

## STATE OF THE ART AND SCIENCE

### Ethical Considerations in Mandatory Disclosure of Data Acquired While Caring for Human Trafficking Survivors

Patrick L. Kerr, PhD, and Rachel Dash, ACSW, MSW

#### Abstract

Accurate data on the prevalence and psychological effects of human trafficking as well as treatment outcomes for survivors are essential for measuring the impact of interventions and generating better understanding of this phenomenon. However, such data are difficult to obtain. A legal mandate for health care professionals to report trafficking opens opportunities for advancing our work in the field of human trafficking but also poses risks to survivors seeking services. In this article, we provide an analysis of some critical ethical considerations for the development and implementation of a mandatory reporting policy and offer recommendations for the ethical implementation of such a policy.

#### Introduction

Human trafficking ("trafficking"), or slavery, is defined as sexual labor (e.g., prostitution, stripping, performing pornography) or nonsexual labor (e.g., agricultural, fishery, factory, or construction work) induced via force, fraud, or coercion [1]. Awareness of this phenomenon has increased over the past two decades, and it is increasingly being recognized as a significant global problem requiring comprehensive intervention [2]. The causes and effects of human trafficking are complex and are characterized by intersecting social, psychological, cultural, and political factors [3].

One primary challenge for anti-trafficking initiatives is obtaining accurate data on the prevalence and impact of trafficking. Even the best current estimates are impeded by limited information sources [3-5]. Estimates of the number of people living in slavery range from 4 million to 27 million [6, 7]; according to the most widely cited estimate, 20.9 million people are enslaved today [4]. Using law enforcement data, the US Department of State identified 369,083 trafficking victims worldwide between 2008 and 2015 [5], which is clearly inconsistent with the above estimates. The lack of accurate data is problematic because it prevents a clear understanding of the prevalence of human trafficking and its impact, thus impeding efficacious interventions. The lack of accurate data is attributable to a combination of factors: the illicit nature of trafficking, the lack of data comparability between countries due to differing data collection

systems, bias due to divergent understandings of reporting requirements, and differences in data collectors' definitions of human trafficking [8, 9]. In the US, a potential option for overcoming these barriers is health care professionals' [mandatory reporting](#) of suspected trafficking to governmental health and human service departments. Mandated reporting by health care professionals is required nationwide under some circumstances [10]; for child victims of trafficking, it would fall under child abuse reporting requirements [11].

### **Mandatory Reporting of Human Trafficking in Health Care Settings**

Required disclosure of information about trafficked persons, including their health status and their health care needs, would follow the same line of reasoning as mandated [reporting for infectious diseases](#). Like public health strategies for infectious disease, ending trafficking requires a multifaceted approach that identifies people being trafficked and responds to their health care and psychosocial needs. This approach should be legally distinct from mandated reporting laws aimed at preventing harm to vulnerable populations (e.g., for child abuse or neglect) but could still facilitate intervention in trafficking cases. In both circumstances, mandated reporting may precipitate intervention and prevent further harm.

Mandated reporting legislation for trafficking is nascent. As of 2016, 13 states have mandated reporting laws for trafficking that are distinct from child abuse or neglect reporting requirements [12]. Yet all but one state statute applies to children only; the exception is Illinois, which extends reporting requirements to youth ages 18-22 in state-run facilities [12]. As the health effects of trafficking and the health care needs of trafficking victims and survivors become better understood, health care professionals' role in identifying trafficking and responding to the needs of adult and youth survivors has become clear [13-16]. If mandatory reporting laws for trafficking are in place with uniform data reporting requirements and a single, unified data collection system is established, health care settings may serve as a useful forum to document the actual volume of trafficking and its impact on survivors. However, calculating the prevalence of trafficking and its health effects from mandated reports would likely be limited in that the number of unreported trafficking cases, like the number of child abuse cases, can only be estimated.

### **Public Health Surveillance as a Response to Human Trafficking**

In the twenty-first century, the concept of public health problems has expanded from infectious diseases to include a multitude of social and psychosocial causes of poor health and death like smoking, suicide, and violence [17, 18]. Trafficking also constitutes a public health problem [19]. Todres [19, 20] has proposed a public health surveillance model that would facilitate better data collection on the incidence, prevalence, and associated social, psychological, and behavioral risk factors for being trafficked. Extrapolating from Todres's proposal, the rationale for this approach is twofold: (1)

trafficking adversely affects the health of survivors and their communities and (2) trafficking cannot be addressed as either a health or societal problem through legislative and law enforcement avenues alone.

Public health surveillance for trafficking could be modeled on public health surveillance for infectious diseases, which involves monitoring the health of the population and identifying risks for outbreaks of infection using a case-based or statistical approach [21]. Case-based surveillance focuses on the individual level and is most effective in preventing the spread of disease within a population [21]. However, the goal of intervention is commonly stymied by a lack of resources for follow-up on identified cases, concern that the disease carrier would be stigmatized if identified, and the specific infection course of the disease (i.e., latency period for symptoms relative to time of infection) [21]. Although this approach is well intentioned, its attendant privacy and confidentiality risks can outweigh the potential health benefits to the person or the population, especially when there is stigma associated with a disease or condition (e.g., HIV, hepatitis C) [21].

By contrast, statistical surveillance is a population-level surveillance methodology that facilitates disease monitoring with minimal risk of violations of patient privacy and confidentiality. One approach to statistical surveillance of disease combines data from death and birth certificates with epidemiological research. Another approach is the use of [disease registries](#), which collect de-identified data on types and outcomes of diseases or conditions. Cancer registries and state trauma registries have been effectively implemented to accurately but confidentially record courses of specific diseases in particular cases when they present in health care settings. The registry approach is thus an effective tool for generating accurate estimates of clinical disease epidemiology, with minimal risk to confidentiality and privacy [21].

These two public health surveillance methodologies can be applied to mandated reporting. In general, a registry appears to be preferable to a case-based investigational method because it affords better protection against breaches of confidentiality and requires fewer resources. However, the use of a registry system for reporting trafficking would likely require systemic changes to facilitate accurate and ethical data collection. By default, survivors have been victimized by gross violations of their basic human rights [22]. There are cogent reasons for their distrust of health care professionals beyond their experiences of victimization by traffickers. Well-intentioned responders sometimes inadvertently violate survivors' rights by "outing" or re-traumatizing them through interviews [22]. Mandated disclosure of information about excruciating experiences in slavery risks retraumatizing survivors [23]. Moreover, survivors are often lied to by traffickers about the harms of seeking help (e.g., they are told they will be shamed, arrested, deported). Thus, disclosure may reinforce victims' and survivors' [distrust](#) of health care professionals. Development of a reporting system that is sensitive and

responsive to the unique experiences of trafficking victims and survivors will be essential, and survivors will have a critical role to play in shaping that system.

### **Benefits and Risks of Mandated Reporting of Human Trafficking by Health Care Professionals**

It is important to note that there is already a system in place for reporting suspicions of trafficking to the National Human Trafficking Resource Center using the national hotline, which victims may also call or text to receive help [24]. Information from these calls is submitted to law enforcement agencies, which then investigate the situations reported. In contrast, the issue addressed here pertains to reporting by health care professionals of confirmed (to the extent possible) cases of trafficking encountered during the provision of health care services.

*Benefits to population.* There are two primary advantages to mandated reporting of trafficking by health care professionals. First, knowing that trafficking is increasing or decreasing in certain regions or during certain time periods may illuminate causal factors that could then be targeted by intervention and prevention efforts. Second, accurate data could inform policy decisions regarding fiscal appropriations for survivors' health care service needs and anti-trafficking initiatives. Funding for anti-trafficking work could benefit from accurate data that might help funnel resources to areas with the greatest need [25-27].

*Risks to individuals.* There are multiple risks to trafficking victims and survivors from mandated reporting of trafficking by health care professionals. First, trafficking victims and survivors may not understand the consequences of reporting. For mandated reporting guidelines to be implemented ethically, consent forms to receive health care services would need to incorporate statements about mandatory reporting of human trafficking—whether suspected or confirmed. This would necessitate consideration of the coercive nature of trafficking and the wide variability in trafficking survivors' backgrounds as well as their potential distrust of clinicians. Trafficking victims' and survivors' English proficiency, literacy, emotional state, history of coercion, comprehension of rights, ability to understand limits of confidentiality, and familiarity with how trafficking is defined can all inhibit effective communication with health care professionals and limit their ability to understand the limits of confidentiality with respect to their experiences in trafficking. For example, most survivors do not self-identify as being trafficked. Some may see themselves as a willing participant in prostitution because their trafficker is their "boyfriend" (a common term for sex traffickers/pimps); others may not understand that their exploitation by a "boss" to whom they are "indebted" and who prevents them from leaving their worksite constitutes trafficking. The challenge of ensuring that informed consent procedures can be followed is tied to broader issues of ensuring survivors' trust and safety, which are

rooted in their experiences of physical threat, danger, loss of power over their lives, and disenfranchisement from decisions that affect their well-being [28].

Second, while protocols for maintaining the security of trafficking data could be implemented, security breaches of personal information are possible even with highly secure data [26]. The more places that health information resides, the more vulnerable the data becomes. This places survivors at risk for identification, which can increase the risk of retaliation by traffickers. Moreover, the mere existence of a system for mandated reporting may be misinterpreted by traffickers as posing a threat to their enterprise. This may deter traffickers from permitting victims to access health care or may induce them to seek retribution when survivors seek health care, thus further limiting opportunities to identify survivors and offer assistance.

### **Is Mandatory Reporting of Human Trafficking by Health Care Professionals Ethical?**

In the US, protection of confidentiality of personal health information is codified in federal law [29]. Exceptions to these protections, such as disclosure for research, are also built into ethical guidelines and laws and are based on the principle of nonmaleficence. Provisions for exempting health information from confidentiality in specific circumstances ensure that the benefits of disclosure outweigh the risks [30]. In evaluating the potential risks and benefits of disclosure, the answer to the question of whether mandatory reporting of trafficking is ethical is “yes”; however, this must be cautiously qualified within a bioethics framework.

Beauchamp and Childress [31] have articulated four principles for ethical decision making regarding medical practice or research: (1) respect for autonomy, defined as a person’s capacity for autonomous/independent decision making; (2) nonmaleficence (“do no harm”); (3) beneficence (“do good” when ethical and feasible); and (4) justice, defined as the equitable distribution of benefits, risks, and costs. Through this bioethical lens, mandated reporting of trafficking must be contextualized. Respect for autonomy, the balance of good versus harm done, and distribution of justice would be situationally dependent. The priority in applying these principles to practice would be a risk/benefit analysis for the individual patient. Health care professionals must be given specific criteria to use in determining if reporting trafficking will pose undue risks to the individual patient to whom they are providing care. Criteria could include whether reporting unduly deprives the survivor of autonomy in the disclosure of health information, whether benefits of reporting this survivor’s information would outweigh the risks of doing so, and whether the potential harm prevented is equal to or greater than the potential harm done.

### **Conclusion**

Future legislation or policies at the state or federal level regarding mandated reporting of trafficking by health care professionals must balance the importance of goals such as

increased accuracy of data with respect for the needs of the patient. In conclusion, we offer the following recommendations for the process of developing such policies:

1. Trafficking survivors must be part of development of such a policy.
2. Research on the potential short- and long-term impacts of mandated reporting on trafficking survivors must be conducted before proceeding with policy development.
3. Legislation for mandated reporting of trafficking must include funding for appropriate training of health care professionals in identification and reporting of trafficking and funding streams for publicly funded health care services for survivors.
4. Models of informed consent that meet the unique needs of diverse trafficking survivor populations must be implemented.
5. A trafficking registry with minimal identifying data should be the first choice considered among public health surveillance methodologies.

Human trafficking is a complex phenomenon, the nature and effects of which are just beginning to be fully understood. Mandated reporting of human trafficking presents both opportunities for better addressing this problem as well as risks. A thoughtful survivor-informed process for developing a system for mandated reporting will be necessary for balancing the needs and goals of all respective stakeholders, including survivors, health care professionals, policymakers, and the general public.

## References

1. United Nations. Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Criminal Organization. <http://www.osce.org/odihr/19223?download=true>. Adopted 2000. Accessed July 10, 2016.
2. World Health Organization. Understanding and addressing violence against women: human trafficking. [http://apps.who.int/iris/bitstream/10665/77394/1/WHO\\_RHR\\_12.42\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77394/1/WHO_RHR_12.42_eng.pdf). Published 2012. Accessed July 10, 2016.
3. Kerr PL. Treating trauma in the context of human trafficking: intersections of psychological, social, and cultural factors. In: Ghafoori B, Caspi Y, Smith SF, eds. *International Perspectives on Traumatic Stress: Theory, Access, and Mental Health Services*. New York, NY: Nova Publishers; 2016:199-222.
4. International Labour Office. ILO global estimate of forced labour: results and methodology. Geneva, Switzerland: International Labour Office; 2012. <http://unact.org/wp-content/uploads/2014/08/ILO-global-estimate-of-forced-labour1.pdf>. Accessed November 22, 2016.

5. US Department of State. *Trafficking in Persons Report*. <https://www.state.gov/documents/organization/258876.pdf>. Published 2016. Accessed September 21, 2016.
6. Farr K. *Sex Trafficking: The Global Market in Women and Children*. New York, NY: Worth; 2005.
7. US Department of State. *Trafficking in Persons Report*. <http://www.state.gov/documents/organization/210737.pdf>. Published June 2013. Accessed November 22, 2016.
8. Kangaspunta K. Collecting data on human trafficking: availability, reliability and comparability of trafficking data. In: Savona EU, Stefanizzi S, eds. *Measuring Human Trafficking: Complexities and Pitfalls*. New York, NY: Springer; 2007:27-36.
9. Aromaa K. Trafficking in human beings: uniform definitions for better measuring and for effective counter-measures. In: Savona EU, Stefanizzi S, eds. *Measuring Human Trafficking: Complexities and Pitfalls*. New York, NY: Springer; 2007:13-26.
10. Durborow N, Lizdas KC, O'Flaherty A. Compendium of state statutes and policies on domestic violence and health care. Family Violence Prevention Fund. [http://www.acf.hhs.gov/sites/default/files/fysb/state\\_compendium.pdf](http://www.acf.hhs.gov/sites/default/files/fysb/state_compendium.pdf). Published 2010. Accessed November 21, 2016.
11. Child Welfare Information Gateway. Mandatory reporters of child abuse and neglect. <https://www.childwelfare.gov/pubPDFs/manda.pdf>. Accessed November 9, 2016.
12. Atkinson HG, Curnin KJ, Hanson NC. US state laws addressing human trafficking: education of and mandatory reporting by health care providers and other professionals. *J Hum Trafficking*. 2016;2(2):111-138.
13. Zimmerman C, Hossain M, Watts C. Human trafficking and health: a conceptual model to inform policy, intervention and research. *Soc Sci Med*. 2011;73(2):327-335.
14. Oram S, Stöckl H, Busza J, Howard LM, Zimmerman C. Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: systematic review. *PLoS Med*. 2012;9(5):e1001224. <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001224>. Accessed November 22, 2016.
15. Hemmings S, Jakobowitz S, Abas M, et al. Responding to the health needs of survivors of human trafficking: a systematic review. *BMC Health Serv Res*. 2016;16:320. <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1538-8>. Accessed November 22, 2016.
16. Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. *Health Hum Rights*. 2011;13(1):e36-e49.
17. World Health Organization. Public health action for the prevention of suicide: a framework.

[http://apps.who.int/iris/bitstream/10665/75166/1/9789241503570\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75166/1/9789241503570_eng.pdf) .  
Published 2012. Accessed November 22, 2016.

18. Taylor AL, Bettcher DW. WHO Framework Convention on Tobacco Control: a global "good" for public health. *Bull World Health Organ.* 2000;78(7):920-929.
19. Todres J. Moving upstream: the merits of a public health law approach to human trafficking. *North Carolina Law Rev.* 2011;89(2):447-506.
20. Todres J. Assessing public health strategies for advancing child protection: human trafficking as a case study. *Brooklyn J Law Policy.* 2012;21(1):92-112.
21. Stoto MA. Public health surveillance in the twenty-first century: achieving population health goals while protecting individuals' privacy and confidentiality. *Georgetown Law J.* 2008;96(2):703-719.
22. Taylor LR, Sullivan M. Raising the standard of ethics and human rights among anti-human trafficking responders in the Mekong Region. *Hum Rights Educ Asia Pac.* 2012;3:55-69. <http://www.hurights.or.jp/archives/asia-pacific/section1/pdf/3%20-%20Raising%20the%20Standard%20of%20Ethics%20and%20Human%20Rights%20Among%20Anti-human%20Trafficking%20Reponders%20in%20the%20Mekong%20Region.pdf>. Accessed September 21, 2016.
23. Macias-Konstantopoulos W, Bar-Halpern M. Commercially sexually exploited and trafficked minors: our hidden and forgotten children. In: Parekh R, Childs EW, eds. *Stigma and Prejudice: Touchstones in Understanding Diversity in Healthcare.* Cham, Switzerland: Springer International; 2016:183-202.
24. National Human Trafficking Resource Center website. <https://traffickingresourcecenter.org/>. Accessed November 10, 2016.
25. Kinney EC. Appropriations for the abolitionists. Undermining effects of the US mandatory anti-prostitution pledge in the fight against human trafficking and HIV/AIDS. *Berkeley J Gend Law Justice.* 2006;21(1):157-192.
26. Bales K. *Disposable People: New Slavery in the Global Economy.* Berkeley, CA: University of California Press; 2012.
27. Bales K, Soodalter R. *The Slave Next Door: Human Trafficking and Slavery in America Today.* Berkeley, CA: University of California Press; 2009.
28. Cwikel J, Hoban E. Contentious issues in research on trafficked women working in the sex industry: study design, ethics, and methodology. *J Sex Res.* 2005;42(4):306-316.
29. US Department of Health and Human Services. Summary of the HIPAA Privacy Rule. United States Department of Health and Human Services. 2003. <https://www.hhs.gov/sites/default/files/privacysummary.pdf>. Revised May 2003. Accessed November 22, 2016.
30. Czajka J, Schneider C, Sukasih A, Collins K. Minimizing disclosure risk in HHS open data initiatives. Washington, DC: Mathematica Policy Research; 2014.

[https://aspe.hhs.gov/sites/default/files/pdf/77196/rpt\\_Disclosure.pdf](https://aspe.hhs.gov/sites/default/files/pdf/77196/rpt_Disclosure.pdf).  
Accessed November 10, 2016.

31. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 5th ed. Oxford, UK: Oxford University Press; 2001.

**Patrick L. Kerr, PhD**, is a clinical psychologist and an associate professor in the Department of Behavioral Medicine and Psychiatry at West Virginia University (WVU) School of Medicine- Charleston, where he directs the WVU Dialectical Behavior Therapy Services Program. He also serves as a member of the West Virginia Human Trafficking Task Force. His research and clinical interests include suicidal behavior, nonsuicidal self-injury, mood disorders, and traumatic stress.

**Rachel Dash, ACSW, MSW**, is an assistant professor in the Department of Behavioral Medicine and Psychiatry at West Virginia University School of Medicine-Charleston, where she directs the family therapy training program for psychiatry residents and is a licensed clinical social worker. Her scholarly and clinical interests include traumatic stress, dissociative disorders, and treatment of the sequelae of childhood abuse.

**Related in the *AMA Journal of Ethics***

[Can There Be healing without Trust?](#), July 2006

[Human Trafficking in Areas of Conflict: Health Care Professionals' Duty to Act](#), January 2017

[Mandatory Reporting of Human Trafficking: Potential Benefits and Risks of Harm](#), January 2017

[Physician Encounters with Human Trafficking: Legal Consequences and Ethical Considerations](#), January 2017

[Privacy and Public Health Surveillance: The Enduring Tension](#), December 2007

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

**Copyright 2017 American Medical Association. All rights reserved.  
ISSN 2376-6980**