or other person responsible for the child commits them (Glosser, Gardiner, & Fishman, 2004). Thus, while a sexual act with a minor may violate the state’s criminal code, it may not be reportable as child abuse if committed by someone other than a parent or guardian. For example, in a state that limits reporting to abuses committed by a parent or responsible caretaker, a 16-year-old girl being trafficked by her older “boyfriend” may violate the state’s criminal laws but not be reportable as child abuse by mandatory reporters. Hence, states are taking steps to extend the scope of reportable offenses to include a range of trafficking situations.

The intent of these mandatory-reporting laws is to interrupt the violence and ultimately to make a positive impact on the lives of trafficked victims. However, in order to achieve these desired outcomes, victim-centered procedures and services must be in place to adequately support and to assist survivors of trafficking. Otherwise, reporting may do more harm than good. This is not an unreasonable concern. Too many states are unprepared to deal with the distinct needs of trafficked victims. State child-welfare systems are already overburdened and need to increase their capacities to respond. Many current protocols, procedures, and services for victims of abuse and exploitation were not developed with trafficking victims in mind (IOM [Institute of Medicine] and NRC [National Research Council], 2013). Reports from the field cite instances where mandatory reporting of trafficked minors has resulted in serious and harmful, even if unintended, consequences (IOM [Institute of Medicine] and NRC [National Research Council], 2013). According to the IOM/NRC Report, “In many states, a report of commercial sexual exploitation or sex trafficking of a minor to child protective services would be considered outside the purview of child protective services if the abuse were extrafamilial in nature. A report to law enforcement, on the other hand might lead to a victim’s arrest or some form of detention” (2013, p. 26). In some states, minors can still be arrested and charged with a crime—prostitution, for example—and prosecuted and incarcerated by law enforcement. To date, only 34 states have passed various forms of “safe harbor” laws, which shield young trafficking victims from criminal charges and require they be treated as victims and referred for services (Polaris, 2015). Most states with safe harbor laws have limited the protection to minors who have been commercially sexually exploited (CSEC), for example, prostitution and prostitution-related-crimes. Importantly, the most recently reauthorized TVPA sets forth the U.S. attorney’s model for state criminal law for protection of child-trafficking victims and survivors and directs that the model law contain a safe harbor provision.

If, after separating victims from traffickers, the goal of every state is to assist victims in their recovery process, then provision of services is key to assessing these statutes’ ultimate effectiveness. But none of the mandatory reporting statutes discussed herein is funded. Furthermore, trafficking victims often do not gain access to or benefit from services that are available (IOM and NRC, 2013). Services may be offered to victims who may then decline assistance for various reasons and then, all too often, end up back in abusive situations. Many trafficking victims have a long history of abuse and chronic exploitation and, thus, face multiple obstacles and unmet complex needs that contribute to the difficulty they have in leaving exploitive environments (Center for Court Innovation, 2015). Ideally, measuring both services offered and provided will give a clearer understanding of effective interventions. In order to respond effectively and sensitively to these difficult cases, all involved
stakeholders, including physicians and other health care providers as mandatory reporters, need to be prepared for the high rates of relapse and continued exploitation after “intervention,” so that their expectations about case outcomes are reasonable. It is important to note, however, that increasing awareness about human trafficking is stimulating an increase in services offered. For example, trafficking victims who escape their traffickers are often in need of legal advice on a variety of issues. Over recent years, an increasing number of pro bono lawyers from the nation’s big law firms have volunteers to fill this need, working collaboratively with law enforcement, nonprofit organizations, and health care providers.

Nevertheless, if health care providers anticipate that appropriate policies, procedures, and resources are not in place to provide for the safety of and services to trafficking victims, then they may decide not to report, despite their obligation to do so. One of the core bioethical principles, non-maleficence, demands that physicians “first do no harm.” The four-decades-long experience with child abuse and neglect gives insight into the ethical and practical dilemmas that physicians face with mandatory-reporting laws.

Lessons learned from child abuse and neglect laws
In response to clinical reports of battered children, all 50 states and the District of Columbia passed laws between the years 1963 and 1967 that required health care providers to report suspected cases of child abuse and neglect to appropriate state agencies (Flaherty et al., 2008). Several states also passed laws that mandated training about child maltreatment. In the ensuing 40 years, numerous ongoing reports in the medical literature document that physicians nevertheless underreport suspected child abuse (Pietrantonio et al., 2013). Investigators have documented that health care providers perceive numerous barriers to reporting. The barriers fall into two major areas: (a) lack of knowledge and failure to identify the underlying abuse and (b) consciously deciding not to report suspected abuse to state authorities due to concerns about the impact on themselves, as well as the children and their families (Sege & Flaherty, 2008). Specific barriers include lack of adequate training, unfamiliarity with the details of mandatory-reporting requirements, ambiguity about the meaning of the term “suspicious” in the statutes, lack of certainty about whether abuse caused the injury, concern over losing trust or disrupting the professional relationship with the child and family, fear of physical or legal reprisal, and stress about the time and effort it takes to report, to cooperate with authorities, and perhaps to testify in court (Sege & Flaherty, 2008).

Importantly, clinicians have repeatedly indicated that both skepticism regarding the overall utility of making reports and previous negative experiences with child protective services negatively influence their decision to report. Qualitative studies that focused on assessing the factors that influenced reporting have found that such doubts about the benefits of reporting played a significant role in clinicians’ decision making. Clinicians conjectured about how child protective services (CPS) would respond to a report, and, if they felt that either CPS would dismiss the case without investigation or that the outcome would not be beneficial to the child and family, then the clinicians sought alternative ways to deal with the situation (Jones et al., 2008). Lack of feedback from CPS about case outcomes may also contribute to low expectations among clinicians and reinforce their skepticism regarding the utility of filing a report. Clinicians give considerable weight to expected outcomes and need to feel comfortable that reporting will not result in further harm. It is important for mandated reporters to know that there is, in fact, a benefit: not only appropriate law-enforcement intervention but also critical services for the trafficking victim.

Barriers to reporting trafficking cases
It is reasonable to expect similar barriers will impede the willingness of physicians and other health care providers to report suspected or confirmed cases of trafficking. Some barriers may even be greater in cases of trafficking. For example, clinicians’ fear of physical or legal reprisal by traffickers is a real consideration, given the brutality often used by traffickers to keep victims compliant.
Reprisals against the victim are a concern as well. In addition, as these laws proliferate and gain traction, traffickers may stop taking exploited children and adolescents to emergency rooms and other health care facilities, thus limiting even further their access to much-needed health care. Health care providers may also find themselves in ethical dilemmas, obliged on the one hand to keep a minor’s medical history related to sexual health confidential, as required by law, and, on the other, to report a situation should certain kinds of information come to their attention while taking a history from an adolescent patient. Numerous studies have documented that adolescents place a premium on confidentiality when seeking sexual and reproductive health services; it significantly increases their willingness to engage with providers (Bender & Fulbright, 2013; Reddy, Fleming, & Swain, 2002). If victims know that health care providers are mandated to report to the state, they may not divulge critical aspects of their history, or they may themselves avoid seeking medical care (National Health Collaborative on Violence and Abuse, 2015). Furthermore, reporting procedures must reflect the reality of trafficking situations, and child-welfare and law-enforcement systems need to better understand trafficking and how it differs from other forms of child abuse and child abuse reporting. For example, required reporting of the victim’s parental names and addresses may not be feasible and may create an obstacle to reporting. Many reporters will have contact only with the minor, not the parents, when a third party (nonfamily) exploiter is involved. Parents may be unavailable or out of state, or the child may be involved in the child-welfare system or homeless.

It is not yet clear that mandatory reporting will improve how physicians and other health care professionals address human trafficking as they encounter it in their practices. The IOM/NRC report “cautions that adopting a universal reporting requirement without ensuring the adequate preparation of child welfare agencies may have unintended consequences that are harmful to the vulnerable children that the laws are designed to assist” (2013, p. 182). As state legislatures consider amending their mandatory reporting laws to include human trafficking, they should take the opportunity to address the known barriers to reporting and make specific provisions, when possible, to lessen their effects. For example, Massachusetts has an anti-retaliation provision to protect reporters and has also directed CPS to notify a reporter within 30 days about any follow-up on a reported case. States should also couple mandatory reporting laws with more protective safe harbor laws in recognition that minors who are trafficked should not be considered or treated as criminals.

**Conclusion**

Seventeen states have enacted training and/or mandatory reporting laws regarding human trafficking that affect health care providers and other professionals. Clearly laudable in purpose, these laws raise the question of how their effectiveness will be measured. We need to understand which approaches to education are most effective in improving health care providers’ awareness about trafficking and in increasing their competency to address it. And we need to understand whether mandatory reporting laws actually advance the goals of identifying, protecting, and assisting victims of trafficking. Currently, there is a lack of reliable and comprehensive data on all aspects of trafficking—prevention, prosecution, and protection—and a concerted effort is necessary to fill this gap. Presently, data sets are not standardized within or across states nor are data collected or shared systematically. Steps should be taken to identify specific data needs, to standardize data sets, to systematically collect data and disseminate data, and to provide useful platforms for key stakeholders, including law enforcement, social service agencies, nonprofit organizations, and, of course, health care facilities to compare strategies and to assess their effectiveness. Research is needed to identify the strengths, weaknesses, and disparities in the web of state criminal and civil laws. The new education and reporting laws discussed herein may well advance all these interests. To help reach that goal, however, adequate funds should be allocated to speed their implementation and to provide for the provision of trauma-informed, culturally sensitive care to victims of human trafficking. Best practices urgently need to be developed, which can then be implemented broadly through both federal and state initiatives.
Thirty-three states have yet to pass laws regarding health care provider training and/or reporting regarding human trafficking. These states would benefit greatly from best practices identified in the 17 states at the forefront of legislative initiatives. Stopping human trafficking requires a wide net, carefully cast, by many hands. States whose laws reflect the complexity of the problem will increase their likelihood of success.

Since this article was submitted, both Florida bills mandating education about human trafficking died in committee during the 2016 Legislative Session.

Notes


4. Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106–386), reauthorized by the Trafficking Victims Protection Reauthorization Act (TVPRAs) of 2003 (P.L. 108–193), the TVPRAs of 2005 (P.L. 109–164), and the William Wilberforce Trafficking Victims Protection Reauthorization Act (WW-TVPA) of 2008 (P.L. 110–457) and the TVPRAs of 2013 (P.L. 113–4). The TVPRA defines “severe forms of trafficking” as 1) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age; and 2) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. 22 U.S.C. §§ 7101–7113 (2000).


7. The number 40 in the search formulation directs the search to look for the words “human trafficking” within 40 words of “training” to limit findings and to avoid returning all general criminal laws relating to trafficking.


17. COLO. REV. STAT. § 18–3–505 (2014) (ordering that education be developed “for organizations that provide assistance to victims of human trafficking, for persons who work in or who frequent places where human trafficking victims are likely to appear, and for law enforcement agencies”); MO. REV. STAT. § 566.223 (2004) (ordering the department of public safety to establish education programs for state agencies such as “the children’s division of the department of social services, juvenile courts, state law enforcement agencies, health care professionals, and runaway and homeless youth shelter administrators”).

New Jersey’s education course is mandatory for employees of “health care facility[ies],” which is defined as a “facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis, or treatment of human disease, pain, injury, deformity, or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential health care facility, and bioanalytical laboratory (except as specifically excluded hereunder) or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer and excluding such bioanalytical laboratories as are independently owned and operated, and are not owned, operated, managed, or controlled, in whole or in part, directly or indirectly by any one or more health care facilities, and the predominant source of business of which is not by contract with health care facilities within the State of New Jersey and which solicit or accept specimens and operate predominantly in interstate commerce” N.J. STAT. ANN. §§ 2 C:13–12 (2013), 26:2 H-2 (2013).


41. MASS. GEN. LAWS ch. 119, § 51A (2008).

42. CAL. PENAL CODE § 11166 (West 2016).


46. In Maryland, for example, the written report must be within 48 hours of the oral report. MD. CODE ANN. FAM. LAW § 5–704. In California, the reporter must send, fax or email a written follow-up to the telephone report within 36 hours of learning of the child abuse or neglect. CAL. PENAL CODE § 11166 (West 2016).


53. MASS. GEN. LAWS ch. 119, § 51A(a) (2008).


57. NC. GEN. STAT. § 7B-301 (2013).


60. In Colorado, if the county department receives the report then it must send the report to the district attorney and law enforcement. COLO. REV. STAT. § 19–3–307. In Maryland, a report to the local department or law enforcement agency must be immediately reported to the other agency that did not receive the initial report. MD. CODE ANN. FAM. LAW § 5–704. In North Carolina, the Department of Social Services must notify the state’s Bureau of Investigation. NC. GEN. STAT. § 7B-301 (2013).


62. Maryland, Massachusetts, Missouri, New Jersey, North Carolina, and Washington do not contain any statutory provisions regarding data collection.


64. CAL. PENAL CODE § 11166 (West 2016); FLA. STAT. § 39.201 (1994); 325 ILL. COMP. STAT. 5/7/7.


67. This article discusses data-collection efforts arising from trafficking education and reporting laws only, not from criminal trafficking laws or child abuse and neglect laws.

68. 325 ILL. COMP. STAT. 5/7/7.


70. FLA. STAT. § 39.201 (1994).


72. In Louisiana, private entities that help trafficking victims must report to the Department of Children and Family Services annually regarding their efforts and services. LA. REV. STAT. ANN. § 46:2161 (2014).


43. A model law is one that provides language that integrates and coordinates differing laws and approaches from the states on a specific topic. States may adopt or reject a model law, in whole or in part.


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