

Psychosocial and Mental Health Service Provision for Survivors of Trafficking

Baseline Research
in the Greater Mekong Subregion and Indonesia

Sean Devine



IOM International Organization for Migration



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The author prepared this report for the International Organization for Migration (IOM), Bangkok, Thailand. Opinions expressed in this document are those of the author and do not necessarily reflect the views of the International Organization for Migration.

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Foreword

Trafficking in persons is a crime that constitutes a serious violation of human rights, undermines human dignity and adversely affects the physical, psychological, emotional and moral development of a person, jeopardizing social cohesion and values. Many trafficked persons feel degraded in their identity as a result of having suffered unbearable kinds of exploitative situations. Many of them are forced physically and mentally to do things against their will and have to stand the use of force, coercion, abuse or even torture, the impacts of which may be difficult to be overcome.

The assistance provided to trafficked persons, therefore, must entail much more than rescuing, sheltering them and/or returning them back to their home country or community. The degree of suffering experienced by the trafficked individual depends on the severity of exploitation they underwent, the living, sanitation and nutrition conditions they had to cope with, and the duration of time they were exploited, among others. That is why provision of psychosocial assistance from the moment of rescue or escape, to the successful (re) integration of the victim into his/her home society, plays a vital role in the assistance trafficked persons should be provided.

“The girl who has been trafficked is like the moon in the sky that has no light” is one of the statements the reader will come across in this publication. The common aim of the service providers must therefore be to bring back the light to the moon. This baseline research on Psychosocial and Mental Health Service Provision for Survivors of Trafficking in the Greater Mekong Sub Region and Indonesia has been developed by IOM Thailand’s Counter-Trafficking Unit to give information on current mental/emotional well being and psycho-social interventions applied in the GMS by government agencies, NGOs and other actors. The preliminary findings of the baseline research were presented as reference material in the regional workshop on “Mental Health and Psycho-Social Assistance for Victims of Trafficking from the Greater Mekong Sub Region” organized by IOM in late 2007. The research provides a situational analysis of the GMS countries on their ability to diagnose, treat, provide counselling services and provide referral mechanisms. It is envisioned that this baseline research will be used as a promotion and advocacy tool by national and regional health authorities and health policy makers to establish a standardized approach to mental health and psychosocial interventions for victims of trafficking in this region.

All the agencies interviewed for this research, in addition to several others agencies in the sub region are working hard to take care of exploited people. Despite this, many of those interviewed stated that there is still a lot to learn and accomplish in order to provide complete and accurate assistance to victims of trafficking. We would like our baseline research to be a useful and informative instrument to all those regularly assisting trafficked persons and to encourage them to try even harder to develop improved insight into the psychosocial issues related to this atrocious crime.



Monique Filsnoël
Chief of Mission

International Organization for Migration, Thailand

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Preface

Human trafficking is a harmful and sometimes deadly practice whereby an individual is enticed by a job offer and hope for a better future into a cycle of migration and exploitation.

Trafficked persons may have chronic as well as acute health problems that are both physical and psychological in nature. If left untreated, the physical and psychological problems could become more severe and often chronic. Good-quality and culturally sensitive health care therefore needs to be provided in all phases of the recovery and reintegration process not only to address the physical health needs of trafficked persons but also to take into account their particular mental/emotional well-being and psychosocial circumstances.

Information on actual health priorities and on the capacity of current health-care systems to assist trafficked persons is severely limited in the Greater Mekong Subregion. In view of this lack of information, IOM supported the drafting of this “baseline paper” which inventories current “psychosocial” intervention measures, while focusing on the mental and emotional well-being of trafficked persons, examining interpretations of “psychosocial” support and constructively critiquing the efficacy and breadth of such interventions. Knowledge of existing psychosocial services that can be tapped for the benefit of trafficked persons is vital when preparing and assisting in their return to and reintegration in their home countries and communities. Importantly, it was deemed necessary to examine also the link between the provision of services and the actual needs and rights of the individual.

A culturally sensitive questionnaire was designed to elicit information from governmental and non-governmental entities that provide trafficked persons with psychosocial assistance at all stages, from their recovery to reintegration. To ensure that the research methodology was sound and practical, a technical reference group was formed to provide the author with ongoing technical guidance. Members of the reference group had backgrounds in the provision of mental health/well-being and a comprehensive understanding of culturally sensitive community-based methodologies for providing trafficked persons with psychosocial support.

This baseline research includes a review and analysis of existing literature, policies and guidelines, a national policy review on mental/emotional well-being and psychosocial service provision for trafficked persons, and a situational analysis of the current mental health/emotional well-being and psychosocial care systems in the Greater Mekong Subregion¹ -with regard to their ability to treat, diagnose and provide counselling services and links to referral mechanisms, as well as to the appropriateness of the psychosocial services (key informant interviews).

¹ Similar information was not available in all countries.

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The purpose of the baseline research is to provide a snapshot view of the provision of psychosocial and mental health services for trafficked persons in the Greater Mekong Subregion and Indonesia, highlighting good practices and providing some constructive recommendations to guide further programming in this crucial area. Hopefully the baseline research will achieve this goal and prove to be informative since so much is at stake.

In the end, it is helpful always to remind ourselves of the human side of this inexplicable trade: men, women and children are being sold, bought and abused. Because of the enormity of trafficking as a crime, it is our moral duty to act and intervene on behalf of the persons trafficked when it is possible to do so. Too often we desensitize or devalue the criminal act of trafficking by diluting or broadening its definition so that this crime conceptually becomes entwined or confused with smuggling and labour migration. In doing so, we detract our attention from "real" trafficked persons – helpless human beings in most need of our help. There are other risks, too. The services and resources directed towards trafficked persons can over time become stretched, ineffective and no longer individualized owing to the large number of such persons being assisted. Such a situation inadvertently results in the misdirection of service provision methodology and, sadly, may possibly affect our mindset as we become more and more influenced by other vulnerable groups also in need of assistance.

On a final note, the author should like to express the hope that trafficked persons would be given the opportunity to accept or deny any assistance offered them – in reality it is their right to do so.

Acronyms

AENEAS	Programme for Financial and Technical Assistance to Third Countries in the Area of Migration and Asylum
AFESIP	Agir Pour Les Femmes En Situation Precaire (Acting for Women in Distressing Circumstances)
AIDS	Acquired Immunodeficiency Syndrome
AIM	Agape International Missions
ARIAT	Asia Regional Initiative Against Trafficking
ATSECC	Aftercare for Trafficked and Sexually Exploited Children in Cambodia
CEDAW	Declaration on the Elimination of All Forms of Discrimination Against Women
COMMIT	Coordinated Mekong Ministerial Initiative against Trafficking
COSECAM	Coalition to address (Sexual) Exploitation of Children in Cambodia
CRC	Convention on the Rights of the Child
DSDW	Department of Social Development and Welfare (Thailand)
ECPAT	End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes
GMS	Greater Mekong Subregion
GO	Governmental Organization
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
ICD X	International Classification of Disease 10
INTERPOL	International Criminal Police Organization
IOM	International Organization for Migration
JLCAMS	Jane Lopacka Counseling and Mediation Services
LICADHO	Cambodian League for the Promotion and Defense of Human Rights
MHD	Mental Health Department
MMPI	Minnesota Multiphasic Personality Inventory
MOU	Memorandum of Understanding
MTI	Mercy Teams International
NGO	Non-Governmental Organization
NPC	National People's Congress
PTSD	Post-traumatic Stress Disorder
SCUK	Save the Children United Kingdom
SSC	Social Services of Cambodia
TAT	Thematic Appreciation Test
TOC	Transnational Organized Crime
TPO	Transcultural Psychosocial Organization
UNFPA	United Nations Population Fund
UNIAP	United Nations Inter-Agency Project
UNICEF	United Nations Children's fund
VOT	Victim of Trafficking
VT	Vocational Training
WHO	World Health Organization

Figure 1. Map of Greater Mekong Subregion

GREATER MEKONG SUBREGION



Map No. 4112 Rev. 2 UNITED NATIONS
January 2004

Department of Peacekeeping Operations
Cartographic Section

Psychosocial and Mental Health Service Provision for Survivors of Trafficking

Baseline Research in the Greater Mekong Subregion and Indonesia

Chapter 1

Executive summary

There is a pressing need to provide trafficked persons with good-quality health care not only to address their physical health needs but also to take into account their particular mental and emotional well-being and psychosocial circumstances when they return to their countries and communities of origin. However, there is a paucity of information about what constitutes such health priorities and about the capacity of current health-care systems to provide such support in the Greater Mekong Subregion (GMS) and beyond. GMS comprises six economies: Cambodia, the Lao People's Democratic Republic, Myanmar, Thailand, Viet Nam and Yunnan Province of China.

When preparing/assisting trafficked persons to return to and reintegrate into their home countries and communities, knowledge of existing psychosocial services that can be tapped for their benefit becomes vital. It is for this reason that the International Organization for Migration supported the preparation of this "baseline" report, which to a degree inventories current psychosocial intervention measures, focusing on the psychosocial well-being and mental health services being utilized in the Subregion and beyond for the recovery of trafficked persons. It also examines interpretations of "psychosocial" support and constructively reviews the efficacy and breadth of such interventions. Further, it focuses heavily on the link between the provision of services and the actual needs and rights of trafficked individuals, because in some instances the services afforded them are inconsistent with their actual needs, that is, not all the services are "individualized". In turn, such services may inadvertently be the cause of further psychological distress or "re-victimization".

The report examines the networks and referral mechanisms utilized by organizations and agencies, as well as the way in which they function and are maintained. It also suggests areas where they could be strengthened.

The report explores the use of written and unwritten policies, principles and minimum standards of care. It finds that some countries are far more advanced than others in the provision of psychosocial services and more specialized mental health interventions for trafficked persons.

Recommendations are made concerning the need for specialist training in psychosocial care and the establishment of more technical networks and mechanisms for information and knowledge-transfer among the organizations and agencies assisting trafficked persons and other technical specialist agencies.

The report uses the term "trafficked person" instead of "victim" or "survivor" as there is a lack of consensus on which of the terms is more appropriate. It does however suggest that trafficked persons at some point should be helped to regain their personal identity, because this is an important step in their rehabilitation process: eventually they should become label-free.

Literature review

Background

Trafficking in persons is a significant yet still largely undetected crime. Although no hard data on the number of cases are available, the United Nations Population Fund (UNFPA) notes that, once domestic trafficking is taken into account, an estimated 4 million human beings are trafficked each year worldwide.¹

According to Interpol, human trafficking is the fastest growing type of crime in the world, with the number of trafficked persons continually rising.² Trafficking in persons includes the recruitment, transportation and sale of persons (males and females, adults and children) for labour or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, or debt bondage. Trafficking is often referred to as a form of modern-day slavery.³ Although many trafficked persons are forced to work in the sex trade, other trafficking situations are domestic servitude, construction, labour in a prison-like factory, or migrant agricultural work.

Human trafficking is differentiated from human smuggling because it involves force, violence and/or deception. Human trafficking is a crime against the person being trafficked and against the country to which a person is being illegally transported. The victims of human trafficking are considered victims of a crime committed by others.⁴

The identification of trafficked persons presents a complex issue and a fundamental problem in all anti-trafficking strategies, constituting a complex and time-consuming process that requires professional guidance and support structures to create a safe space for the persons concerned. For a variety of reasons -- many of them subjective in nature, including perceptions such as mistrust towards public officials and feelings of fear and shame -- those caught up in human trafficking often do not want to reveal their status.⁵ Trafficked persons may be identified by a variety of actors such as law enforcement officials, non-governmental organizations (NGOs), local welfare organizations and labour unions, particularly if personnel are trained and if a referral system is in place.

Trafficking represents a gross violation of basic human rights. Trafficked persons often come from economically disadvantaged circumstances and have little or no formal education or skills training; therefore, they have limited opportunities for economic independence. In some cases, trafficked persons may have received a formal education but, owing to limited economic opportunities in their home country, they have fallen prey to traffickers' false promises of legitimate, well-paying jobs. Regardless of their background, trafficked persons typically feel great shame and responsibility for their victimization. Trafficked individuals suffer varying degrees and forms of exploitation, the impact of which differs from person to person. While the needs of trafficked persons are sometimes complex and acute, they are not always so, as the impact on an individual is not uniformly consistent

¹ <http://www.unfpa.org/gender/violence1.htm>

² <http://www.interpol.int/Public/THB/default.asp>

³ http://www.un.org/Pubs/chronicle/2007/webArticles/041607_humantrafficking.htm

⁴ <http://www.interpol.int/Public/THB/default.asp>

⁵ International Organization for Migration, *Psychosocial Notebook*, vol. 4, 2004.

⁶ Phyllis Coontz and Catherine Griebel, "International approaches to human trafficking: The call for a gender-sensitive perspective in International law", *Women's Health Journal*, vol. 4, 2004.

from case to case. Often a person may require a period of weeks or months before she or he develops the trust necessary to overcome emotional distress and start to talk with others about her or his situation. This fact is often emphasized by care providers.

Capitalizing on trafficked persons' fear and isolation, traffickers make repeated profits from their victims' situation. This cyclical effect distinguishes human trafficking from other organized crimes...where profits are collected once based on a single service or product.⁶

While trafficked persons share some of the same needs as those who have been the victims of other types of crimes, such as domestic violence, trafficked persons require additional services. For example, persons trafficked from other countries typically experience language and communication barriers, and lack information about their legal rights under the national laws and legal process while abroad, or lack knowledge about the victim assistance programmes that may be available, no matter how scarce they may be. Some critical factors in rehabilitation, recovery and reintegration include the trafficked persons' age, physical and psychological health, background, social and family life, culture, duration of exploitation and perceptions of the damage done to their person and their future as a result of having been trafficked. The long-term recovery, rehabilitation and reintegration of trafficked persons can involve the provision of educational and economic opportunities, as well as extended psychosocial and health-care services, depending on the individual needs of these persons.

The United Nations Trafficking Protocol itself contains a series of recommendations for victim protection, including training in this discipline for immigration and law enforcement officials, support for facilitating the "physical, psychological and social recovery of trafficked persons especially in the provision of appropriate housing, counselling, medical care, material assistance and employment, educational and training opportunities"; the granting of temporary residence permits and making a commitment to the safe and voluntary return of trafficked persons. However, these provisions are not binding on States.⁷

According to the International Organization for Migration (IOM), trafficking in human beings, whether they be men, women or children, is a phenomenon of disturbing proportions in GMS.⁸ While the number of persons trafficked annually from and within the Subregion is not known with certainty, estimates range from 200,000 to 450,000. Those numbers however generally refer to women and children. Accurate figures on the number of trafficked men are even more elusive.⁹ In the last decade, GMS Governments have recognized that individuals deceived and exploited by traffickers should be treated as trafficked persons, rather than simply illegal migrants. On that basis, a general consensus has emerged on the need to focus counter-trafficking responses on the areas of trafficking prevention, protection of trafficked persons and prosecution of traffickers.¹⁰ This consensus is evinced by the signing of the Coordinated Mekong Ministerial Initiative against Trafficking (COMMIT) Memorandum of Understanding in 2005.¹¹

⁷ <http://www.interpol.int/Public/THB/default.asp>

⁸ http://www.iom-seasia.org/resource/pdf/Infosheet_CT.pdf

⁹ http://www.iom-seasia.org/resource/pdf/Infosheet_CT.pdf

¹⁰ http://www.iom-seasia.org/resource/pdf/Infosheet_CT.pdf

¹¹ http://www.no-trafficking.org/content/COMMIT_Process/commit_background.html

Psychosocial support

The term “psychosocial” refers to the dynamic relationship between psychological and social elements affecting human development. The concept of psychosocial is closely linked to the concepts of “well-being” or “wellness”. Most definitions of psychosocial are based on the assumption that psychological and social factors are responsible for the well-being of people. Humanitarian agencies have come to prefer the term “psychosocial well-being” over narrower concepts such as “mental health”, because it points explicitly to social and cultural as well as psychological influences on well-being. The term psychosocial implies a very close relationship between psychological and social factors.

In this report, the psychosocial well-being of an individual is defined with respect to three core domains: human capacity, social ecology, and culture and values. Psychological factors include emotions and cognitive development, that is, a person’s capacity to learn, perceive and remember. Social factors concern a person’s capacity to form relationships with other people and to learn and follow culturally-appropriate social codes. Human development hinges on social relationships. Forming relationships is a human capacity as well as a human need, a factor that becomes especially relevant in humanitarian work, when the natural social structures that support the normal functioning of people have been disrupted.¹²

Psychosocial care and support are interventions and methods that enhance a person’s ability to cope in his or her own context and to achieve personal and social well-being. In the past, psychosocial recovery was understood and implemented in different ways by different organizations. There was very little consensus about how the term should be defined and what elements are essential in a psychosocial programme. Recovery encompasses the psychological and social dimensions that are part of the regeneration of an individual or a community. The psychosocial support approach was developed for helping people in situations of emotional distress and stress. It includes a time frame, mechanisms and various activities that protect people in distressing and difficult situations and provides them with positive human relationships in order to help restore their sense of self-respect and ability to overcome anxiety and despair. The specific objectives of psychosocial support programmes are to reduce the impact that stress and emotional distress have on individuals and to strengthen individual and community coping mechanisms and healing processes.¹³

“Psychosocial interventions seek to positively influence human development by addressing the negative impact of social factors on people’s thoughts and behaviour. They also seek to ameliorate the effects of negative thoughts and behaviour on the social environment through facilitating activities that encourage positive interaction among thought, behaviour, and the social world.”¹⁴

¹² http://www.no-trafficking.org/content/COMMIT_Process/commit_background.html

¹³ <http://www.unfpa.org/gender/violence1.htm>

¹⁴ <http://www.interpol.int/Public/THB/default.asp>

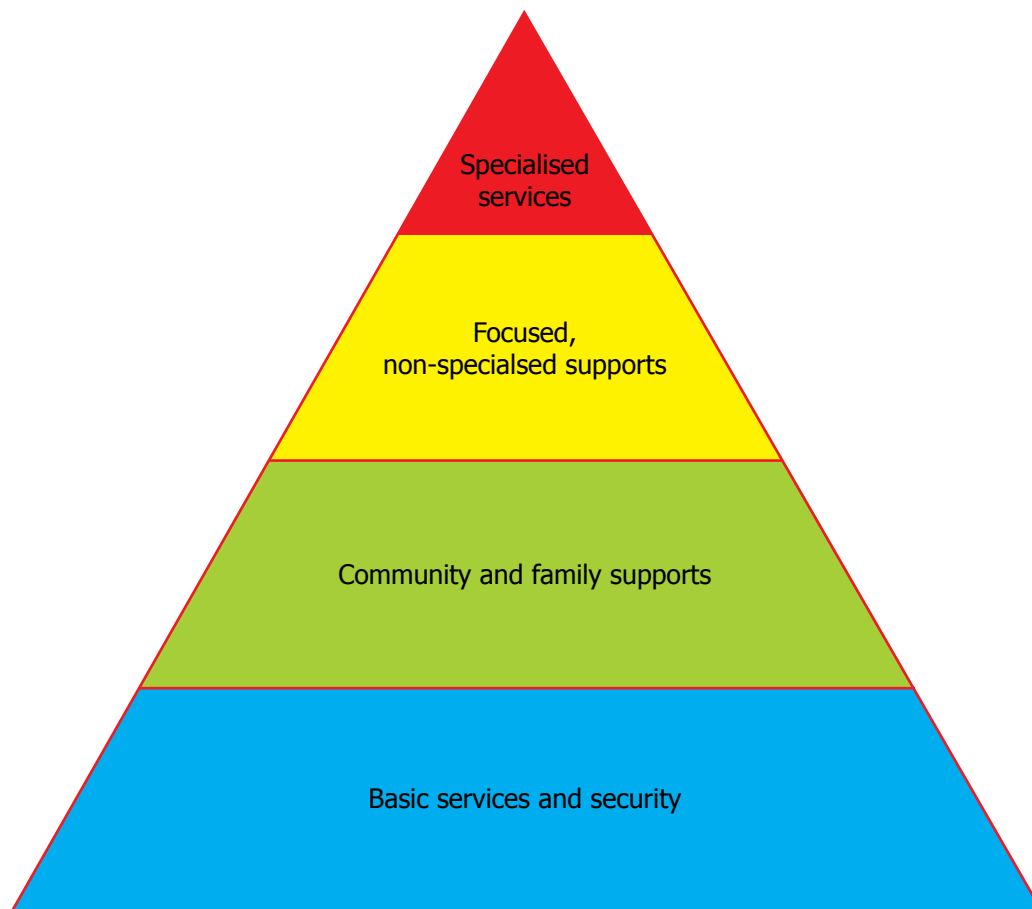
IOM refers to the “psychosocial approach” as a particular way of comprehending and dealing with mental well-being. Taking a psychosocial approach implies that there is a link between social and cultural factors and mental well-being. This means that, in order to understand the functioning of the individual, he or she must be seen within his or her context, be it the family, community or culture etc. A psychosocial approach implies that the mental well-being of an individual or group of people can be affected by acting on the social factors surrounding them. The approach does not deny or exclude the need for more psychological and/or psychiatric interventions by specialists. It is important that the specific ways of dealing with mentally ill persons in different societies be respected, as these methods can range from the provision of Western-type psychiatric care and medication to treatment by traditional and spiritual healers.¹⁵

The Inter-Agency Standing Committee (IASC) issued a set of guidelines to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people’s mental health and psychosocial well-being in the midst of an emergency. Mental health and psychosocial problems in emergencies are highly interconnected, yet may be predominantly social or psychological in nature. Although these guidelines are focused on emergency situations, they include basic principles that can be applied to service provision in other areas such as human trafficking. Identifying people as being “at risk” is not to suggest that they are passive victims. Although at-risk people need support, they often have capacities and social networks that enable them to contribute to their families and be active in social, religious and political life. Most such groups have assets or resources that support their mental health and psychosocial well-being. The nature and extent of the resources available and accessible may vary with age, gender, socio-cultural context and the emergency environment. A common error in work involving mental health and psychosocial well-being is to ignore these resources and to focus solely on deficits, such as the weaknesses, suffering and pathology of the affected group.¹⁶

The 2006 strategy paper of the United Nations Children’s Fund (UNICEF), which builds on and compliments the IASC guidelines, suggests that four levels of intervention are involved in developing psychosocial support and intervention programmes for children. Each level has corresponding psychosocial services and activities as follows:

¹⁵ http://www.un.org/Pubs/chronicle/2007/webArticles/041607_humantrafficking.htm

¹⁶ <http://www.interpol.int/Public/THB/default.asp>

Figure 2. Intervention Pyramid¹⁷

- Level 1 – a safe and supportive environment. This means ensuring that the basic needs of children, families and communities, such as food and nutrition, water and sanitation, and livelihood and economic opportunities, are met;
- Level 2 -- prevention. This includes family and community support services which encompass play and recreational activities, school and other educational activities, family tracing and reunification activities, economic and livelihood activities, adult and peer support groups, cultural and religious activities;
- Level 3 – non-specialized services for at-risk groups. These include structured support groups and recovery, rehabilitation and reintegration programmes;
- Level 4 – medical treatment and care. This includes clinic- and hospital-based mental health services, such as counselling services, medical treatment and psychiatric care.

¹⁷ http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

Mental Health

“The girl who has been trafficked is like the moon
in the sky that has no light”.¹⁸

The terms psychosocial well-being and mental health are often used interchangeably but they really refer to different yet complimentary approaches. Mental health tends to use labels related to psychopathology and connotes illness and disease. Mental disorders are clinically significant conditions characterized by alternation in thinking, mood, emotions or behaviour associated with personal distress or impaired functioning. They are disabling and make people dysfunctional. Psychosocial problems are often situational and relational and are within the range of what is considered normal behaviour under abnormal situations.

Some experts consider mental health as a continuum. Thus, an individual’s mental health may have many different possible values. Mental wellness is generally viewed as a positive attribute, such that a person can reach enhanced levels of mental health, even if he or she does not have any diagnosable mental health condition. This definition of mental health highlights emotional well-being, the capacity to live a full and creative life and the flexibility to deal with life’s inevitable challenges.¹⁹

According to the World Health Organization (WHO), mental health has been defined in various ways by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and self-actualization of one’s intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. However, professionals generally agree that mental health has a broader definition than simply a lack of mental disorders.²⁰

WHO describes mental health as follows:

... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.²¹

In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and a community. This core concept of mental health is consistent with its wide and varied interpretation across cultures.

¹⁸ Victims of Trafficking Workshop Report 2, Tricked by the Trade: Trafficked Cambodian Girls Speak Out, by Diane Lawrence, May 2004.

¹⁹ WHO, The World Health Report 2001 - Mental Health: New Understanding, New Hope (Geneva, World Health Organization, 2001).

²⁰ Ibid.

²¹ Ibid., p. 1.

How Trafficking Has an Impact on the Psychosocial and Mental Health of Trafficked Persons

Trafficked persons often endure brutal conditions that result in physical, sexual and psychological distress. They may suffer from an array of physical and psychological health issues stemming from inhumane living conditions, poor sanitation, inadequate nutrition, poor personal hygiene, brutal physical and emotional attacks at the hands of their traffickers, dangerous conditions in the workplace, occupational hazards and a general lack of good-quality health care. Clandestine migration often requires suboptimum means of transportation, putting the trafficked person at risk of starvation, drowning, suffocation and exposure to the elements. Numerous reports of accidents, injuries and deaths have caused IOM to identify trafficking as the most dangerous form of migration. Other health risks in transit include exposure to violence and communicable diseases.²²

“Really pity the Cambodian children,
living in bad conditions, who were sold like chickens and ducks.
Is this the life God provided us?”²³

Experts in the field define psychological distress in different ways. Psychological trauma is a type of damage to the psyche that occurs as a result of a traumatic event. A traumatic event involves a singular experience or an enduring event or events that completely overwhelm the individual’s ability to cope with that experience or integrate the ideas and emotions involved with it. The individual feels emotionally, cognitively and physically overwhelmed. Psychological trauma may accompany physical trauma or exist independently of it. Research, particularly in Europe, suggests that many trafficked persons experience numerous and concurrent trauma-related outcomes, in particular changes in identity and relationships. Changes in identity involve changes in all structures of the “self”, including identity deprivation and the “feeling that the perpetrator is still there even after the rescue”. Changes in relationships may be manifested as traumatic bonding, extreme relationships, passivity and helplessness, as well as hostility and anger. The most atrocious and damaging forms of abuse are often borne by children and adolescents, who are more easily controlled and forced into domestic service and other hazardous forms of work than adults. They may go through some confusion about their identity and may have fluctuating feelings about being a child, about being an adolescent, about being an adult, or they may end up feeling isolated. Trafficked adolescents develop common defence mechanisms against psychological pain when thinking about their traumatic experience or when experiencing overwhelming feelings. Assistance and healing processes for adolescents and trafficked adults involve restoring their ability to form relationships, being able to regain the power to make choices as an individual, come to terms with themselves, reach reconciliation with others and feel a sense of meaning in their lives.

²² <http://www.interpol.int/Public/THB/default.asp>

²³ COSECAM, 2004, op. cit.

Caution should be exercised however, as the word trauma is generally overused and even misused by many clinicians and lay persons. High anxiety, hyper-vigilance, depression, flattened affect and hopelessness may all result from being exposed to an acute or sometimes chronic (longer-term) stressor. These are normal reactions to abnormal situations and may not indicate that someone is traumatized unless the symptoms are prolonged and interfere with normal psychological and social functioning. To this end, many people who have been trafficked or who have experienced some form of adversity frequently are clinically misdiagnosed with post-traumatic stress disorder (PTSD) when in reality very few trafficked persons exhibit the chronic symptoms outlined in the diagnostic criteria for this disorder. According to a widely accepted manual of psychiatric disorders, PTSD is a condition that includes three symptom constellations: intrusive imagery and memories of the trauma (flashbacks, nightmares, periods of dissociation in which the person feels and acts as if the trauma were recurring); avoidance and numbing, including phobias of places or events that trigger memories of the trauma, social withdrawal and a general dampening of emotions; and hyper-arousal or over-activity of the autonomic nervous system, including symptoms such as poor concentration and memory about new events, startle reactions, perspiration, palpitations, irritability and insomnia.²⁴ The following terms may be used to specify the onset and duration of the symptoms of PTSD:²⁵

Acute: This specifier should be used when the duration of symptoms is fewer than three months;

Chronic: This specifier should be used when the symptoms last three months or longer;

Delayed onset: This specifier indicates that at least six months have passed from the time when the traumatic event occurred and the onset of symptoms.

Being wrongly clinically diagnosed with a disorder such as PTSD can be stigmatizing and counterproductive to the healing process and may encourage the development of a passive victim identity. Such a diagnosis also deflects attention from the broader social environment by “individualizing” the problem. The severity, duration and proximity of an individual’s exposure to a traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables and pre-existing mental disorders may influence the development of PTSD. However, this disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

²⁴ American Psychiatric Association: Diagnostic and Statistical Manual Of Mental Disorders - Fourth Edition, Text Revision: DSM-IV-TR. Washington, D.C. American Psychiatric Association, 2000.

²⁵ Ibid.

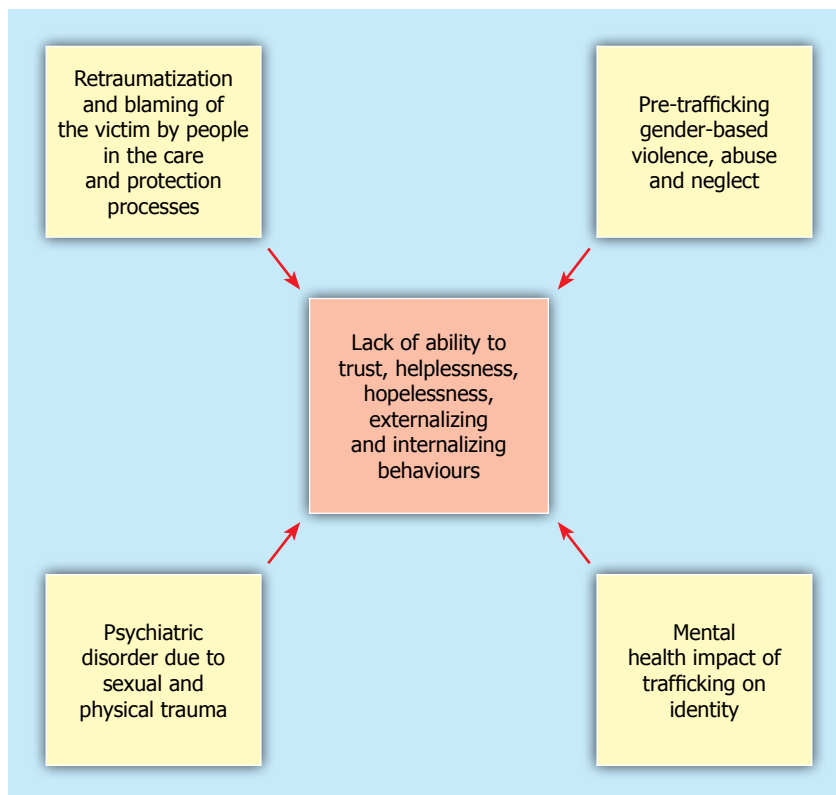
Figure 3. Impact of Trafficking on a Person's Mental Well-Being/Health

Figure 2 highlights the potential negative issues surrounding a trafficking situation and the potential impact on a person's ability to adapt and recover. People subjected to abuse and violence, particularly the types of extreme violence used to coerce trafficked persons, automatically use instinctive reactions in order to survive. Overwhelming violence can suppress the mind and body's ability to respond to stress and danger, leading to troubling symptoms and behaviours. Such behaviours can become entrenched, making it very difficult for trafficked persons to be able to access or make use of the help and resources available to them. Gender role expectations can further shape the ways in which trauma is experienced and they can influence the ways in which recovery from stress/trauma proceeds or does not. Although men and women may have different coping mechanisms for dealing with trauma, many of the short- and longer-term effects of trauma in both sexes are similar.²⁶ In some cases, trafficked persons experience severe levels of trauma over a long period during which they endured physical abuse and psychological manipulation, yet they may demonstrate resilience strategies and defence mechanisms that normalize the abuse in their minds. What they once may have viewed as abuse may later be considered as a normal part of everyday life, making it difficult for the individual to self-identify as a victim.

People who go through traumatic and stressful experiences often have certain symptoms and problems afterwards. How severe these symptoms may become depends on the person, the type of trauma involved and the emotional support the person receives from others. It is important

²⁶ <http://un.org/ga/president/62/ThematicDebates/humantrafficking/ebook.pdf>

to note that not everyone experiences trauma in the same way. Two people could undergo the same adverse event: one person might be stressed or traumatized; the other, relatively unscathed emotionally. This phenomenon reinforces the fact that victim support interventions need to be comprehensive; also, an individualistic case management philosophy should be employed as “one size does not fit all”. The first principle of an effective rehabilitation programme is to work towards strength-based assistance which acknowledges the strengths of people and designs the recovery process to draw upon those strengths.

Even after they are out of the trafficking situation, trafficked persons may face real fears of retaliation by their traffickers, aimed both at themselves and their families. In addition, they may face many uncertainties about their status and complex social and legal systems. It is important for trafficked persons who are exhibiting severe stress or trauma-related symptoms to have access to expert help as early as possible since their reactions or behaviours may be misinterpreted as “uncooperativeness” by law enforcement officials or others attempting to provide them with assistance. Trafficked persons are vulnerable to the negative effects of severe stress and trauma because they are physically away from social supports, familiar surroundings, routines and habitual roles that would normally help them to alleviate the effects of stress and trauma. Reminders of past violence, such as sounds or interviews, can trigger states of severe terror and anxiety.

Children are highly susceptible to long-term psychological damage from trafficking. The impact of violence on children can be very different from that on adults because children’s brains and cognitive processes have not yet matured. How a child copes with a stressful or traumatic experience depends on the developmental stage of the child and the level of resilience he or she possesses. Physical and psychological violence potentially can cast a long shadow on the way children develop. For this reason, when dealing with trafficked children, it is important to be aware of the unique impact that the stressor or trauma may have at their different cognitive, emotional and relational developmental stages in order to address the wide spectrum of children’s needs.

Special care must be taken when attending to the needs of trauma survivors, as interactions pose the risk of “re-traumatizing” such persons. This situation refers to an interaction that can mimic victimization, where the person ends up feeling helpless, coerced or abused. This type of feeling can increase traumatic stress symptoms and further entrench the trafficked persons in a maladaptive behavioural pattern, such as avoidance or isolation. During recovery, trafficked persons may fear that outsiders will find out what had happened to them, or that returning home will bring shame to their families. They may experience a number of emotions, including guilt, for having made such a grave “mistake”, and anger at themselves for “letting it happen”. They may also feel anger towards others for not helping them, while feeling powerless to help themselves. They may need to re-learn how to trust other people, make friends and have healthy relationships. Overcoming all of these feelings is important to the recovery process.

Psychosocial support and counselling help trafficked persons free themselves from the anxiety and depression brought on by their stressful and sometimes traumatic experience, and enable them to begin the process of rebuilding their self-esteem and self-confidence.²⁷ As previously mentioned, numerous factors associated with trafficking may have damaging effects on the trafficked persons’

²⁷ Cathy Zimmerman and others, *Stolen Smiles: A Summary Report on the Physical and Psychological Health Consequences of Women and Adolescents Trafficked in Europe: Preliminary Findings on the Prevalence of Physical and Mental Health Consequences* (London, 2006). London School of Hygiene and Tropical Medicine, 2006.

psychosocial well-being and possibly their mental health. Such conditions can provoke feelings of hopelessness, helplessness and low self-esteem. Depression and suicidal thoughts and attempts are often reported by trafficked persons. Substance abuse is also a common coping mechanism for people trafficked into the so-called sex industry. In some instances trafficked persons report having been drugged by brothel owners so that they would be more compliant and accepting of their plight. In addition to the risk of chemical addiction, substance abuse also has implications for sexual health, as it is associated with increased risk-taking. Traffickers purposefully isolate trafficked persons from a positive support structure and foster controlled environments where the victim is kept in a state of complete dependency and may even become traumatically bonded to the trafficker, as in the so-called Stockholm syndrome.²⁸

The long-term effect of trafficking on the trafficked persons' human development and emotional health requires further exploration, particularly within Asian cultures. Persuasive evidence shows that trafficked persons who have been subjected to sexual exploitation or sexual violence within forced prostitution or domestic labour require a certain period of time to recover from the physical and severe stress-related symptoms and mental health trauma that they have endured. That time is needed in order to reach a stage where they are able to make informed decisions about their future and whether or not to cooperate with the authorities. A 2006 report by researchers at the London School of Hygiene and Tropical Medicine found that it took up to three months for the majority of trafficked persons to experience a significant improvement in their mental health.²⁹ That report also showed that the psychological reactions are both severe and prevalent, and can be compared with or surpass the symptoms experienced by torture victims. However, that research was based on the European context.

The cultures of racial and ethnic minorities influence many aspects of mental health and illness, including how patients from a given culture communicate and manifest their symptoms, their style of coping, their family and community support systems and their willingness to seek treatment. Likewise, the cultures of the clinician and other staff influence the diagnosis, treatment and service delivery. Cultural and social influences are not the only determinants of mental illness and patterns of response to treatment, but they do play important roles. Mental well-being and health are socially constructed and socially defined; in other words, different professions, communities, societies and cultures have very different ways of conceptualizing the nature and causes of mental health, determining what is mentally healthy and deciding what interventions are appropriate. Therefore, different professionals have different cultural and religious backgrounds and experiences, which may influence the methodology applied during treatment.³⁰ The Western focus on individual well-being is very limited in its application in most developing societies, where individual well-being can be viewed as inextricably interconnected with social relationships and with local culture and values.³¹

Importantly, not all trafficked persons develop significant psychological problems. Many show resilience or the ability to cope relatively well in situations of adversity. Numerous interacting social, psychological and biological factors influence whether people develop psychological problems or exhibit resilience in the face of adversity. Two major perspectives can be identified, according to

²⁸ Ibid.

²⁹ Ibid.

³⁰ J.M. Witmer and T.J. Sweeny, "A holistic model for wellness and prevention over the lifespan", *Journal of Counseling and Development*, vol. 71, 2002, pp. 140-148.

³¹ Psychosocial Working Group. (2003) *Considerations in Planning Psychosocial Interventions*. Edinburgh: The Psychosocial Working Group.

which the healing process can be viewed and articulated. One is the so-called damage model (focusing on deviance and damage, i.e., a pathology frame of explanation and action); the other, the challenge model (focusing on development and identifying, and building individual strengths and resources).

The challenge model is oriented towards helping people withstand the hardships of life and repairing their self-confidence. These endeavours can be accomplished by supporting the persons in trouble, breaking their cycle of troubled living and helping them to master painful memories by putting the past in its place. The challenge model supports self-development through the raising of awareness (insight) and enhancing independence, initiative, humour, creativity and morality, but most of all by providing trafficked persons with knowledge and understanding of the importance of articulating their own needs in relationships with others.³²

The Story of Saa

Saa is a 27-year-old Thai woman currently working as a bartender in a Bangkok restaurant. Originally she came from a village 20 km outside of Khon Kaen, a medium-sized city in north-eastern Thailand. Saa stated that she had been working in Bangkok for a number of years doing menial jobs when she was approached by a woman who asked her if she would be interested in making a considerable amount of money as a masseuse in Bahrain. Saa said that she was very interested, as she often needed money to provide her family with financial support. She agreed to travel to Bahrain and also agreed to pay a fee to the agent who would organize her travel documents and air tickets.

When she arrived in Bahrain she was met at the airport by a woman and two men who drove her directly to a brothel where her passport and return tickets were confiscated. The brothel owner was very aggressive and told her she would have to repay approximately 300,000 baht (currently about US\$ 8,500) in fees, which was far more than what she originally was told the amount would be. She tried to argue that she had agreed to be a masseuse only and not to sell her body for sex, but her cries fell on deaf ears. Saa was kept in slavery-like conditions and had to provide sexual services for at least 20 men per day. She was not allowed outside and she never had a day off to relax. After many months Saa managed to pay off her debt; she then returned to Thailand voluntarily.

Saa had an amazing ability to talk openly about her experience and had noticeably moved on with her life, compartmentalizing this bad incident. She stated that she would never encourage anyone to do what she had done and be tricked the way she had been, yet she still encouraged other women to take similar risks even though she knew of other young women who had been subjected to very similar bad circumstances overseas.

Despite her inconsistent behaviour, Saa's very positive attitude to life seems to have helped her to somehow rationalize what had happened to her and move forward with her life. This is often not the case with many trafficked persons.

³² <http://www.projectresilience.com/resself.htm>

Service providers need to be able to recognize that trafficked persons come from many different ethnic, racial and age groups. Many trafficked persons have special and varied social and health-care needs; thus, it is crucial that assistance plans be tailored to meet their individual circumstances. Psychosocial care is central to restoring the well-being of the trafficked person; however, it should be recognized that all care needs to be rights-based and not infringe on the needs of the survivor. As part of the comprehensive approach to all cases of trafficking, care providers need to be educated about the prevalence and dynamics of trafficking and how to effectively assess and intervene on behalf of trafficked persons. Culturally-sensitive training for health-care providers is needed to address the specific needs of trafficked persons. They need programmes that reach them at all stages of their plight, from identifying them to acquainting them with their rights and the resources available to them. Interpretations of current protocols and definitions of trafficked persons also needs to be better standardized because, if defined broadly, the term detracts from the seriousness of the crime and unwittingly forces persons to receive unwanted or misdirected assistance. It is also crucial that best practice resources such as the the IOM Handbook on Direct Assistance for Victims of Trafficking³⁴ be utilised to ensure that duty of care principles are adhered to in all facets of care being provided to the trafficked person.

Research objectives

The objective of this research was to generate a background report on current mental health and psychosocial interventions applied in GMS and beyond by government agencies, NGOs and other actors for future use as baseline reference material for a regional workshop entitled “Mental Health and Psychosocial Assistance for Trafficked Persons from the Greater Mekong Subregion”. This report is also intended to be used as a promotional and advocacy tool for national and regional health authorities and health policymakers in GMS. It is envisioned that it will serve as a tool to facilitate and inform discussions aimed at establishing a standardized approach to mental health and psychosocial interventions for trafficked persons in GMS. It is also envisaged that a project will be developed to address some of the more obvious deficits in psychosocial and mental well-being and health service provision in GMS and Indonesia.

For the purposes of this report, the definitions of psychosocial and mental health reflect those outlined in the guidelines drafted by IASC. “Psychosocial” refers to a continuum of support, with mental health being a more specialized service within this framework. Mental well-being and mental health are referred to consistently throughout the report as mental “well-being”, which avoids the negative connotations that often accompany mental health terminology and focuses on its more positive aspects.

³⁴ IOM, The IOM Handbook on Direct Assistance for Victims of Trafficking (2007)

Specific aims of this report

1. To solicit information on the level/type of assistance being provided to trafficked persons in GMS and Indonesia;
2. To explore other psychosocial and mental health interventions that may be applied to assist trafficked persons;
3. To determine what definitions/interpretations exist regarding psychosocial and mental health support;
4. To determine what referral and case management systems are being utilized by agencies assisting trafficked persons;
5. To highlight the therapeutic methodologies currently being utilized by GMS economies and Indonesia;
6. To explore potential areas for sharing coordination/information and technical assistance among GMS economies and Indonesia, with particular focus on enhancing the current services for trafficked persons.

Research methodology

Procedure

A culturally-sensitive questionnaire was designed to solicit information from governmental and non-governmental organizations providing trafficked persons with psychosocial assistance as it is related to each stage of the recovery and reintegration process (see annex I). The questionnaire was also useful for acquiring information from service providers that imparted details on psychosocial and mental health support for a broad range of social problems not specifically related to trafficking.

A questionnaire guide was constructed to ensure that there were no discrepancies in understanding by the interviewers. Key players/key informants were interviewed for the study, using a purposeful sampling technique. To ensure that the research methodology was theoretically sound and practical, a small technical reference group was also formed to provide the researcher with ongoing technical assistance. Members of this reference group were chosen because of their extensive professional background in psychosocial and mental health/well-being service provision and comprehensive understanding of culturally sensitive community-based methodologies for providing trafficked persons with psychosocial support. The research was conducted over a two week period by one researcher with the assistance of IOM country offices. Due to time and resource limitations a wider sample group was not engaged. Furthermore, travel restrictions to certain countries limited the researcher's access to data.

The results of this report are structured to provide readers with direct answers and comments from service providers as well as summaries for each economy and the Subregion as a whole. Owing to the richness of the information collected, this methodology was deemed appropriate. It should be noted that some agencies were unable to provide feedback on some sections of the questionnaire as it was not relevant to the type of service they provided. Some of the agencies that were consulted provide both governmental and non-governmental organizations with various forms of technical assistance and their feedback is incorporated within the final summaries. Because the information on service provision in Yunnan Province of China and Viet Nam was quite limited, the results for these economies are structured differently from those of the other participating countries. Due to the above mentioned limitations, the results of the research are intended to provide only a snapshot of services being provided to trafficked persons in the Subregion. The rights and confidentiality of respondents was also respected in the write up of this research.

Chapter 2

Cambodia

Six agencies were interviewed in Phnom Penh, the capital of Cambodia. The mandates and delivery mechanisms of these agencies varied, with some providing trafficked persons with direct services and others providing them with more technical or network support.

Service provision for trafficked persons in Cambodia has evolved greatly during the last five years or so, according to several key respondents. The signing of a Memorandum of Understanding (MOU) by five government ministries and 23 NGOs was reported by several respondents as having been the catalyst for change, producing direct improvements in networking, coordination and referral systems. A predicted benefit of the MOU is that it will provide a more standardized and systemized mechanism for service provision, as referrals in the future will be made only to NGOs that are signatories to the MOU and have become part of the network, while receiving official recognition by the Government of Cambodia.

According to one government agency, about 34 agencies currently operate shelters in Cambodia, a number of them operating in a freelance fashion without any formal supervision or monitoring system in place. The Government of Cambodia and many service providers agree that stricter controls are needed to ensure that service provision is of a high standard and in the best interest of the trafficked persons.

As a country, Cambodia has undergone massive psychosocial trauma in the last few decades, yet little, if any, mental health services were available throughout that country until relatively recently. Now a number of mental health clinics have been opened in rural areas. The mental health system, as with any other system in Cambodia, must contend with the scars that remain from the country's traumatic past as well as the grinding poverty in the present.³³ Between 1979 and 1992, no mental health services were available in Cambodia, although services and training programmes did exist in that period in some refugee camps along the Thai-Cambodian border. The first Cambodian National Health Plan, established after the elections in 1993, made psychiatry one of its priorities. Since then, several NGOs and intergovernmental organizations, such as IOM, have helped to provide mental health services and training in the country.³⁴

³³ D. Savin, "Developing psychiatric training and services in Cambodia", *Psychiatric Services*, vol. 51, July, 2000, p. 935.

³⁴ *Ibid.*

Psychosocial Support

The following represents some agencies' definition of psychosocial support:

- "Psychosocial support is the support that focuses on helping individuals heal from trauma and mental health problems, and at the same time supports them in coping with life events/life circumstances, to enable them fulfil their social needs";
- "My organization provides psychosocial intervention in the following areas: training for key people in the community to allow them to recognize mental health issues, stress and trauma, to manage some of the basic problems and make referrals when appropriate";
- "Psycho-education about mental health and psychosocial problems, using posters, leaflets and a radio-education programme";
- "Facilitating a self-help group for women who are victims of domestic violence, for alcoholic men, etc.";
- "Counselling";
- "Psychiatric treatment, using psychotropic medication";
- "We have provided degree programmes and training for counsellors and professional care-giving staff. Our mission is to provide medical, mental health and family assessment for girls between 5 and 16 years of age that are survivors of child sexual exploitation or rape. We provide care immediately after rescue. Girls will on average stay in our centre for two months. We care for up to 144 girls per year. Two hundred girls have been cared for in our assessment centre during the first two years of operation. A counsellor is assigned to each child and meets weekly with her one-on-one. All children also attend weekly group therapy sessions. We also have many activities which provide therapy: art, drama, music, sports as well as classes in hair and beauty, sewing and literacy";
- "To provide a range of care and psychological support that also includes reintegration support for families";
- "We provide basic social work training for professionals working with people who have experienced gender-based violence, and also operate a sexual assault centre, but we do not work with trafficking -- only rape, incest and sexual harassment cases".

Table 1 Types of Services Available

Provision of Basic Services						
Agencies	Basic health needs	Family support/mediation	Secure environment	Housing	Medical assistance	Others
1.						
2.	✓	✓	✓	✓	✓	
3.	✓	✓	✓	✓	✓	
4.	✓				✓	
5.	✓	✓	✓	✓	✓	
6.						
Assessment/Recovery/Education						
Agencies	Psychological assessment	Counselling	Psychotherapy	Life skills	Education (formal and informal)	Community education
1.						
2.	✓		✓			
3.	✓	✓	✓	✓	✓	
4.	✓	✓		✓	✓	
5.	✓	✓	✓	✓	✓	
6.					✓	
Reintegration						
Agencies	Reintegration support	Family assessments	Vocational training	Seed grants	Legal aid	Follow-up
1.						
2.	✓		✓			
3.	✓	✓	✓	✓	✓	
4.	✓	✓		✓		
5.	✓	✓	✓	✓	✓	
6.						

The level of psychosocial support in Cambodia is quite comprehensive, with multiple agencies providing trafficked persons with an array of services, as outlined in table 1. Trafficked persons receive medical support generally within one week of being identified and rescued:

- “When VOTs (victims of trafficking) have medically-related problems, we refer them, rather we bring them, to the clinic”;
- “Usually the first week in the centre; sooner in an emergency”;
- “On arrival”;
- “Referred as soon as possible”;
- “On arrival, if medical problems exist”.

Most agencies suggested that it is beneficial to provide trafficked persons with a period for reflection and assessment prior to their reintegration. It was not clear however how voluntary this arrangement is. Family assessments are important in the prevention of re-trafficking, particularly for children. Most agencies were unable to comment whether trafficked persons had a choice to return home immediately if they desired to do so. Several commented that there was a need to conduct screening of trafficked persons in order to determine the preparedness and appropriateness of the family environment before reintegration would take place:

- “We assess each girl’s situation. Even when a girl may have had no harm done to her, her home situation needs to be assessed. If a girl was sold by her mother and rescued in a virginity sting operation, she may not have been sexually abused. However, a return home may be inappropriate for some time since mothers usually know exactly what is going to happen to their daughters when they sell them”.

Organizational Orientation

Several respondents provided the following statements that elaborate what guides their provision of services for trafficked persons:

- “We know that these types of victims suffer from mental health and psychological problems. In Cambodia, this service is not available; therefore, we think that it is important and we as a psychosocial organization should provide this type of service for these types of victims”;
- “Our Christian faith. We are a Christian relief and development (agency) working to alleviate suffering and injustice through education, enterprise and community health”;
- “To combat trafficking in women and children for sex slavery; to care for and rehabilitate those rescued from sex slavery; to provide occupational skills; and to reintegrate those rescued into the community in a sustainable and innovative manner”;
- “We want to support the vulnerable. We support abandoned babies and orphans, victims of trafficking and other abused and vulnerable children”;

- “We work from a social work perspective and according to social work values. Cambodia has no established social work training system. Numerous non-governmental organizations provide a patchwork of services like shelters, legal aid and counselling for women and children who have been subjected to violence and/or commercial sexual exploitation. The goal of the training centre is to improve the support for women and children affected by gender-based violence, including commercial sexual exploitation and trafficking; it aims to achieve this by strengthening the social work and counselling skills of the staff of NGOs providing direct service delivery and support for them”.

Table 2 Populations Assisted and Institutional Guidelines

Target Populations/Guidelines							
Agencies	Women	Children	Women and children	Men	All	Do trafficked persons receive the same services/ assistance as other persons?	Institutional policies/ guidelines in place
1.			✓			✓	✓
2.			✓			✓	✓
3.			✓			✓	
4.			✓			✓	
5.			✓			✓	
6.			✓			✓	

Respondents reported that services do not differ for trafficked persons from outside Cambodia, as reported below. However, some of the agencies interviewed provide services only for trafficked persons:

- “No. Khmer, Khmer Krom, Vietnamese and Cham all receive the same care. We have Khmer, Khmer Krom and Vietnamese care-giving staff so we can communicate on a culturally appropriate level with almost all children. Cham girls speak Khmer; however, we do not have any Cham staff”.

Differing opinions were evident with regard to whether there is a clear understanding as to the roles and responsibilities of the governmental and non-governmental sectors in relation to providing assistance and services for trafficked persons:

- “There has been some degree of coordination between different sectors to monitor and support VOT in principle, but I think this has not been closely followed up and would not really work. Each NGO seems to be responsible for its own tasks and cares about its own problems. They make sure that they can fulfil the requirements of their donors...”;

- “Yes, it is very clear. The police investigate and rescue. The courts approve or disapprove the rescue and prosecute the criminals. The Ministry of Social Affairs receives the trafficked children from the police and refers children to approved NGOs for aftercare. Most of our partners (Hagar, World Vision, Agape International Missions (AIM), International Justice Mission, etc.) have an MOU with the Ministry of Foreign Affairs and a project agreement with the Ministry of Social Affairs. A few also have project agreements with (the ministries of) Justice, Women’s Affairs, and others. We also report quarterly to the Council for the Development of Cambodia. This system works well, except when corruption money interferes somewhere along the line”.

A number of agencies provide extensive services for victims of domestic violence or sexual abuse; they could potentially serve as extremely useful technical resources for less experienced agencies supporting trafficked persons. For example, Social Services of Cambodia provides counsellor training courses and implements projects to reduce gender-based violence and the widespread commercial sexual exploitation of children in Cambodia. Formal network agreements are currently in place, but some respondents questioned their effectiveness. Thus, further strengthening of technical networks is warranted:

- “There is some coordination within the various coalitions: Chab Dai, NGO Coalition to Address (Sexual) Exploitation of Children in Cambodia (COSECAM), End Child Prostitution, Child Pornography, and Trafficking of Children for Sexual Exploitation (ECPAT). There is now a National Task Force. However, there is no formal coordination of trafficked persons support. Is this linked to individual and/or family needs? It is primarily for victim support”.

Table 3 Assessment Methodology

Assessment Methodology				
Agencies	Use of assessment tools	In-depth counselling	Translation available	Is information on the mental/emotional well-being of the victim/survivor also collected in this initial assessment?
1.	✓	✓	✓	✓
2.	✓	✓	✓	✓
3.	✓	✓	✓	✓
4.		✓	✓	✓
5.		✓	✓	✓
6.			✓	✓

Assessment methodology is fairly well developed in Cambodia. A number of checklists and screening instruments are in use; however, no standard checklist is utilized by all the agencies assisting trafficked persons:

- “There is a clinical outcome form, which is used for people who receive counselling. The form assesses four areas: psychological well-being, physical well-being, social functioning and risk. This assessment is done pre and post counselling session”;
- “We utilize the Harvard Trauma Questionnaire – Cambodia Version; however, not in interviews with the girls. It is used as a guideline. The Child Trauma Assessment Check List (Cambodia) for AIM only, (and) the Achenbach Child Behaviour Checklist – second part (are used) to interview the care-giving staff concerning the children’s behaviour. We use an Anxiety and Depression Checklist. Our social worker utilizes a family assessment questionnaire”.

Needs reportedly vary across groups and generally change over time. Most trafficked persons need a safe environment and psychosocial care:

- “The immediate needs (of trafficked persons) are to have their medical issues addressed, to protect the children from the bad guys, and to assist the girl to settle down and start building relationships with staff”;
- “Safe environment, medical and psychological care. Nutritious meals and general support”.

In the majority of cases, language interpretation services are made available to trafficked persons. More in-depth screening takes place after the trafficked persons have adjusted to their new environment and begin to build some rapport with the care givers:

- “After about a week, we start counselling and assessment. Many of the girls that have open court cases will also be meeting with police, courts and their lawyer. So we try to go easy on them through the assessment process. Our care-giving staff accompany the children through all external activities, such as family meetings, doctor’s office (and) lawyer’s interviews”.

Table 4 Case Management Processes

Case Management Processes				
Agencies	Is case management information made available if a referral to another agency takes place?	Does the victim/survivor need to provide consent before information can be transferred?	Are there security measures in place to secure files?	Are trafficked persons themselves counselled on their own case management process; are translators accessible?
1.	✓		✓	✓
2.	✓	✓	✓	✓
3.	✓		✓	✓
4.	✓		✓	✓
5.	✓		✓	✓
6.	✓		✓	✓

All respondents reported having an effective and personalized/individualized and confidential case management system in place. Case management information is transferred when a referral takes place:

- "Ninety per cent of the girls in our care are referred onto other centres for continued aftercare. This is because we are only a short-term care facility averaging two months per stay. Girls that come to us are almost always highly traumatized and/or in danger. Court cases typically take up to a year or longer, so the bad guys will always have family or friends out looking for the girls and threatening their families. When we transfer a child, we provide as a minimum a transfer document, copies of police and ministry documentation, assessment summary, medical records and other supporting (documents). Different aftercare centres require different documentation, so we will often tailor what we give them based on what they request".

Feedback suggested that the respondents for this report are adopting and adhering to many case management best-practice principles. Trafficked persons in most cases are reportedly counselled on the case management process:

- "All children who come to us have some level of documentation upon entrance: acceptance form, document from police or Ministry of Social Affairs, letter signed by mother, police, human rights organization (for rape only). A child is assigned a case number and a counsellor. A case file is opened. Weekly case management meetings are held to discuss the progress and various issues for each child. Notes are taken at each meeting. Each file will contain medical and mental health records, family assessment, legal/court status form, etc.";
- "We also make a plan for each client according to her needs and strengths, and what we cannot do ourselves we provide via referral, which we also follow up. We have no set time limits, although our confidential residence is intended for short-term (under three months stays) to give a client safety and a place to think and recover. She is welcome to bring family members along, as we think that forcing a woman/girl to go to a shelter when she has done nothing wrong reinforces the message that she is somehow at fault".

A rights-based approach is promoted but in many cases not entirely followed, as the consent of the trafficked person is not always requested before information is transferred to other agencies:

- “No. Since we work with children, we recognize that, although the child’s opinion is very important, a child cannot be expected to make these types of decisions after suffering rape, torture and other horrific events. We of course will offer the child options if there are options; however, there are often not many options for a child to choose from. We have had children from dangerous, child-trafficking homes and the child still wants to go home. We had other children from very good homes, but the child is so ashamed of what happened that she does not want to go home. We have to work through these difficult issues regarding what the child wants to do”;
- “Yes, in some instances”.

All respondents reported having good security measures in place to ensure the confidentiality of case management information:

- “Kept in a secure office”;
- “We keep acceptance forms and transfer documents in a safe. Case files are kept in an office which has 24/7 (24 hours a day, 7 days a week) guards. Only counsellors and the director have access to case files”;
- “All files are under lock and key”.

Table 5 Standards of Care/Community Involvement in the Recovery and Reintegration Processes

Standards of Care/Community Involvement in the Recovery and Reintegration Processes					
Agencies	Does your organization/department have minimum standards of care in place for trafficked persons?	Do trafficked persons actively take part in outlining the care they would like to receive?	Do persons from the community also assist trafficked persons in the recovery process?	Do you see the potential of community networks in assisting trafficked persons in recovery and sustainable reintegration?	Is the confidentiality of the victim/survivor protected?
1.	✓	✓		✓	✓
2.	✓	✓		✓	✓
3.				✓	✓
4.				✓	✓
5.				✓	✓
6.				✓	✓

It is evident that standards of care were being utilized by some agencies, but these are not used universally by all service/care agencies:

- "My organization provides psychosocial support services only, so there are no such (things as) minimal standards of care yet. We treated this VOT the same as other people who suffer from mental health and psychological issues";
- "Yes. We developed a minimum standards document with our partners at World Vision and Hagar. It was based on the COSECAM document".

Most respondents reported that trafficked persons do not take an active role in planning the type of care they wish to receive:

- "So far this has not happened yet";
- "Depends on the age, level of trauma and other factors as to how able a child is to provide input. Children discuss their situation, past, present and future with their counsellor. They will be asked about their hopes and dreams...what they would like to do in the future. Some children will return home but be enrolled in VT (vocational training) at their request. Others may be sent on to a particular centre that specializes in something such as repatriation to Viet Nam, links to foster home families, long-term care, short-term care and reintegration etc."

However, all agreed that the care provided was oriented towards the individual needs and wishes of the trafficked person:

- "Yes";
- "Absolutely";
- "All our work is voluntary, and no one who does not want our services is forced to receive them".

With regard to community involvement, many suggested that this was a difficult matter owing to stigma and confidentiality issues and the like, but most agreed that community-based care would be useful but challenging:

- "We are not aware of successful community-based care. However, more organizations are discussing how to do this. Social Services of Cambodia (SSC) recently opened a community-based day centre in Kandal. But I think it is only for victims of rape";
- "Every community is different. Svay Pak is a nightmare. Other communities have very supportive police, Sankat leaders, human rights workers and people who will protect the victim";
- "Yes; however, community values must change. If a community believes the child victim is in fact unlucky, a bad girl, or the cause of all her family's problems, then the child will not be safe returning in the near future. If the community has enlightened people in leadership, then the child may be able to return and reintegrate successfully".

All respondents stated that the confidentiality of the victim/survivor is protected:

- “We do not share names of children outside our organization and the organization where the child is referred. We never take pictures of the children. If a child’s story is distributed, we first change the name, and a few facts such as age, ethnicity, village, etc., to ensure that she is protected. We work with police to ensure they do not give out the trafficked person’s name to the news media”.

Mental Health

Most respondents suggested that there is a difference between “psychosocial support” and “mental health support”:

- “From my understanding, there is a difference between the two:
 - Psychosocial support mainly consists of a multidisciplinary team ranging from, for example, counselling (individual or group) and at the same time providing other social services such as legal, rights, vocational training, and other services that enable VOT to receive maximum care;
 - Mental health support provides treatment to patients who meet diagnostic criteria of mental disorders. Treatment mainly focuses on medications”.

Table 6 Specialist Mental Health and Counselling Services

Specialist Mental Health Services							
Agencies	Are trafficked persons suffering from mental health problems receiving assistance?	If your organization/ department offers more specialist mental health services, are there any specific guidelines in place for the provision of these services?	Are clinical screening tools used to make an assessment?	If used, do you believe that these types of tools are culturally applicable, reliable or effective in making an accurate diagnosis?	Is counselling available?	Are these programmes tailored to suit the needs of each victim/survivor?	Are there other (less formal) ways a victim/survivor can be assisted in the healing process?
1.	✓				✓	✓	
2.	✓		✓	✓	✓	✓	
3.	✓		✓	✓	✓	✓	
4.	✓				✓	✓	
5.	✓				✓	✓	
6.	✓				✓	✓	

All respondents stated that the trafficked persons were receiving adequate mental health assistance when needed. If the service provider does not provide more specialist forms of mental health care then the trafficked person is referred to agencies or hospitals specializing in mental health care:

- “My organization does not deal with trafficked persons alone. We deal with a lot of types of victims. Therefore, mainly trafficked persons as well as others are referred to us by other NGOs who provide a different type of service for them. After (the person has received) treatment, we refer the trafficked person back to that NGO”;
- “Yes. From our counselling and care-giving staff and for severe cases we have also utilized psychiatric services in Phnom Penh”.

No organizations reported having any institutional guidelines in place for the provision of mental health treatment and care:

- “There are no guidelines in place as yet”.

Several agencies reported using clinical screening tools as diagnostic instruments and for screening purposes. Some said that they rely on the capability of their staff to identify trafficked persons that have more clinical indications of mental health problems:

- “We don’t use clinical screening tools as our staffs have sufficient clinical knowledge to screen this problem”;
- “Clinical outcome measure was used to make pre and post counselling assessment”;
- “Child Trauma Assessment Check List (Cambodia), Achenbach Child Behaviour Checklist – second part to interview the care-giving staff concerning the children’s behaviour. We use an anxiety and depression checklist. Our social worker utilizes a family assessment questionnaire”.

The agencies that utilize clinical and screening instruments/tools believed that these mechanisms were useful in assisting them to better help trafficked persons:

- “Somewhat effective. Some tools are more suited to adults”.

All respondents reported that counselling was provided by persons who had received adequate training and who were qualified:

- “Yes, counselling either individuals or groups is available at our organization. Counselling is a process that provides trafficked persons a chance to talk over what is on their mind, express their inner feelings and allow space for trafficked persons to talk about their own problems in a safe and secure environment with professional counsellors. The counselling will give the opportunity to clients to think clearly of what happen to them and to have positive problem-solving. Counsellors of TPO (social workers, nurse, psychiatric nurse, psychologist...) provide counselling to trafficked persons”;
- “Our counsellor supervisor has a degree in psychology from the Royal University of Phnom Penh as well as training at SSC and Mercy Teams International (MTI). Our other counsellors have (undergone) various training (programmes) at SSC, MTI, and elsewhere. Basically, they have the best training available in Cambodia at the present time”;

- “Cambodia has no established social work training system. Numerous non-governmental organizations provide a patchwork of services like shelters, legal aid and counselling to women and children who have been subjected to violence and/or commercial sexual exploitation. The demand for professional social workers far outstrips the availability of adequately trained staff. The skills deficit of the service providers is often addressed with short, one-off courses, mostly conducted by experts unfamiliar with the Cambodian socio-cultural context and unable to take local beliefs, values and learning styles into account. Social Services of Cambodia offers a high-quality basic social work and counselling course of 30 days, delivered 5 days per month for 6 months, with intervals of application and self-learning phases. The course promotes a client-centred approach to social support and counselling where the social workers and their clients meet on the level of being human beings of equal value. It also puts emphasis on challenging the social worker’s traditional, culturally embedded patterns and beliefs about gender, violence and approaches to helping. Participants learn how to use active listening, effective responding and other case management tools that help their clients to find a way to achieve a good-enough life. The social worker develops an understanding of the clients’ situation and helps her to explore possible strategies and solutions. In this aspect, the course breaks with a traditional approach to helping, whereby trafficked persons come to service providers in order to request help and receive advice from the workers. (A total of) 122 social workers from 47 NGOs have been trained through Social Services of Cambodia as of the beginning of 2007. The final beneficiaries of the course are the girls and women that have received qualitatively better services due to the increased technical capacities of NGOs”.

Counselling services were found to be generally flexible, responsive and tailored to the needs of the individual:

- “Counselling is flexible, it becomes more intense when the client’s problems become severe (this depending on the availability of the client too). Yes, we see there are improvements in the four areas that we measure after counselling sessions”;
- “It is for as long as the child is with us”;
- “Yes, they are based on individual needs”;
- “Yes, depending on the child’s individual situation, age, issues, trauma, etc.”

Respondents reported that several strategies are employed to prevent re-traumatization of the trafficked person, but in general there are no formal written guidelines or standard operating procedures in place:

- “There is no clear strategy in place to prevent re-traumatization, but I think working collaboratively with other NGOs who can provide other alternative support to those clients would help reduce this”;
- “We and our partners prepare children for trial and confrontation with the perpetrator (brothel owner, trafficker, rapist, etc.) in court. We also prepare children for the lengthy interview process and reintegration”.

Most respondents said that they do not rely on less formal ways to assist trafficked persons in the healing process. Most stated that religious practices and in some cases traditional healers are used by trafficked persons, yet there are no systems in place to monitor or formalize these practices within their framework of support:

“Multidisciplinary approaches to care for these trafficked persons mentioned above are very helpful. Religion is another way to help them deal with the victim’s mental health problems as well. Yes, I think it is very helpful too”.

Respondents made the distinction that trafficked persons may have been enticed into the trafficking situation for various reasons and therefore their reintegration planning should reflect this fact:

- “I do not have experience with this but I think there should be appropriate mechanisms to help these people differently. For example, the first case can be dealt with by working with the spouse....maybe the new domestic violence law that has been ratified in Cambodia can help in this case. The latter case can be done, for example through skills training, job creation or other small business which help these persons not (to get) trapped in trafficking again...”;
- “We attempt, within two months, to figure out what is a good solution for each child. None of the children are put on a standard track. We take a look at the family situation, how she ended up trafficked, how she is doing physically and emotionally, what she wants to do with her life, whether she is literate or not and many other things. We determine the risk to her being re-trafficked/raped and other factors and try to come up with the best medium- to long-term care solution. Sometimes the parents are involved in the decision and other times (they are) not”.

Table 7 Reintegration and Follow-up Services

Follow-up Processes and Care for Carers				
Agencies	Does the nature of the reason for persons to leave their community (domestic abuse vs. desire to travel) influence their reintegration plan?	Does your agency/ department provide follow-up services/assistance for persons reintegrated into their communities?	Are there care-for-the-carer processes in place to protect staff from burnout?	On a scale of 1 to 5 (5 being highly effective) how would you rate your services in assisting the recovery and reintegration process for trafficked persons?
1.	✓	✓	✓	2-3
2.	✓		✓	Recovery (4) Reintegration (1)
3.	✓	✓		5 for immediate after-care and protection of trafficked persons. 2 for reintegration.
4.	✓			4
5.	✓			3
6.	✓			

It was found that currently there are no formal systems in place to assist trafficked persons reintegrate back into their communities:

- "There is a plan to implement a project called "Mobile reintegration support team" to help trafficked persons successfully reintegrate into their community. The elements of this team include: health, legal, rights, police, skill training and psychosocial... work. But this has not worked out!"
- Not at present. We will typically coordinate with a local human rights organization that can provide follow-up such as the Cambodian League for the Promotion and Defense of Human Rights (LICADHO) or World Vision. We have a programme called New Steps which is out for funding. It proposes that we provide additional support and follow-up for those girls that go directly home from our care. New Steps will start in October 2007 should funding be successful.

Respondents further stated that no support networks/mechanisms had been established in communities to assist the mental/emotional well-being of returning trafficked persons:

- Unknown;
- Not that we are aware of.

The emotional well-being of staff is important to prevent burnout and other associated problems related to repetitively being exposed to persons who have experienced sometimes severe abuse and trauma. Some agencies reported that they have provided some training and implemented strategies to prevent burnout, but on the whole this is an area that is generally overlooked:

- We are mindful of this as we are dealing a lot with people who have emotional problems. We (maintain) close supervision (of) staff so that they can be supported and (can) learn. We have regular training every year to update new knowledge among staff;
- We have had lots of training in the past year to support our care-giving staff. This was offered under the ATSECC programme which was administered by World Vision. Training included caring for caregivers, peer debriefing and other programmes to assist care-giving staff. We also have hired Jane Lopacka Counselling and Mediation Services (JLCAMS) to provide supervised practice, group debriefing and individual assessments of our caregivers.

Respondents' reported issues/constraints

- Many interviewed governmental organizations and NGOs expressed concern over the lack of donor coordination and the support of NGOs outside of the formal network, which is supported and solidified by the previously mentioned MOU signed by 5 ministries and 23 NGOs;
- Some agencies expressed concern that donor regulations relating to core funding are too strict, which leaves them under-resourced (with serious staff shortages), yet donors always demand/expect a high level of quality in service provision. More experienced mental health professionals/practitioners in Cambodia demand higher rates of remuneration, which are difficult for some NGOs to attain;

- Government resources and capacity to implement are still quite low, although there is ongoing improvement in these areas;
- The service provision of some NGOs is driven by their own desire to secure funding rather than serving the best interests of the trafficked persons;
- Referral networks seem to need further strengthening as decisions are made at a centralized level and there seems to be a breakdown in communication at the provincial or district level, where activities should be implemented;
- Some service providers still believe they have a better idea of the needs of the trafficked persons than those persons themselves;
- According to one source, 90 per cent of girls/women do not provide real input into their recovery and reintegration plan;
- One respondent reported that sometimes there are issues caused by mixing girls/women who have been involved in sex work with other girls/women suffering from other social problems. Some girls/women that have been involved in sex work have more money and nice clothes and have, or may, become role models and negatively influence the behaviour of other girls/women. This may not be the case in all instances, but shelter providers need to be aware of this potential problem. (This statement was not intended to be a discriminatory one but more an area of concern.);
- Some caretakers in shelters tend to negatively stereotype girls/women who have been trafficked into sex work and always give them menial tasks to undertake, thus further demoralizing them.

Summary and Conclusions

As previously mentioned in the above introductory summary, the level of competency and qualifications of the agencies assisting trafficked persons in Cambodia are quite varied. A number of highly qualified agencies are doing extremely good work with trafficked persons. It is evident that there is growing network that is facilitating the transfer of knowledge, training and skills among some agencies. However, a number of service providers are still operating without any formal supervision, with some respondents suggesting that the care being provided is not necessarily in the best interest of the trafficked persons and may in fact have a negative impact on their recovery and ability to achieve some sense of normality in their lives.

In this regard, it is recommended that there be a further strengthening and expansion of networks to include agencies that are not related to trafficking but which are technically competent agencies, and that a system be put in place to facilitate the transfer of technical knowledge on an ongoing basis. Furthermore, a “watchdog” system needs to be instituted to monitor agencies operating outside of any formal agreements adopted by the Government. This is indeed the primary responsibility of the relevant government agency, but it is evident that the resources and technical capacity of that agency still require strengthening.

Chapter 3

China

Domestic trafficking remains one of the most important challenges in China, with an estimated minimum of 10,000 to 20,000 persons trafficked internally each year, according to the United States Trafficking in Persons Report. International organizations reported that 90 per cent of those persons are women and children, trafficked primarily from Anhui, Henan, Hunan, Sichuan, Yunnan and Guizhou provinces to more prosperous provinces along the eastern coast of China for the purpose of sexual exploitation. While it is difficult to determine the exact imbalance in China's sex ratio (number of males per 100 females), some experts believe that the presence of more males than females in the population has already become, or may soon become, a contributing factor to the trafficking of women as brides.

The State Council of China recently released its first National Plan of Action on Combating Trafficking in Women and Children (2008-2012) (hereafter referred to as the "Plan of Action"), which went into effect on 1 January 2008. It covers a number of topics: guiding principles; general objectives and strategy; working structure; action measures and responsibilities; and implementation, supervision and evaluation. It describes the responsibilities of all the relevant ministries in combating trafficking, including the Legislative Affairs Committee of NPC, Ministry of Education, Ministry of Civil Affairs, Ministry of Labour and Social Security, Ministry of Health and the All China Women's Federation.

Although the Ministry of Public Security is the lead agency, the Plan of Action strongly supports interministerial responses and shared responsibilities. This national multiminsty mechanism for combating trafficking calls for a lead committee to report directly to the State Council. It is an important positive development in that it shows that China is moving towards an interministerial efforts on counter trafficking; it also highlights the importance of regional and international cooperation in the prevention of trafficking, and the assistance and rehabilitation of trafficked women and children who have been rescued. There are still some overlaps between the actions detailed in the Plan of Action and the counter-trafficking issues. Thanks to the strong support from the Government of China, IOM Liaison Office in China has made great progress in the following areas: victim identification training for border officials of the Ministry of Public Security; inspection of labour recruitment agencies; and information campaigns under the European Commission-funded AENEAS Project, return and reintegration as a complement to GMS work undertaken from the IOM Bangkok office. Consultation continues between IOM Liaison Office in China with the Government on follow-up activities to the current efforts.

The Plan of Action is an important instrument guiding China's efforts to combat trafficking. It accords with measures outlined in related international conventions which the Government of China has signed, in particular the Convention on the Rights of the Child, the Convention to Eliminate All Forms of Discrimination against Women, the Convention against Transnational Organized Crime, the Convention Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour as well as the country's constitution, its criminal law, law on the protection of the rights and interests of women, law on the protection of minors and other related laws. The Plan of Action has been developed in order to effectively prevent and combat the criminal activities

of trafficking in women and children; actively provide assistance and give appropriate aftercare to rescued women and children; and earnestly safeguard the legal rights and interests of women and children.

According to the previously mentioned Trafficking in Persons Report, China made tangible progress in protecting trafficked persons by focusing particular attention on its vulnerable southern border provinces. The Ministry of Public Security reported that it had opened two border liaison offices along the country's borders with Myanmar and Viet Nam in the autumn of 2006. Those offices provide short-term shelter and medical care. The All-China Women's Federation, a government-funded and -directed nationwide social organization, thereafter assists trafficked persons with regard to their repatriation. Ministry officials in these offices reportedly have received training to help them better identify trafficked persons. Additionally, the Women's Federation has reported having opened shelters in Guangxi, Jiangsu, Yunnan and Sichuan provinces. Provincial authorities in Guangxi also established the Border Trafficking Aid Centre in February 2006, which provides shelter, medical care and short-term rehabilitation for up to 30 trafficked persons at a time. The Women's Federation and NGOs have also set up national and regional hotlines that can help women obtain legal advice and assistance.

Nonetheless, protection services remain temporary and inadequate for addressing the needs of trafficked persons; for example, in Yunnan Province, victims of commercial sexual exploitation are not offered psychological assistance and they are generally sent home within a few days of their rescue. The Government is open to assistance and relies on organizations such as Save the Children to repatriate trafficked persons safely. However, China has taken steps to improve intragovernmental coordination and cooperation with organizations outside the Government in the most vulnerable provinces. Victim support in China can be divided into three categories:

- Foreign trafficked persons in China
- Repatriated Chinese trafficked persons
- Domestic trafficked persons

According to one respondent, under current Chinese laws and regulations, NGOs may have some role and have access to the repatriated Chinese and domestically trafficked persons. Foreign trafficked persons receive care from the Entrance and Exit Administration Bureau of the Government; no other agencies are permitted to open victim centres to provide such persons with services. This is the prime reason that more efforts are needed on the ground to help the victims of trafficking. In general, support for all three groups of trafficked persons is provided by the local Women's Federation and its counterparts. Support mechanisms do however differ from place to place and may depend on the financial and staff capacity of the organizations concerned. In Yunnan Province, owing to the support provided by Save the Children, the provincial office of the Women's Federation has been able to help repatriate 40 trafficked children and women. The support generally covers family assessments, vocational training and the provision of limited funding and follow-up. Although the Women's Federation can provide trafficked persons with services at the provincial level, after they have returned home, follow-up in a country as large as China entails such high costs that neither Save the Children nor the Women's Federation are able to cover them.

Mental Health

Yip³⁵ argues that community mental health services in China still face many challenges, such as high demand and scarce resources, government's difficulty in funding for related services, the inability of people in remote rural areas to access services, high levels of mental health illiteracy and problems in the formation of a multidisciplinary team.³⁶

The reporting of low rates of mental illness by China appears to reflect different definitions of disorders and somatic expressions of personal and social distress, which are viewed instead by health personnel as physical conditions. Acute mental health services are provided at community and county hospitals; and special psychiatric hospitals are available for more intractable cases. Chronically disturbed patients may receive long-term care in sanatoriums associated with large industries, or they may be maintained in at-home care facilities within their production brigades and with the assistance of their family and "barefoot" doctors. Psychiatric practice in teaching hospitals is similar to psychiatric practice in the West, although little attention is devoted to psychosocial problems in general medical care.³⁷

Respondents' Reported Issues/Constraints

- Limited government services/resources available to assist trafficked persons;
- Support for reintegration into communities is very limited or non-existent due to limited resources and large areas of coverage;
- Government hesitation makes the efforts less effective of other organizations working with groups at risk;
- Training is needed on case management best practices and other basic issues;
- Stigma related to trafficking still remains a considerable obstacle for reintegration into communities, particularly if health issues such as HIV/AIDS are evident.

³⁵ K.S. Yip, "Community mental health in the People's Republic of China: A critical analysis", *Community Mental Health Journal*, February 2006, vol. 42, No. 1, pp. 41-51.

³⁶ Ibid.

³⁷ A. Kleinman and D. Mechanic, "Some observations of mental illness and its treatment in the People's Republic of China", *Journal of Nervous Mental Disorders*, May 1979, vol. 167, No. 5, pp. 267-274.

Chapter 4

Indonesia

Indonesia is a prime destination and transit country for migrants owing to its numerous entry/exit points and weaknesses in its border and immigration management system. It also experiences important internal migration flows. As the country having the world's fourth largest population, Indonesia is also a source of out-migration, with hundreds of thousands of labour migrants regularly seeking employment in Malaysia and Singapore as well as in the Middle East.

Efforts are needed to improve the Government's capacity to employ appropriate strategies and technology to monitor and take action against irregular migration and address other critical issues, such as human trafficking and smuggling. IOM has an ongoing project in Indonesia that assists in the development of effective and sustainable rehabilitation and reintegration support mechanisms among government entities, including the Indonesian Embassy and Consulates in Malaysia and NGOs catering to the diverse needs of trafficked persons returning home. It provides trafficked persons with protection, return transportation, comprehensive medical and psychological care and reintegration assistance in Indonesia. Activities include support for the establishment of a recovery centre, NGO-run shelters, psychosocial support, educational classes, skills development, returns, legal assistance and reintegration packages/supplements. As of April 2007, over 2,200 trafficked persons had been provided with direct assistance through this programme.³⁸

IOM also operates a free medical recovery centre, designed for trafficked persons in Indonesia. The official opening took place on 10 June 2005 at the Kramat Jati Police Hospital in Jakarta. IOM cooperates with the national police, local NGOs and faith-based organizations. The establishment of the recovery centre marked a serious step forward for the national police in countering trafficking. The centre consists of a one-stop crisis location for providing services for all victims of violence and an in-patient facility, especially for trafficked persons. Admitted patients are given comprehensive medical services, including psychological care and, with the patients' permission, testing for sexually transmitted infections. In-patients are put under the care and supervision of doctors and social workers providing services in the recovery centre. After the trafficked persons have received medical services, IOM, in cooperation with its NGO partners and faith-based organizations, facilitates the patients' return home and their reintegration. IOM also provides direct assistance for trafficked persons through police hospitals in Surabaya and Makassar.³⁹

Psychosocial Support

Psychosocial support consists of emotional support and information support. It is provided starting from the time when a trafficked person is received and continues through her/his return and reintegration processes. Psychosocial support may be provided in the form of individual or group counselling and includes recreational activities and education sessions also. IOM provides direct counselling at the time a trafficked person receives recovery assistance. This form of psychosocial support is then continued by its NGO partners in the area to which each trafficked person is returned.

³⁸ IOM website.

³⁹ Ibid.

Table 8 Services Provided

Provision of Basic Services						
Agencies	Basic health needs	Family support/mediation	Secure environment	Housing	Medical assistance	Others
1.	✓	✓	✓	✓	✓	
Assessment/Recovery/Education						
Agencies	Psychological assessment	Counselling	Psychotherapy	Life skills	Education (formal and informal)	Community education
1.	✓	✓	✓	✓	✓	✓
Reintegration						
Agencies	Reintegration support	Family assessments	Vocational training	Seed grants	Legal aid	Follow-up
1.	✓	✓	✓	✓	✓	✓

IOM Indonesia's receiving points for trafficked persons are the four recovery centres located in the country. Medical services are provided directly upon the arrival of the trafficked persons (detection of medical emergencies and the provision of other services take place in the following days). If the trafficked persons insist on returning home immediately, even though they had been informed of all the services they would be provided, including their importance, their return will be facilitated in order to ensure their safe return home as soon as possible. For children though, family tracing prior to return is mandatory in order to ensure the children's safety upon returning home.

Organizational Orientation

IOM standards of services guide the provision of services for trafficked persons and those services are available to all trafficked persons. The services are specifically designed to assist trafficked persons. Upon arrival in Indonesia, all such persons are offered the same set of services. Whether or not the persons were afforded services prior to reaching Indonesia would depend on the local resources in that specific country/region.

Indonesia has established a standard operating procedure for assisting trafficked persons. On paper, the network appears comprehensive, but implementation in the field is still very challenging as communications between government institutions and other organizations are difficult. Recently a law on trafficking was passed and currently efforts are being made to develop appropriate guidelines for its implementation. However, although there is no national or local system of coordination and monitoring established for governmental organizations and NGOs offering recovery and reintegration services for trafficked persons, such a system is in the pipeline.

Assessment Methodology

No specific assessment methodology exists when making the initial basic needs assessment of a trafficked person. A case record is utilized for each such person assisted, which describes qualitatively her/his current needs, problems, etc., and ways to meet those needs and solve problems. In general, the immediate needs of trafficked persons are security, shelter and finances. The need for security is higher for trafficked children than for adults, while financial needs are more prominent with adult trafficked persons. More in-depth (psychological) screening takes place at a later stage, using the Hamilton Rating Scale to identify anxiety and depression; the Mini Mental Test and a graphic test are also used. So far, formal interpretation services are not needed as the capacity of the recovery staff to speak local dialects is quite strong. Information on the mental/emotional well-being of the trafficked persons is collected in the initial assessment by means of observation, interview, and information supplied by the trafficked persons' friends and that based on group activities etc.

Case Management

A case management process is conducted for each trafficked person assisted. A specific social worker is assigned for every such person. The social worker is responsible for building close rapport with the trafficked person and developing a case record through counselling sessions and in-depth interviews. The type of information collected includes, among others, a clear identity, chronology of events (not necessarily too detailed), description of the person's needs and the problems faced, problem solving and future plans. Case management information is made available if a referral to another agency is made and the trafficked person provides written prior consent. To ensure the security of such files, a code system is utilized (instead of using real names) in medical records and all files are locked safely in cabinets in a specific room. Case workers are not allowed to write/type case records at home; a photocopy machine is available in the recovery centre to make sure that original information is not taken outside the facility. All trafficked persons are counselled on their own case management process and interpreters are available but so far have not been needed.

Standards of Care/Guidelines

Minimum standards of care are in place for the provision of care for trafficked persons. These have been formulated by or adapted from those used by other IOM missions, in consultation with national experts who have assisted in ensuring the developed minimum standards of care are practical in the local context. Trafficked persons actively take part in outlining the care they would like to receive by means of individual counselling sessions and discussions during visits to the doctor. The assistance offered is oriented towards the individual needs and wishes of the trafficked person. However, besides informal verbal discussions, no formal avenue exists for trafficked persons to provide feedback on the services they receive. Community resources are not utilized to assist trafficked persons recover, but the potential for communities to be involved in reintegration assistance is recognized. Ward security staff monitor all who enter and leave, and they screen visitors to ensure the safety of the trafficked persons.

Mental Health

The respondent for Indonesia was of the opinion that there was a difference between “psychosocial support” and “mental health support”. The presence of a severe mental health problem requires the assistance of a psychiatrist; thus, mental health support would be required rather than psychosocial support. Trafficked persons suffering from mental health problems are reportedly receiving assistance from a psychiatrist who fills in the trafficked persons’ medical records using the “International Classification of Disease 10” (ICD X) code and who provides a diagnosis. No guidelines are in place for the provision of more specialist mental health care. Clinical screening tools such as the Hamilton Rating Scale are utilized to detect depression and anxiety; the Mini Mental Test and a graphic test are also widely used. The respondent believes that these are useful screening tools; they have been used by professionals in other parts of Indonesia where they were proven to be effective and appropriate.

Trained social workers, with social welfare educational qualifications (bachelor’s degree), and a psychologist provide flexible and responsive counselling that is tailored to suit each case. The social workers and psychologist avoid re-traumatizing the trafficked person by trying not to ask too many detailed questions about the traumatic incident. Other less formal ways to assist a trafficked person in the process of healing are also used, such as “family support”. When relatives come to visit the individual at the recovery centre, their presence greatly accelerates the recovery process; usually such trafficked persons can be discharged much earlier than those who receive no family support.

It was also reported that the Trans-cultural Psychiatry Organization works along with traditional healers in community-based mental health rehabilitation programmes. The respondent recognized that recovery and reintegration planning must be individualized in order to meet the specific needs of the trafficked person:

- “Yes, the process is different, as trafficked persons who have (had) previous traumatic experiences and problems require longer support, wider coverage area, and it also affects their return home whether they will return to the place they come from or we should locate a new permanent settlement for her”.

Follow up services/assistance for persons reintegrated into their communities is provided, yet existing or new support networks/mechanisms have not been established in communities to assist the mental/emotional well-being of returning trafficked persons.

No formal strategy is in place to protect the emotional well-being of staff and shield them from burnout:

- “There’s nothing formal in place. We do have sharing sessions among us, and sometimes activities outside the office”.

When asked to describe on a scale of 1 to 5 (5 being highly effective) how the respondent would rate services in assisting the recovery and reintegration process for trafficked persons, the reply was “4”.

Chapter 5

Lao People's Democratic Republic

Four governmental and non-governmental organizations were interviewed in the Lao People's Democratic Republic. Psychosocial support is very much oriented towards trafficked persons returning from Thailand, more so than anywhere else. The Lao People's Democratic Republic has a bilateral MOU with Thailand that outlines the process for returning trafficked persons. Several case management meetings (workshops) have taken place so that social workers from both countries could learn about the return and reintegration processes and discuss problematic cases. These workshops were organized and facilitated by IOM Bangkok.

Before returning, Lao women and children receive recovery assistance at Baan Kredtrakarn, which is the main government facility shelter in Thailand. A senior person from the Lao Women's Union reported that all returning trafficked persons returned home without any evident psychological trauma or mental health issues, as such issues had already been dealt with during their stay in Thailand. Psychosocial support for trafficked persons in the Lao People's Democratic Republic is carried out in a national context that lacks a mental health infrastructure. There is no mental health policy, mental health programme, or special programmes for populations affected by mental health illnesses or conditions.

Mental Health

Mental health issues are still new for the people of the Lao People's Democratic Republic. The population has a strong belief in spirits and mental illnesses are often thought to be caused by possession by evil spirits. Medical professionals are not trained to recognize mental health problems; consequently, many psychosomatic symptoms are dismissed as being inconsequential. There are only two public clinics delivering mental health services to patients: the mental health units of Mahosot Hospital and the Military Hospital, both of which are located in the national capital, Vientiane. Together, these units offer a total of 29 beds dedicated to mental health patients, or 0.03 beds per 10,000 people. The country as a whole has only 2 psychiatrists, 1 neurologist, 8 general practitioners, 5 medical assistants and 12 nurses. This tiny number of specialized staff means that community-based mental health care cannot be delivered effectively and research cannot be undertaken. Drug availability is still limited. Mahosot Hospital provides limited services to those who can afford to travel to the hospital. Since mental health services are available only in Vientiane, access to treatment for people with mental illnesses living in the countryside is severely limited.⁴⁰

Apart from insanity, characterized by obvious abnormal behaviour, mental suffering is not recognized as such or mentioned as a problem. Researchers have stated that, in general, mental health in the Lao People's Democratic Republic is referred to as *chit chay* (spirit and heart), *neo kit* (thought) and *samong*, *sen pasath* and *labob pasath* (physiology of the brain, nerve fibres and nervous system)⁴¹. They found that mental disease is perceived as a behavioural disorder, brain damage,

⁴⁰ Basic Needs website.

⁴¹ D. Bertrand and C. Choulamany, *Mental Health Situation Analysis In Lao People's Democratic Republic* (Geneva, WHO, 2002).

a cognitive disorder (troubles with memory, speech and hallucinations) and affective-emotional disorder, as well as matters of physical appearance (e.g. untidiness and dirtiness).

In the absence of mental health workers, the people of the Lao People's Democratic Republic effectively support one another through such crises and role changes. They accomplish this by employing social institutions and traditions that have been present in their culture from ancient times. Central to these traditional social resources are religious rituals (especially baci), community "elders" and various home-centred religious activities involving the extended family, neighbours and friends.

Psychosocial Support

Respondents stated the following about the interpretation of psychosocial support and mental health support:

- "Psychosocial support is to provide psychological care and social activities, which may relate to occupational therapy, vocational therapy and livelihood sustainability. My organization will provide microfinance to stabilize mentally ill people and (enable) their carers to ensure the sustainability of (their) livelihoods and improve their quality of life";
- "Need both mental and social support to effectively reintegrate trafficked persons. Mental issues should be dealt with beforehand and integration depends on this. Psychosocial activities need to be relevant and supportive of mental health. If the victim is confident, then the activities will be successful. Trafficked persons are all different, so case-by-case management is necessary. If the victims are confident and happy, then they can do anything".

Table 9 Provision of Basic Services

Provision of Basic Services						
Agencies	Basic health needs	Family support/mediation	Secure environment	Housing	Medical assistance	Others
1.	✓	✓	✓	✓	✓	
2.	✓	✓	✓	✓	✓	
3.	✓	✓	✓	✓	✓	
4.		✓	✓			
Assessment/Recovery/Education Service						
Agencies	Psychological assessment	Counselling	Psychotherapy	Life skills	Education (formal and informal)	Community education
1.		✓				
2.		✓	✓	✓	✓	
3.	✓	✓		✓	✓	✓
4.	✓	✓	✓			✓
Reintegration Service						
Agencies	Reintegration support	Family assessments	Vocational training	Seed grants	Legal aid	Follow-up
1.						
2.	✓	✓	✓	✓	✓	✓
3.	✓	✓	✓	✓	✓	✓
4.						

There are few providers of psychosocial support in the Lao People's Democratic Republic, but service provision is reasonably comprehensive, as shown in table 9. Government resources are relatively small; NGOs fill most of the gaps when needed. A strong coordination network is evident which enables this to happen in a reportedly effective manner:

- "At the moment, we provide no support to trafficked persons. As trafficked persons may pass through several shelters and finally will be living in their own community. At this stage, if he/she has mental health problems, our organization could provide him/her some assistance like life-skills education, horticulture therapy, counselling, psychotherapy, follow-up visits and psychotropic medication if needed..."

Respondents reported that trafficked persons receive medical assistance either on arrival or within the first few days at their respective shelters:

- “When the VOT presents somatic (insomnia, headache, pain...) or mental health problems (depression, illusion, adaptation problem...)”;
- “On arrival. If their condition is bad, then we take them directly to the hospital”;
- “On the second day after arrival they will receive a medical assessment”;
- “The same day they arrive”.

Most respondents report that, if a person is identified as a trafficked person, she or he must stay at a shelter for at least seven days regardless of whether or not the person has been harmed and wishes to return home immediately:

- “Provide him/her some information: (1) alert symptoms such as mental health problems (mood problems, anxiety...), somatic symptoms (insomnia, sorrow...); (2) reference contact; (3) VOT has to keep in touch with our organization”;
- “No an assessment is needed because sometimes trafficked persons don’t tell the truth. We do a medical, legal and then family assessment before we reintegrate the individual”;
- “They stay for one week and if they have no problems, then we release them. If they have problems, then they need to stay longer”;
- “Our services are totally voluntary; they can leave anytime they want”.

Organizational Orientation

Table 10 Populations Assisted and Guidelines

Target Populations/Guidelines							
Agencies	Women	Children	Women and children	Men	All	Do trafficked persons receive the same services/ assistance as other persons?	Institutional policies/ guidelines in place
1.			✓	✓		✓	
2.			✓	✓		✓	✓ (in pipeline)
3.			✓		✓	✓	
4.			✓		✓	✓	

Respondents stated the following about what guides their service provision for trafficked persons:

- “First, we have to identify their basic needs and will try to provide support accordingly to their needs”;
- “A client-centred approach and safe reintegration practices”;
- “We provide psychological and legal counselling, and vocational training and employment (plus) follow-up after reintegration. We also conduct prevention activities and awareness-raising on trafficking. We work on the policy aspects as well”;
- “It is our duty to assist trafficked persons and make sure their human rights are respected. We also assist them to integrate back into society”.

Services are available for all trafficked persons, including men, which is quite progressive as there is not as yet any trafficking legislation in place that covers males. There are however very few institutional operational policies, standard operating procedures and strategies in place to guide their service provision:

- “Mainly women and children, but will assist men when needed”;
- “We provide assistance not only to trafficked persons, but also victims of violence and sexual abuse. Men can also receive assistance if they have family problems....even foreign men”;
- “Women, and boys and girls under 18”;
- “Women and children”.

All respondents stated that the types of services provided to trafficked persons are similar to services provided to persons experiencing other problems such as domestic violence. It is however, recognized that trafficked persons have specific needs. All responded that they deal only with returning trafficked persons from Thailand:

- “Yes”;
- “Equal, but it depends on the case”;
- “Equal”;
- “Services are dependent on the directives and policies of the ministry”;
- “We deal only with trafficked persons”.

Most respondents stated that there needs to be greater clarity as to the roles and responsibilities of the governmental and non-governmental sectors in relation to providing assistance and services for trafficked persons:

- “It’s a bit unclear but okay. Certain protocols need establishing that outline the steps to be taken”;
- “We work with various sectors both private and non-government”;
- “There is a governmental and non-governmental MOU in place, but at ground level it is unclear who is doing what”.

However, positive steps are being taken to improve the coordination and monitoring systems for governmental organizations and NGOs offering recovery and reintegration services to trafficked persons, including the following:

- “National system”;
- “National Committee for Protection of Women and Children”;
- “The Centre of Counselling under the Lao Women’s Union”;
- “Ministry of Labour and Social Welfare, NGOs”;
- “AFESIP”.

Assessment Methodology

Table 11 Assessment Methodology

Assessment Services				
Agencies	Use of assessment tools	In-depth counselling	Translation available	Is information on the mental/emotional well-being of the victim/survivor also collected in this initial assessment?
1.		✓	✓	✓
2.		✓	✓	✓
3.	✓	✓	✓	✓
4.		✓	✓	✓

Some agencies stated that they use specific assessment methods or tools when making the initial basic needs assessment of a trafficked person but no standardized tool is available:

- “At the moment, Basic Needs-Lao People’s Democratic Republic has no checklist”;
- “Yes, we use a basic check list”;
- “Staff will ask questions to gain basic information on arrival (of the trafficked person). We conduct more in-depth interviews at a later stage. Some trafficked persons keep secrets for long periods of time, for example if they had been raped. It takes them time to open up and discuss these sensitive issues”.

In general the immediate needs of trafficked persons do vary depending on whether they are adults or children, males or females:

- “Yes, their needs vary”;
- “Some want to study; some want grants; some want nothing!”
- “Most need vocational training and education”.

Respondents stated that more in-depth (psychological) screening takes place at a later stage once the trafficked person settles into his or her new environment and starts to build trust and relationships with staff. Interpretation services are not needed very often as most such persons are Lao nationals. However, interpretation is provided for minority groups if needed.

Case Management

Table 12 Case Management Methodology

Case Management Processes				
Agencies	Is case management information made available if a referral to another agency takes place?	Does the victim/survivor need to provide consent before information can be transferred?	Are there security measures in place to secure files?	Are trafficked persons themselves counselled on their own case management process; are translators accessible?
1.	✓		✓	✓
2.	✓		✓	✓
3.	✓	✓	✓	✓
4.	✓	✓	✓	✓

All respondents stated that they have a personalized case management process in place to provide on-going care for trafficked persons:

- “Each case management should be tailored to each individual in order to respond to his/her needs”;
- “The victim arrives and is met by social workers and counsellors who collect initial information. A meeting then takes place between staff and management to discuss the victim’s recovery plan. A case conference is also held with the network (outside agencies) to make decisions on what the victim should receive, for example counselling, medical, legal assistance. The next step is to provide psychosocial assistance and counselling to make the victim confident. They are then provided with vocational training. The last stage is an assessment on whether they are ready to be reintegrated. A family assessment is undertaken and also the readiness of the victim to find employment. Some actually find employment in town and don’t go home”;
- “Yes”;
- “The initial assessment reveals whether the victim requires one-on-one work or group work”.

All respondents stated case management information is made available when a referral takes place. Consent is however not always sought by all agencies before information is transferred. All have security measures in place to protect the confidentiality of case management material:

- "All files should be sealed and the (person) responsible for each reference point should keep the information confidential";
- "Files are kept in a locked cabinet";
- "They are secured".

The respondents of all the agencies interviewed said that the trafficked persons are counselled on their own case management:

- "Normally, trafficked persons should get involved in the management process in order to ensure the sustainability of the process";
- "Yes, of course, they need to be informed of the process";
- "They get this information during their orientation";
- "Yes, timelines are made, expectations are decided and planning takes place".

Standards of Care/Guidelines

Table 13 Standards of Care/Guidelines

Standards of Care and Community Involvement in Recovery and Reintegration Processes					
Agencies	Does your organization/ department have minimum standards of care in place for trafficked persons?	Do trafficked persons actively take part in outlining the care they would like to receive?	Do persons from the community also assist trafficked persons in the recovery process?	Do you see the potential of community networks in assisting in the trafficked persons' recovery and sustainable reintegration?	Is the confidentiality of the victim/ survivor protected?
1.	✓	✓		✓	✓
2.		✓			✓
3.	✓	✓		✓	✓
4.		✓		✓	✓

Half of the agencies/departments interviewed reported that they have minimum standards of care in place for the care of trafficked persons:

- “Not yet at the moment”;
- “Only the regulations of the shelter at this point in time. These outline what trafficked persons can do and what they can’t do within the shelter. This is a 90-day programme, and staff and trafficked persons agree on guidelines”;
- “Only shelter rules”;
- “Yes, they were formulated and based on UNICEF and Save the Children protocols”.

As reported, these minimum standards of care were formulated:

- “Based on international best practices”;
- “Based on women’s laws, the United Nations convention on organized crime, the CEDAW convention, the national constitution, government and party policies”.

All respondents stated that minimum standards of care guidelines would be helpful in their work and beneficial for trafficked persons. They also stated that it is important for trafficked persons to take an active, participative role in their recovery and reintegration planning:

- “Yes, they would be helpful”;
- Normally (with regard) to outlining the care, the victim should (be involved) in order to meet at least their basic needs/wants.

Respondents further stated that the assistance offered is oriented to meeting the individual needs and wishes of the trafficked person:

- “Yes, it is. We stay as one big family”;
- “Yes”;
- “All of our processes are individualized”.

The respondents reported that the following avenues exist for trafficked persons to provide feedback on the services they are offered:

- “Yes, weekly meetings are held between trafficked persons and staff”;
- “Only via very informal ways...for example discussions with social workers”;
- “Not really; this is done only very informally”.

Most respondents stated that communities are not really involved in the recovery process. They do however assist in some reintegration, but confidentiality concerns are still a predominant barrier to their further involvement. All respondents agreed that for sustainable reintegration communities must be sourced in some way:

- “In order to get the community assisting the recovery process, it is important to establish a community network with a clear assignment and a description of the support/care provided”;

- “Yes, we work with nine villages as part of a cluster and frequently have meetings. Village persons find and refer trafficked persons to us and help with security measures. Trafficked persons also hold activities in some villages”;
- “We previously did monitoring in the community, but now there is no budget. The provincial government’s staffs now follow up with cases when they have time”;
- “Not really; only vocational training resources were sourced”;
- “Confidentiality concerns are still a major concern”;
- “Stigma against trafficked persons etc”;
- “Yes, we are expanding our child protection network and use volunteers to monitor and assist trafficked persons when needed”.

Mental health

Table 14 Mental Health Methodology and Guidelines

Target Populations/Guidelines							
Agencies	Are the trafficked persons that are suffering from mental health problems receiving assistance?	If your organization/ department offers more specialist mental health services, are there any specific guidelines in place for the provision of these services?	Are clinical screening tools used to make an assessment?	If used, do you believe that these types of tools are culturally applicable, reliable or effective in making an accurate diagnosis?	Is counselling available?	Are these programmes tailored to suit the needs of each victim/ survivor?	Are there other (less formal) ways a victim/ survivor can be assisted in the healing process?
1.	✓			No	✓	✓	
2.	✓			Possibly	✓	✓	
3.	✓			Possibly	✓	✓	✓
4.	✓			Possibly	✓	✓	✓

All respondents thought there was a difference between “psychosocial support” and “mental health support”:

- “Mental health support could be (provided) through moral support (tying a string around the wrist in order to appease all (spirits) of the individual facing a difficulty...), Buddhist rituals....Psychosocial support is the combination of mental health support and social support, such as leisure activities, occupational therapy, vocational therapy and long-term follow-up (home visit...) in order to improve their quality of life”;

- “Yes, it is the social aspects and the more specialised mental health aspects”;
- “Different, but we don’t treat separately; we treat them together. We believe that people can have dual roles, for example a doctor can be a counsellor and a lawyer can be a counsellor etc.”

Mental health problems were reportedly being treated at the following places or through the following means:

- “Yes, at the government Mahosot Psych-hospital”;
- “Basic Needs works with community-based organizations to address mental health issues within a community setting. We call this the Mental Health and Development Model. Any field intervention begins with a consultation with the stakeholders through community consultation workshops. This involvement of stakeholders continues through periodic planning, reviews and evaluations. Thus, the model is original in its approach, inclusive in its construct and participatory in its application; the model has five key components:
 1. Capacity-building
 2. Community mental health
 3. Sustainable livelihoods
 4. Research
 5. Management and administration”;
- “Yes, we refer cases when they are problematic or too serious”;
- “Mental health in the Lao People’s Democratic Republic is always neglected by the community, even among the health sector. There are only two psychiatrists in the country, but there are some general practitioners working at the mental health unit trained (through) on-the-job training. Mental health care is only available in Vientiane City”;
- “Minor cases we can assist but we refer more serious cases to Mahosot Hospital where we have two focal persons”.

No respondents reported using clinical instruments to screen for mental health problems. Respondents were further asked if they believe that these types of tools are culturally applicable, reliable or effective in making an accurate diagnosis:

- “No”;
- “Possibly; we are exploring some tools that could be useful”;
- “They would need to be assessed before use to see if they are culturally applicable and reliable”;
- “There are very few, if any, translated and tested screening instruments available”.

All agencies/departments reported that counselling services were available and provided to trafficked persons by trained and qualified staff. Counselling services are generally flexible and responsive to the needs of the trafficked person; however, some still provide a fixed term of service for trafficked persons:

- “Yes. Counselling is a type of consultation among counsellor and counselee in order to keep views, plans of the counselee and discuss (these) together. The counsellor (has) the learning skills and should not talk too much”;

- "All staff need to be trained in counselling and case management. Without proper training they can't work with cases";
- "Yes, it is available. Our staff have had basic in-house training";
- "Available constantly. Counsellors are trained and university graduates";
- "It should be a fixed counselling service";
- "Our counselling is flexible";
- "Yes, very flexible and respondent to needs";
- "If a programme is tailored to each individual's needs, the counsellor should have strong skills in counselling".

Table 15 Follow-up Processes and Care for Carers

Follow-up Processes and Care for Carers				
Agencies	Does the nature of the reason for a person to leave their community (domestic abuse vs. desire to travel) influence their reintegration plan?	Does your agency/ department provide follow-up services/ assistance for persons reintegrated into their communities?	Are there care-for-the-carer processes in place to protect staff from burnout?	On a scale of 1 to 5 (5 being highly effective) how would you rate your services in assisting in the recovery and reintegration processes for trafficked persons?
1.	✓	✓		3 (step-by-step ...learning by doing...it is difficult to be perfect at everything)
2.	✓			Recovery (4) Reintegration (1)
3.	✓	✓		4
4.	✓			Unable to rate

Respondents suggested that the reason a person becomes susceptible to a trafficking situation will influence the nature of the reintegration planning process (for example leaving home as a result of domestic violence as opposed to the desire to travel):

- "In this case, I think that during the intake phase, the caregiver should take the history of the problem, assess the emotional status, the needs and future plan (of the person). After that, the caregiver should decide on type of recovery and reintegration plan which will be tailored to the individual";
- "Yes, the assessment team would outline a strategy in these different cases. One may receive vocational training while the other needs family mediation etc.";
- "They are very different cases. It is important in domestic violence cases to undertake a family assessment or find an alternative location for the person. The other (choice) would probably (be for the person to) receive employment or vocational training".

Several respondents suggested that the following strategies are in place to prevent the re-traumatization of the trafficked person during the recovery phase:

- “Basic Needs enables mentally ill people to develop and articulate their perceptions about their situation and needs. We generate new information, insights and learning rooted in the realities confronting the mentally ill and carrying the authenticity of their ‘voices’. Underlying all our work have been the “life stories” that trace the experience of mentally ill people and their families. This is central to the research process. It is this rich yield of ‘evidence’ that is at the core of our research, policy and advocacy programme. We already possess compelling evidence of the reality of the lives of people who suffer mental ill health and the ability of our model to effect real and sustainable change. Thus, we use research to better inform our own work and to help design policy recommendations to introduce community mental health and development programmes within the frameworks of government policy and health provision”;
- “We try to build relationships and not force the trafficked persons to remember if they don’t want to”.

Other less formal ways a trafficked person can be assisted in the recovery/healing processes are:

- “Tying a white string around the wrist, and seeking advice from monks”;
- “We provide a safe environment that is conducive to healing. We also have pets which help. Interactions with staff and other trafficked persons are important and a good way to assist people to feel more comfortable and happy”.

In some cases follow-up services/assistance is provided for persons reintegrated into their communities; however, a lack of funding remains a problem:

- “Yes, via our network”;
- “Yes, we did but now we have budget problems so we rely on (our) provincial network and other counterparts working in the community to conduct follow-up”.

Respondents stated that the following support networks/mechanisms had been established in communities to assist the mental/emotional well-being of returning trafficked persons:

- “Yes, but at the district level”;
- “Capacity-building of our partners is central to the extension of our ideas and the replication of our work. Most community organizations have no experience in the field of mental health. Our partner organizations have worked either in community-based rehabilitation or in community development. We help our partners improve their capacity to work with people with mental illness. We use a form of group dynamics called animation to enhance the skills of people we work with – be they groups of mentally ill people or formal organizational structures. Moreover, many mentally ill people and their carers (usually family members) often form mutual support groups where innovative approaches to care are adopted”;

- “We have learned from our consultations that the primary need of people with mental illness is access to mental health care in their communities. We build close partnerships with providers of mental health services and together work out the most effective approach to extend their ability to provide care within the communities. Regularly-held field clinics (conducted) by professional providers of care have been an effective way of delivering improvements. This has expanded the range of work of mental healthcare professionals and enhanced their development – introducing them to new models of care delivery. Training of the staff of community-based organizations to act as ‘barefoot’ counsellors, and the training of local general health practitioners and district-based practitioners to supplement more specialized staff will also be key factors in the module’s effectiveness”;
- “Stabilization enables mentally ill people, once more, to exercise a degree of choice in their daily lives and re-enter productive employment. The Basic Needs programme identifies the capabilities of individuals and helps them return to their previous employment or find new work. People learn the skills they need to start micro enterprises and are supported in their efforts to access credit. Meaningful work that makes a visible contribution to a person and the family’s well-being reduces the impact of poverty, promotes recovery and transforms the way a mentally ill person is seen both from within and outside the family. Thus, the sustainable livelihoods approach is an effort to reduce both absolute poverty and exclusion – facilitating acceptance and reintegration into family, community and society”.

Respondents suggested the following strategies are in place to protect the emotional well-being of their staff to prevent burnout:

- “They may be stressed out. We have to take care of our caregivers”;
- “We have a self-administered check-list. If they score low on this, they are sent to counselling by management staff. Once a week a staff meeting takes place to discuss issues and concerns etc. We also have sporting and leisure activities”;
- “Management has a good relationship with staff and frequently holds social activities as a measure to wind down. Team planning is also important”.

Respondents’ Reported Issues/Constraints

- There are still some problems with the transfer of case management information from Thailand to the Lao People’s Democratic Republic when a return takes place;
- NGOs still lack stable funding sources, so the sustainability of their work is questionable;
- NGOs have in general very good technical skills and these could be shared via the established networks in place, but there still remains the issue of funding as government budgets are unable to fund these activities;
- It is still a little unclear how much control trafficked persons have over case management information transfer and input into planning;
- There are still very few NGOs working specifically in this area;

- Community outreach still remains problematic. Good quality or effective reintegration and follow-up in outlying areas is very difficult, considering the limited resources that the Government and NGOs have. It is noted however that the networks of governmental organizations and NGOs enable greater coverage.

Summary and Conclusions

It is evident that the provision of psychosocial services is fairly comprehensive for trafficked persons returning from abroad. None of the respondents interviewed suggested that there was a great incidence of domestic trafficking and if there is then there may be concerns over the identification process. The provincial network which provides a certain degree of community outreach in five provinces seems to be working effectively, although there may be certain remote areas of the country that may be neglected and reintegration support is limited for this reason. Overall, the respondents suggested that there is a very good functioning referral network among governmental and non-governmental organizations. There does however appear to be some weaknesses in the system, as there are only a few key agencies focusing on trafficking. The case management systems in place appear to follow best-practice principles, but in some instances the amount of control the trafficked persons have over their recovery and reintegration planning is questionable. It is obvious that some service providers believe they are acting in the best interest of the trafficked person, but this may in itself be a breach of their fundamental right to choose the best path for themselves.

With regard to more specialist mental health care, several respondents reported that the incidence of women or children returning with any serious psychological problems was extremely rare. Another respondent suggested that it may take some time for the individual to open up, as trust in the service providers takes time to build.

The NGO known as Basic Needs is a specialist mental health agency that could provide some technical input, particularly to government departments. AFESIP is also an experienced psychosocial service provider and part of the formal network. The first and often most important thing that mentally ill people need is care that they can access in their communities. What little mental health care that is available is often found only in psychiatric hospitals in capital cities. That means that people who live in very remote rural areas have to travel great distances to get treatment. Transport is not free and many people cannot afford the fares. If people do get treated in psychiatric hospitals, the conditions are normally very dire, although work is being carried out in cooperation with Governments to help them improve mental health care services in the community. Nonetheless, many people in rural areas turn to traditional healers or faith healers to cure their illnesses. While these healers are successful in treating some mental illnesses by using counselling methods in their treatments, often their methods are inappropriate and ineffective. Effective treatment is a vital first step in giving mentally ill people the chance to start a new life.⁴² A recent report recommends that the much-needed provision of mental health services requires extensive background study that has so far not been forthcoming.⁴³ The social psychology of the various groups, the psychopathologies and their epidemiology, what is or is not aberrant, all are unknown and unstudied, even for ethnic Lao, not to mention the situation of the diverse ethnic groups in the country. Eventually, how all of this can be put together within a viable mental health service system will need to be addressed.

⁴² Basic Needs website.

⁴³ http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/microsites/IDM/workshops/Health_and_Migration.../se2_pre_investing.pdf

Chapter 6

Myanmar

Three agencies were interviewed in Myanmar: one governmental and two non-governmental. Psychosocial and mental health service provision for trafficked persons in Myanmar is quite a new field and unfortunately there are very few service providers despite the rather significant numbers of people being trafficked from Myanmar into countries such as Thailand. Resources are limited, but on a positive note, psychosocial and reintegration support is receiving more attention from the Government and there are concrete plans to upgrade the current services.

Psychosocial support

Respondents provided the following interpretations of “psychosocial support”:

- “Our organization considers psychosocial support as counselling and we provide counselling services to the trafficked persons”;
- “Psychosocial support is more than physical needs. It is some sort of dealing with psychological and emotional needs. Most of the time our department provides for only the physical needs but (gives) less focus to emotional needs. As psychosocial support is an on-going process of meeting one’s emotional, social, mental and spiritual needs, due to our staff shortage, the department has less focus in this area”.

Table 16 Psychosocial Services

Provision of Basic Services						
Agencies	Basic health needs	Family support/mediation	Secure environment	Housing	Medical assistance	Others
1.						
2.			✓			
3.						
Assessment/Recovery/Education Service						
Agencies	Psychological assessment	Counselling	Psychotherapy	Life skills	Education (formal and informal)	Community education
1.	✓	✓	✓			
2.					✓	
3.	✓	✓		✓	✓	✓
Reintegration Service						
Agencies	Reintegration support	Family assessments	Vocational training	Seed grants	Legal aid	Follow-up Visits
1.						✓
2.	✓	✓	✓	✓	✓	✓
3.	✓	✓	✓	✓	✓	✓

Respondents stated that trafficked persons receive medical assistance in Thailand (as the majority of persons are processed there before being returned to Myanmar), but treatment is available on their return if they have on-going or persistent medical problems. Trafficked persons are also encouraged to remain in a shelter for at least two weeks in order to receive assistance:

- “When VOT is too traumatized and needs medical health care and also when they have infectious diseases, such as HIV/AIDS and sexually transmitted diseases”;
- “When they are seriously ill or need some medical attention”;
- “We request and explain to them that they must stay for two weeks at the shelter”.

Organizational Orientation

Table 17 Organizational Orientation

Target Populations/Guidelines							
Agencies	Women	Children	Women and children	Men	All	Do trafficked persons receive the same services/ assistance as other persons?	Institutional policies/ guidelines in place
1.			✓			✓	✓
2.			✓			✓	
3.			✓			Not in every case	

Respondents suggested that the following of guidelines help them in their provision of services for trafficked persons:

- “Procedures and guidelines which are the outcome of workshops on (the subjects of) return and repatriation organized by IOM, The UN Inter-Agency Project on Human Trafficking in the Greater Mekong Sub-region (UNIAP), Save the Children UK (SCUK) were adapted by the organization since 2001”;
- “There are some guidelines developed to assess the trafficked persons”.

The agencies/departments interviewed reported that they provide services to women, children and men. Most reported providing additional or special care to trafficked persons when and if needed:

- “Yes, the department provides services to women and children of VOT. There are institutional policies (for them to remain) for two weeks’ training at a shelter. In this programme we took guidelines from the Asia Regional Institutional Anti-Trafficking (ARIAT) (on) Prevention, Protection, Prosecution (the 3Ps) and Rescue, Return and Repatriation, Reintegration (3Rs)”;
- “Provide services to all trafficked persons”;
- “Yes, there are some guidelines in providing services, mainly for trafficked persons”;
- “Special services are given to the victim/survivor”;
- “No; it depends on the situation of the trafficked persons, because there are some trafficked persons that may need medical or psychosocial attention”.

Respondents stated that there is a reasonably clear understanding concerning the roles and responsibilities of the governmental and non-governmental sectors in relation to providing assistance and services for trafficked persons. Government resources are quite limited; thus, NGOs currently fill the gaps when needed. Respondents reported that there is no coordination or monitoring system in place for governmental organizations and NGOs offering recovery and reintegration services for trafficked persons:

- “There is a clear understanding of the roles and responsibilities of governmental and non-governmental (organizations) when (facing an) ad hoc event”;
- “Yes, it is linked to individual and family needs”;
- “Unknown”.

Assessment Methodology

Table 18 Assessment Methodology

Assessment Services				
Agencies	Use of assessment tools	In-depth counselling	Translation available	Is information on the mental/emotional well-being of the victim/survivor also collected in this initial assessment?
1.		✓	✓	
2.	✓	✓	✓	✓
3.	✓	✓	✓	✓ (Staff check the trafficked persons' emotional status by talking to them)

Only one respondent reported the use of a specific assessment method or tool when making the initial basic needs assessment of a victim of trafficking. Respondents further stated that different groups of trafficked persons in some cases have different needs:

- “Yes, there are some family assessments conducted before receiving the victim. World Vision has its own tools for the initial assessment. The facts are number of family members, income level, debts, housing status, education etc.”;
- “Through observation we find that children have different needs from adults”;
- “In general, the immediate needs are monetary matters, regardless of age”.

Translation services are available in most cases for trafficked persons and persons providing assistance:

- “Yes, translation is available to enable communication between trafficked persons and caregivers”;
- “Yes, sometimes”.

Case Management Systems

Table 19 Case Management Systems

Case Management Processes				
Agencies	Is case management information made available if a referral to another agency takes place?	Does the victim/survivor need to provide consent before information can be transferred?	Are there security measures in-place to secure files?	Are trafficked persons themselves counselled on their own case management process, and are translators accessible?
1.			✓	
2.		✓	✓	✓
3.		✓	✓	✓

Only one respondent suggested that a personalized case management process is in place to provide on-going care for trafficked persons. No respondents provided feedback on whether case management information is made available if a referral to another agency takes place. Consent to release case management information is not always requested by all agencies/departments before it is released. Trafficked persons in most instances are counselled or provided with information regarding the case management process:

- “An individual case is documented. Although the programmer has tried to install the program for case management, due to technical failure (we) still could not have proper data installation; rather (we do so) manually”.

Respondents stated that the security of case management files are ensured via the following means:

- “Keep in the departments; (we do) not share with other agencies”;
- “One focal staff (member) maintains all the files for security purposes”.

Standards of Care/Guidelines

Table 20 Standards of Care/Guidelines and Reintegration Process

Standards of Care and Community Involvement in Recovery and Reintegration Processes					
Agencies	Does your organization/department have minimum standards of care in place for trafficked persons?	Do trafficked persons actively take part in outlining the care they would like to receive?	Do persons from the community also assist trafficked persons in the recovery process?	Do you see the potential of community networks in assisting in the trafficked persons' recovery and sustainable reintegration?	Is the confidentiality of the victim/survivor protected?
1.	✓	✓		✓	✓
2.		✓	✓	✓	✓
3.					✓

Only one respondent reported having institutionalized minimum standards of care for trafficked persons. Furthermore, only one respondent suggested that trafficked persons actively take part in outlining the care they would like to receive. Avenues for feedback from trafficked persons on the services they were receiving were also described as very limited:

- "Yes we have these in place. They are department-formulated guidelines";
- "Yes, by sharing their experiences in the training course".

Respondents stated that communities assist trafficked persons in the recovery process in the following ways:

- "Yes, the community assists the victim/survivor in the recovery process. The local authority, community elder and religious leader assist in the recovery process. There is no programme to raise awareness in the community";
- "Yes, some people will not accept VOT because some thought VOT are annoying for the community";
- "It depends on their community context, as in some environments, (people) did not care for the victims while some treated them with empathy".

Respondents stated the following about the potential of community networks being involved and assisting in the recovery and sustainable reintegration of trafficked persons:

- "Yes, the community can assist (in the) recovery and sustainable reintegration (of the) VOT";
- "Can't say for sure".

The following strategies were suggested to protect the confidentiality of the trafficked person:

- “Yes, the community can protect and keep confidential the plight of the victim/survivor”;
- “As per the request of the victim, staff do not disclose their plight to the family or community (e.g. if they had been sold as a sex worker)”.

Mental Health

The following statements were provided by respondents regarding whether they believed there was a difference between “psychosocial support” and “mental health support”:

- “Yes, psychosocial support is psychological cure. Mental health support is mental cure”;
- “Yes, psychosocial support is more likely to (be dealt) with by the community and mental health support is more likely to depend on the individual’s mental health problem”.

Table 21 Mental Health Methodology

Target Populations/Guidelines							
Agencies	Are the trafficked persons that are suffering from mental health problems receiving assistance?	If your organization/ department offers more specialist mental health services, are there any specific guidelines in place for the provision of these services?	Are clinical screening tools used to make an assessment?	If used, do you believe that these types of tools are culturally applicable, reliable or effective in making an accurate diagnosis?	Is counselling available?	Are these programmes tailored to suit the needs of each victim/survivor?	Are there other (less formal) ways a victim/survivor can be assisted in the healing process?
1.	✓ (Yes, they are referred to a hospital)		no		✓		
2.			no		✓	✓	
3.			no		✓		

Specialist mental health care is very limited in Myanmar. Trafficked persons with more severe forms of psychological/emotional trauma are referred to a hospital (details unavailable) for medication. No guidelines are in place for the provision of this care and it is unknown what therapeutic modality is utilized by the hospital. No respondents reported that they used clinical screening instruments. Counselling (flexible and responsive) is however available and training is provided by a qualified and reputable institution:

- “Yes”
 - Counselling is a helping relationship with skilled dialogue;
 - The Psychology Department, University of Yangon, provides the training;
- “Yes, from time to time. Mostly this counselling training is provided by a professional from the Psychology Department. The training is about stress management, how treat those with trauma, the changes of attitude depending on age, etc.”;
- “Counselling is flexible”;
- “Yes, it is sort of flexible”.

The respondents provided the following statements regarding whether their programmes were tailored to suit the needs of each trafficked person:

- “Yes”;
- “Not really; however, something is better than nothing!”

No formal strategies were in place to prevent the re-traumatization of the trafficked person, but there was recognition of the need to have them:

- “The family and community need to provide care to prevent further re-traumatization”;
- “We do not have any strategies”.

No less formal ways in which a trafficked person could be assisted in the recovery/healing processes were brought forward:

- “It is dependent on the victim/survivor’s emotional status and any evident mental health problems.... the doctor will ultimately decide what is best for the victim/survivor”.

Table 22 Follow up and Care for Carers

Follow-up Processes and Care for Carers				
Agencies	Does the nature of the reason for a person to leave their community (domestic abuse vs. desire to travel) influence their reintegration plan?	Does your agency/ department provide follow-up services/ assistance for persons reintegrated into their communities?	Are there care-for-the-carer processes in place to protect staff from burnout?	On a scale of 1 to 5 (5 being highly effective) how would you rate your services in assisting in the recovery and reintegration processes for trafficked persons?
1.	no	✓		3
2.	unknown	✓		2
3.	unknown			

Follow-up services/assistance are provided by some respondents' agencies/departments for persons reintegrated into their communities. One respondent stated that support networks/mechanisms had been established in communities to assist the mental/emotional well-being of returning trafficked persons; however, it is unclear what this entails:

- "Yes";
- "Yes, for the first two weeks staffs revisit the returnee. They are asked (about) types of assistance. Depending on their requirements, the department arranges for them accordingly".

Respondents suggested the following strategies for the purpose of protecting the emotional well-being of their staff and to prevent burnout. They also stated that they would be very receptive to any training that would assist them in dealing with burnout issues.

- "Helping the helpless. Yes, we welcome regular training/capacity-building sessions on psychosocial/emotional well-being";
- Yes, if available we would welcome such training".

When asked if they would like to provide any other information they thought was relevant, the response was:

- "With limited resources, the organization is doing its best to help trafficked persons, but we are still very much aware that there is still a lot needed to be done".

Respondents Reported Issues/Constraints

- Very few services are available for trafficked persons in Myanmar;
- A lack of government resources is clearly evident;
- There are not as yet any formal coordination or monitoring systems in place to gauge the effectiveness of recovery and reintegration assistance;
- Reintegration support is very limited and restricted geographically;
- Once reintegrated, trafficked persons have access to few, if any, follow-up services;
- Very limited numbers of mental health professionals provide services to those with more serious problems; they range from very limited to non-existent;
- Owing to the ethnic diversity that exists within Myanmar, reintegration processes need to be responsive and in touch with the trafficked persons and communities' cultural practices and norms. To date, this has not been happening due to the small number of actors providing recovery and reintegration services and the lack of resources available to governmental organizations;
- Very few alternative reintegration options are available to returning trafficked persons in Myanmar;

- The majority of trafficked persons are returning from Thailand. If they are returned through formal government-to-government channels, then they will have spent a considerable amount of time in a shelter in Thailand. Processes in Myanmar need to be brought into line with case management practices in Thailand to ensure that duplicative assistance is not being provided to trafficked persons and that they are not detained for periods longer than necessary.

Chapter 7

Thailand

Data were collected from five governmental and non-governmental agencies involved in providing services for trafficked and vulnerable persons. Three MOUs on trafficking were signed in March 2003: the first between governmental agencies, the second between governmental agencies and non-governmental agencies and the third between non-governmental agencies only. These MOUs outline clearly the division of responsibilities in the anti-trafficking and psychosocial support sectors. Feedback from respondents suggested that a functioning system is in place to assist trafficked persons, yet there remains some hesitancy on the part of NGOs in handing over complete service provision to governmental agencies. This is probably due to a lack of resources and in some cases the capacity of government agencies to respond adequately to the needs of trafficked persons. NGOs are networking with government agencies and follow the suggested guidelines; nevertheless, they still conduct follow-up on cases and provide their services within government shelters. This is by no means a negative situation but it is suggestive or reflective of a strong cohesive network that is responsive to needs or gaps.

Broad Overview of the Mental Health System

In the past, mental illness in Thailand had been considered to be a result of karma (fate) and taken care of only within the family and by Buddhist temples. Physiological ailments could be tended to and cared for in temples. Then, along with the social progress of the country, the Government started to provide mental health services under the Mental Health Department (MHD). However, temples and monks still play a significant role in providing mental health services.⁴⁴

There are 122 out-patient facilities in the country that provide mental health services; they are located in both mental and general hospitals. Of these facilities, 11 per cent are for children and adolescents only. There are no day treatment facilities in Thailand. The only residential facilities are for mentally retarded people and substance abusers. There are 25 community-based psychiatric units with 0.4 beds per 100,000 people and 17 mental hospitals with 13.8 beds per 100,000 people. The rate of users in community-based in-patient units is 173 per 100,000 people; in mental hospitals, it is 158 per 100,000 people. The majority of patients admitted to mental hospitals had been diagnosed with schizophrenia. Thus, for security reason, all forensic beds are located in one mental hospital. It is estimated that most admissions to mental hospitals and in-patient units are involuntary.

⁴⁴ K. Tangchontip, "Philanthropy groups and organizations in Thailand", in A. Pongsamlee and K. Achavanichkun, eds., *Thai Civil Society Movement: Civic Movement* (Bangkok, Ammarin Printing, 1999), pp. 233-258.

Mental health care has long been integrated into primary health care by the Mental Health Department. However, primary health care doctors have limited training in mental health services. An average of 7.29 personnel works in the field of mental health for every 100,000 people in the population. Few psychiatrists and psychosocial staff work in mental hospitals. In terms of the staff-to-bed ratios, there are 0.01 psychiatrists; 0.15 nurses; 0.02 psychologists, social workers or occupational therapists; and 0.05 other mental health workers per bed in mental hospitals in Thailand. Some professionals work for both in-patient and out-patient facilities.

A disproportionate amount of resources are concentrated in the major cities, which limits the access of rural people to mental health services. There are five user associations and three family associations in the country that interact with a few mental health facilities. Public education and awareness campaigns are overseen by coordinating bodies. Links exist between departments/agencies responsible for mental health and those responsible for primary health care/community health, HIV/AIDS, reproductive health, child/adolescent health, substance abuse, child protection, education, employment, housing, welfare, criminal justice and the elderly.⁴⁵

Psychosocial Support

All respondents reported similar definitions of psychosocial support and these are in line with the definition outlined in internationally agreed guidelines:

- "To build the capacity of the child to survive in society by providing knowledge and life skills to protect them from harm";
- "It is divided into two parts: the social and mental. The social part is related to the community and problems with their environment. Trafficked persons that need mental support or more specialized services are referred to Srithanya Hospital".

⁴⁵ WHO-AIMS, A Report on the Assessment of the Mental Health System in Thailand using the World Health Organization -Assessment Instrument for Mental Health Systems (WHO-AIMS) (Nonthaburi, Thailand, 2006)

Table 23 Psychosocial Support Services

Provision of Basic Services						
Agencies	Basic health needs (such as clean water, adequate nutrition, clean environment) –	Family support/mediation	Secure environment	Housing	Medical assistance	Others
1.		✓	✓	✓	✓	
2.	✓	✓	✓	✓	✓	
3.	✓	✓	✓	✓ Housing for Thai trafficked persons only	✓	
4.	✓				✓	
5.	✓	✓	✓	✓	✓	
Assessment/Recovery/Education Service						
Agencies	Psychological assessment	Counselling	Psychotherapy	Life skills	Education (formal and informal)	Community education
1.	✓	✓		✓	✓	
2.	✓	✓	✓	✓	✓	
3.	✓	✓	✓	✓	✓	
4.	✓	✓		✓	✓	
5.	✓	✓	✓	✓	✓	
Reintegration Service						
Agencies	Reintegration support	Family assessments	Vocational training	Seed grants	Legal aid	Follow-up
1.	✓	✓			✓	✓
2.	✓	✓	✓	✓		✓
3.	✓	✓	✓	✓	✓	✓
4.	✓	✓		✓		
5.	✓	✓	✓	✓	✓	

Psychosocial support in Thailand is quite comprehensive, with multiple agencies providing an array of services for trafficked persons, as outlined in table 23. Trafficked persons receive medical support very shortly after they have been identified and rescued:

- “Within the first three days”;
- “In the first few days. Two nurses and a nurse’s assistant are on call to provide assistance when needed. The social workers conduct an initial assessment and screening and, if necessary, they refer (the trafficked person) to medical staff. Screening includes an HIV test for women/girls who have worked in the sex industry. Social workers will educate the victim and they generally agree to take the test. If the victim is HIV-positive, the nurse and social worker will provide counselling and on-going medical assistance where possible”;
- “Within the first three days. Injuries must be recorded for the evidentiary process. When and if some girls need medical attention, immediately we arrange this”;
- “When they feel the need to see one”.

Trafficked persons in most cases need to spend some time in a shelter, as the majority of trafficked persons identified in Thailand come from surrounding countries and it takes some time to conduct return and reintegration logistics:

- “It really depends on each case. We conduct a staff meeting to assess the case to see what other needs must be met”;
- “We need to give them time so we can work out the best way we can assist them”;
- “Yes, but we will try to follow up with them later if they want”;
- “We work with children, so this is not possible”.

Organizational Orientation

Several respondents provided the following statements which elaborate on their guidelines for the provision of services for trafficked persons:

- “We try to build the capacity of children to survive in society by giving them knowledge and life skills to protect them from harm”;
- “We try to give children a new start. We try to normalize their lives and provide some skills to develop them”;
- “All children are our customers and we must care about their needs. If they are Thai, we assist them reintegrate successfully back into society. If they are foreign, we assist them to get compensation”.

Table 24 Organizational Orientation

Target Populations/Guidelines							
Agencies	Women	Children	Women and children	Men	All	Do trafficked persons receive the same services/ assistance as other persons?	Institutional policies/ guidelines in place
1.			✓			✓	✓
2.		✓				✓	
3.			✓		✓	✓	
4.		✓				✓	
5.			✓			✓	✓

Respondents reported that the services do differ for trafficked persons from outside Thailand because their needs differ, as reflected below:

- “Yes, they are undocumented persons, so we provide specialized services (with regard to legal assistance etc.)”;
- “Differences exist, for instance foreign trafficked persons have different religious practices and need special time to do culturally applicable things”;
- “We provide them with the same services”;
- “Basic services are the same but there are religious, food and cultural needs of persons from outside Thailand. They also need interpreters”;
- “Yes, different services are provided because they are illegal aliens and need legal (help) and immigration assistance”;
- “Trafficked persons generally have the same needs, but this depends on the level of trauma they have gone through. Family tracing and assessments are needed. We coordinate with NGOs in the country of origin to do this”.

All respondents recognized the legal, cultural and special needs of these people. No organizations or agencies reported that they provide trafficked men with any substantial assistance. With the current legislation (which covers trafficked men) having been passed, organizations/departments urgently need to fill this gap. All respondents reported that there are several agreements that outline the roles and responsibilities of the governmental and non-governmental organizations in place; however, in actual practice at the ground level further improvement is needed:

- “There is a clear understanding (of the) roles and responsibilities of government and non-government (organizations concerning) ad hoc events”;
- “Yes, governmental organization (GO) to governmental organization and governmental organization to non-governmental organization etc. In most cases it works when operationalized. GO to GO and GO to NGO works well, as it is drafted according to the law. Bilateral MOUs are also working well”;

- “In our opinion, this is not clear and there is a definite need for improvement. Formal agreements exist via MOUs but, in practice, coordination rarely happens effectively. The Government needs to provide comprehensive services, yet it is overwhelmed. It needs to be proactive and provide more programmes enhancing empowerment and not just provide seed funds”;
- “It sometimes works and on paper it looks good, but there is still a lot that needs to be done to improve the coordination mechanisms”;
- “We try to educate government staff regarding the rescue process. There are frequent problems, particularly when a labour case becomes a trafficking case. Police sometimes just see these as illegal immigrant cases and don’t see the exploitation. The Department of Social Development and Welfare DSDW has a good understanding but lacks resources and the process at the shelter needs refinement as trafficked persons stay there too long waiting for (the) prosecution (of the trafficker to begin). If prosecution takes too long, trafficked persons do not want to cooperate”.

Monitoring and coordination mechanisms also need to be established. Most organizations/departments do not have institutional guidelines but rely on legislation and international agreements and conventions. Respondents felt that more formal mechanisms are needed:

- “Yes, an MOU exists, but in practice no, or very limited, monitoring/coordination takes place”;
- “Yes, the national committee under the social development ministry”;
- “There is a definite need for this to happen but as yet there are no mechanisms in place”;
- “We desperately need this to be established and hopefully in the near future this will happen”.

Table 25 Assessment Methodology

Assessment Services				
Agencies	Use of assessment tools	In-depth counselling	Translation available	Is information on the mental/emotional well-being of the victim/survivor also collected in this initial assessment?
1.		✓	✓	✓
2.	✓	✓	✓	✓
3.	✓	✓	✓	✓
4.		✓	✓	✓
5.			✓	✓

Assessment methodology is well developed in Thailand. A number of checklists and screening instruments are in use. Respondents said that the needs of trafficked persons vary across groups and generally change over time:

- “Varies across groups: women, teenagers, children etc. Also, factors such as forms of exploitation need to be considered, for example how abusive their experience was, the length of time (they were) exploited etc.”;
- “The immediate need is safety! Needs however change over time”;
- “They need information, a safe environment, food and shelter. These needs often change as the individuals become more relaxed and able to discuss their situation”.

Respondents reported that more in-depth screening takes place after the initial assessment. Most reported that the trafficked persons need a period of time to adjust and to build trust so that more accurate information is actually reported by the trafficking victim/survivor. External assistance for more problematic cases is sought from professionals and clinicians from local universities and the psychiatry and psychology departments of hospitals, highlighting the fact that an effective referral mechanism is in place. According to respondents, interpretation is offered; however, interpreters of some languages are hard to find, particularly for trafficked persons from minority groups from the Lao People’s Democratic Republic.

Table 26 Case Management Processes

Case Management Processes				
Agencies	Is case management information made available if a referral to another agency takes place?	Does the victim/survivor need to provide consent before information can be transferred?	Are there security measures in-place to secure files?	Are trafficked persons themselves counselled on their own case management process, and are translators accessible?
1.	✓	✓	✓	✓
2.	✓	✓	✓	✓
3.	✓	✓	✓	✓
4.	✓	✓	✓	✓
5.	✓	✓	✓	✓

All respondents reported having an effective and personalized/individualized and confidential case management system in place:

- “Yes, we hold case conferences between multidisciplinary staff. We initially fact-find, then make an assessment, and then implement an intervention. The process is individualized as much as possible but sometimes this has been difficult due to the large number of trafficked persons”;

- “First, we receive a phone call from police or others saying they have someone that needs help. We receive the person and keep good records of the interviews and everything that has transpired. We plan together with the individuals (concerning the) activities (in which) they may partake. Files are always kept confidential in all instances”.

Some agencies/organizations however indicated that they lacked resources, particularly human resources (staff), which was a potential problem with regard to the provision of more comprehensive services. All respondents stated that they do in fact counsel trafficked persons on the case management system, using proven interpreters when needed:

- “Yes, we always share information with the children. The children always ask!”;
- “We always talk with the person about our case management system”;
- “Yes, translators are available if needed. We often discuss issues with our clients”;
- “Sometimes we try but it is difficult due to the number of trafficked persons that we assist. They can however approach our staff any time to discuss any issue”.

Table 27 Standards of Care and Reintegration Processes

Standards of Care and Community Involvement in Recovery and Reintegration Processes					
Agencies	Does your organization/department have minimum standards of care in place for trafficked persons?	Do trafficked persons actively take part in outlining the care they would like to receive?	Do persons from the community also assist trafficked persons in the recovery process?	Do you see the potential of community networks in assisting in the trafficked persons’ recovery and sustainable reintegration?	Is the confidentiality of the victim/survivor protected?
1.	✓	✓	✓	✓	✓
2.		✓	✓	✓	✓
3.		✓			✓
4.		✓		✓	✓
5.	✓	✓		✓	✓

All respondents reported having limited internal minimum standards-of-care guidelines:

- “Yes, a manual is in place”;
- “We use current legislation, conventions etc.”;
- “We follow the MOU on trafficking which has some guidelines”;
- “Yes, minimum standards of care or a manual would be useful in our work, particularly with staff turnover/rotation etc.”

However, respondents did see the benefits of having guidelines/principles in place. All respondents reported that trafficked persons are able to access the means to provide feedback on the services with which they are provided:

- “Yes, of course”;
- “Yes, we provide information to them and they decide what is best for them”;
- “Yes, they do. They can provide feedback on services via a comment box”;
- “Yes, when we visit the person in Baan Kredtrakarn we are seen as being external or outsiders and the trafficked persons are more relaxed and able to talk freely with us. We then provide this feedback to the shelter staff to assist them in their work”;
- “We discuss issues that are important to them and then provide information”.

Some agencies were found to access outside community-based agencies to assist in their service provision; however, this is limited to more professional bodies:

- “Yes, we have networks in the hospital (psychiatrists and a multidisciplinary team)”;
- “Only via formal volunteers that conduct visits”;
- “It is difficult as there is stigma and some discrimination”.

All respondents agreed that communities should be involved in some way in the return and reintegration process but also recognized that stigma and maintaining confidentiality are problematic:

- “Yes, but with caution as there are confidentiality issues”;
- “Yes, it is most important for reintegration but difficult to make it happen. Some persons in the community are traffickers. Also, people’s attitude towards child labour needs to change, as in many communities people believe it is a good thing if children are sent to work to earn money”.

For those agencies that do access community-based assistance, most of them rated confidentiality as a major constraint and emphasized the need for strong case management principles and practices to be in place:

- “Via good case management principles, discretion and a positive outlook towards assisting those in need”;
- “We keep information confidential”;
- “We can’t involve communities too much because of this problem (confidentiality)”.

Mental Health

All respondents reported similar definitions of psychosocial support; these were aligned with the definitions outlined in internationally agreed guidelines:

- “They are different. Psychosocial (support) concentrates on reintegration, for example building their confidence to generate income etc. Mental health is a specialized service which is needed to help people go back to live happily again”;
- “Yes, there is a difference. Social support is easier to deal with”;
- “Yes, social versus specialised (support)”;
- “There is a real lack of mental health practitioners with experience in providing assistance to trafficked persons”.

Table 28 Mental Health Service Provision

Target Populations/Guidelines							
Agencies	Are the trafficked persons that are suffering from mental health problems receiving assistance?	If your organization/ department offers more specialist mental health services, are there any specific guidelines in place for the provision of these services?	Are clinical screening tools used to make an assessment?	If used, do you believe that these types of tools are culturally applicable, reliable or effective in making an accurate diagnosis?	Is counselling available?	Are these programmes tailored to suit the needs of each victim/ survivor?	Are there other (less formal) ways a victim/ survivor can be assisted in the healing process?
1.	✓		✓		✓	✓	
2.	✓		✓	✓	✓	✓	
3.	✓		✓	✓	✓	✓	
4.	✓			✓	✓	✓	
5.	✓			✓	✓	✓	

All respondents stated that they refer trafficked persons with more serious mental health problems to specialist agencies/professionals. Clinical screening instruments are widely used and are seen as useful tools:

- “Yes, the Minnesota Multiphasic Personality Inventory (MMPI), Rorcharts, Bender neuropsychiatry test, Thematic Appreciation Test (TAT) for family relationship”;
- “Self-esteem tests etc.”;
- “Thammasat University is currently trialling some psychological tests”.

Respondents reported that counselling is provided by staff counsellors and psychologists as well as by visiting external professionals. Most reported that their counselling is flexible in nature and responds to the needs of the trafficked person:

- “Yes, an external counsellor was hired and visits the shelter twice a week”;
- “There are time limits due to the large number (of trafficked persons) but it generally helps the person deal with their concerns and issues”;
- “Yes, we also have a peer group that provides counselling. These persons were previous trafficked persons. It is a really effective measure”;
- “To a degree, but we have limited staff so more individualized services are difficult to put in place”.

With regard to preventing re-traumatization, respondents suggested several strategies; however, this is another potential area that may need further strengthening:

- “Refer and keep them in a safe environment”;
- “Be sensitive to their needs”.

Other means to assist persons were reported to be rarely and infrequently used. All respondents agreed that training in more specialized areas would be beneficial in their work.

Table 29 Follow-up Processes and Care for Carers

Follow-up Processes and Care for Carers				
Agencies	Does the nature of the reason for a person to leave their community (domestic abuse vs. desire to travel) influence their reintegration plan?	Does your agency/ department provide follow-up services/ assistance for persons reintegrated into their communities?	Are there care-for-the-carer processes in place to protect staff from burnout?	On a scale of 1 to 5 (5 being highly effective) how would you rate your services in assisting in the recovery and reintegration processes for trafficked persons?
1.	✓	✓		3
2.	✓			Recovery (4) Reintegration (1)
3.	✓	✓		4
4.	✓			4
5.	✓			4

Respondents stated that their reintegration planning is influenced by the nature of the reasons that led the trafficked person to leave his or her respective community and then be deceived. If the person left as a result of domestic violence, then their plan would differ from that for a person who left and was then trafficked owing to a desire for travelling or seeking better employment:

- “Yes, it is a different situation. The person who has left home because of domestic violence or marital break-up needs family mediation and possibly foster care if they are young”;
- “Yes, a different process is followed. Some persons need special skills to find employment while others need family mediation etc.”;
- “In the case of a (trafficked) child, if the (child) can’t go home, we look for alternatives. We always conduct a family assessment before returning them. If they don’t want to go home, we can send them to receive vocational training if their family agrees”.

Follow-up services after reintegration were found to be shared and often conducted through agencies in existing networks. This is indicative of a well-coordinated system, with agencies that have greater reach and resources being instrumental in the follow-up processes:

- “Yes, but not in every case”;
- “In the past we did everything, but now we work through our partners in the communities”;
- “No”;
- “Some communities have support groups, but this is quite rare”;
- “The provincial MOU is good, as there are anti-trafficking teams that can assist in reintegration”.

Respondents stated that very few, if any, strategies are in place to care for carers besides staff meetings and some infrequent retreats. Most would welcome more formal guidelines or institutionalized strategies aimed at preventing burnout:

- “We have staff meetings, debriefing sessions and a retreat every six months. We would welcome any training available”;
- “No measures are in place, except talking to other staff members about issues. We don’t really have a budget for training, but would welcome the chance to attend (such courses)”;
- “Through team consultations and a peer advisory group”.

Summary and Conclusions

Service provision for trafficked persons is generally of a high standard in Thailand. Respondents reported that case management best practice principles are followed and trafficked persons have access to a variety of services that assist them to reintegrate domestically and across borders. However, there is a real lack of minimum standards of care that outline and guide how case management best practices should be conducted well. Without such written documents, problems such as staff turnover may have an adverse impact on the quality of service provision. All respondents stated that their case management systems were individualized and consultative, with the trafficked persons having a key role to play in deciding on their recovery-and-reintegration package. The current lack of staff/resources however makes it extremely difficult for service providers to institute this fundamental right. Some organizations are establishing peer support groups in communities made up of trafficked persons. This is really a positive step, as in the past there had been little on-going support once reintegration took place. All respondents reflected on the difficulty of having community involvement in the recovery and reintegration processes due to the still-evident stigma associated with sex work and trafficking. More community education about this subject would be beneficial. Reportedly traditional healers are not used formally; however, highly regarded persons such as monks may provide on-going informal counselling once the person has been reintegrated. With regard to more specialized mental health services, it is evident that a strong referral system is operating; external specialist agencies are regularly consulted in more difficult cases. Service providers may benefit from more training in how to identify individuals in distress, whether they are clients or staff.

Respondent-Reported Issues/Constraints

- A lack of resources for governmental and non-governmental organizations, a situation which prevents the provision of more individualized care;
- More coordination is needed among agencies and networks; however, the mechanisms that are in place need to be further strengthened;
- The Government should take more responsibility in providing services for trafficked persons;
- Funding remains a perennial problem for both governmental and non-governmental organizations;
- Identification of trafficked persons by the police needs strengthening, particularly with regard to labour cases.

Chapter 8

Viet Nam

Several agencies were interviewed in Hanoi, predominantly a mix of non-governmental and quasi-governmental agencies, as well as an international organization that at some level provides trafficked persons with support services. Unfortunately, no governmental agencies were able or willing to provide feedback on their services for trafficked persons. Gaps may therefore be evident in this section of the report.

In general, actors and counter-trafficking service providers are paying increased attention to the psychosocial needs of trafficked persons. The issue of internal trafficking and trafficking in males has been raised in some official discussions and is attracting more attention from researchers and agencies responsible for trafficked persons.

IOM Viet Nam has recently been focusing on the issue of labour trafficking. Although no hard data are available to show that this form of trafficking is on rise, many believe that the negative side of exporting labour should be redressed. In many instances such persons are actually being trafficked. According to one respondent, four groups of people require attention in Viet Nam: (1) migrant workers in abusive situations; (2) trafficked women and children with limited access to services and confined to their workspace; (3) regulated brides in servile marriages; and (4) trafficked women and children doing sex work but refusing intervention.

The governmental organization for combating trafficking in persons remained unchanged in the previous year. On 27 September 2007, Inter-Ministerial Circular 116/2007/TTLT-BTC-BLDTBXH (involving the Ministry of Labour, War Invalids and Social Affairs and the Ministry of Finance) was issued to give "guidance on rates for verification, reception and reintegration support to trafficked women and children who returned from abroad" in relation to implementation of Decision No. 17 of the Prime Minister, which laid out the policy and mechanism for the reception and reintegration of trafficked persons. Another interministerial circular on procedures for verification, identification and reception of trafficked persons returning from abroad has been finalized and is pending adoption. The Ministry of Justice, in cooperation with the Committee for Social Affairs of the National Assembly, has initiated a process for the development of an anti-trafficking law, along with the process of lobbying for the ratification of the Convention against Transnational Organized Crime (TOC) and participation in the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children. In general, laws and procedures related to trafficking are strictly implemented and observed, especially in the areas of investigation and prosecution. However, in some other areas, such as coordination in the rescue of trafficked persons living abroad or their reception from abroad, there could be some delays in implementation or reaction due to bureaucratic obstructions or lack of cooperation among agencies. Examples of these are migrant workers who were not trafficked but were abused and exploited in their work situations. There are trafficked women and children who are locked up and have no access to any services. There are brides who enter a marriage legally but end up in servile marriages. There are trafficked women and children in prostitution and there are brides who refuse to be "rescued". Trafficking in terms of the type of forced labour currently has not been thoroughly analysed or given adequate attention. In terms of legal support for trafficked persons, there is no specific law on anti-trafficking yet.

The criminal law is being used to punish traffickers, but it excludes the acts of selling and buying. The highest level of punishment for this type of crime is imprisonment for 20 years. If the crime committed involves minors or the sexual exploitation of children, then the highest level of punishment is life imprisonment. Different levels of punishment are applied to rape cases. The lowest level is from 2 to 7 years in prison; the highest level, the application of the death penalty if the crime is considered to be a severe case. Viet Nam's domestic violence legislation was approved in November 2007 and the law on domestic violence was scheduled to be passed in July 2008. Cases of rape and sexual violence were to be included in the new law; however, the general opinion is that the current legislation is not strict enough to punish traffickers and that it does not cover all forms of trafficking, particularly the more sophisticated types.

With regard to legal redress: there are no civil remedies, only the above-mentioned criminal sentences. This makes the prosecution of traffickers very complicated. The cases can fail if the criminal prosecution procedures cannot be fully met. Some criminal rings which were responsible for trafficking a large number of persons were broken and prosecuted in court in the previous year. Special powers and direction are given to pursuing cases of organized crime. Witness protection is also a high priority for the law enforcement agency. However, there is a lack of information on this issue, as well as agreement on its extent. A few cases of child sex abuse by foreigners were publicized in newspapers. Although there is no specific law on child sexual abuse, the Law on the Protection, Care and Education of Children is often used to prosecute such offenders. Some of the articles in the country's criminal code also cover sexual abuse.

IOM Viet Nam has been working in close cooperation with the relevant governmental agencies responsible for the protection of trafficked persons. It provides governmental partners with technical and financial support through different projects, training programmes and workshops. In some projects, trafficked persons are also provided with direct assistance. In all cases where trafficked persons are being returned from abroad and assisted in reintegration, their relevant information is shared with the agencies/authorities responsible for their care. The information then can be used by the police or prosecutors for investigation/prosecution purposes. However, the main purpose is to help the trafficked person to more effectively reintegrate into his or her community.

In 2007, IOM also actively worked with NGOs and United Nations agencies in setting up a reintegration network in the country. In working together, they have set up linkages and referral systems to assist trafficked persons and provide services. However, there is a need to build more capacity in assisting the different needs of women and children in the reintegration process, and more attention needs to be paid to reintegration follow-up.

The Government actively assists trafficked persons to return home, for example it performs the screening of trafficked persons for the purpose of returning them to determine if they are actually Vietnamese citizens and to assess whether assistance from their family or community is available for their eventual reintegration. In cases where Viet Nam is a transit or destination country, the Government liaises with the sending country for the safe return of trafficked persons. To date, very few trafficking cases have been identified in Viet Nam. Many trafficked women are forced to return to Viet Nam without their children, as they had been born in the destination country. Once these women have returned, they are unable to contact their children and no support is provided by the Government in order to have the women's children returned to them.

To date, there are no specific methods for the protection of trafficked persons. If trafficked persons are involved in a court case, other general protection methods are applied. At the national level, the Government assists trafficked persons through social aid centres and the facilities of the Ministry of Labour, War Invalids and Social Affairs in the country. Stigma and discrimination are however major obstacles for successfully protecting and reintegrating trafficked persons in the community; these factors compel many to hide from the authorities and their friends and family the truth about the exploitation they had experienced.

Resettlement of trafficked persons in a third country with the assistance of the Government has not yet happened. Currently the Department of Labour, War Invalids and Social Affairs at the provincial and city levels is in charge of victim reintegration. With the new decree and programme in force, trafficked persons are entitled to legal, medical and financial assistance. However, the level of assistance is still very limited in terms of services, finances and availability. The Government provides rescued trafficked persons whose security is at risk with housing, but only temporarily. The Government is establishing initial support and assessment shelters to provide services for trafficked persons. So far, two shelters of this kind are being constructed or renovated with some support from IOM. A few shelters run by NGOs provide services for trafficked persons, regardless of the nature of the exploitation they had endured.

Some financial support has been given to the Viet Nam Women's Union to implement activities aimed at raising public awareness about the dangers of trafficking; however, the assistance is very limited. The Women's Union usually integrates its prevention activities with other existing programmes it conducts, such as poverty reduction, family and culture, in order to maximize the effectiveness of its programmes. As a result, the effectiveness of these education programmes may be significantly diluted with regard to the prevention of trafficking.

Potential trafficked persons are the main target of the Women's Union's awareness campaigns, although the general public also comprise a target audience. Campaigns are designed to inform the public about the dangers of trafficking, the patterns they need to be aware of, and the tricks and methods that traffickers use so that people will be able to protect themselves from being trafficked. As cross-border trafficking is the main target – internal trafficking is still not seen as a serious issue -- information campaigns have not yet been designed to address the demand side of trafficking. The latest national plan of action includes mainly poverty-reduction measures (income generation and job creation) as poverty is seen as the main reason for trafficking. Other factors have also been mentioned in the prevention plan but are not really being implemented.

Little attention is paid by the Government to health awareness and prevention programmes related to the demand side of trafficking, for example awareness campaigns about commercial sex tourism, the demand for trafficking, the health risks associated with commercial sex, condom use and safe sex. However, some lobbying has been undertaken in recent times to address this potential problem.

A few activities related to commercial sex tourism/child sex abuse are being implemented, but these are mainly aimed at foreign tourists visiting Viet Nam. In general, the government officers who work to combat human trafficking are inadequately sensitized and aware of the issues related to trafficking. For example, they often fail to consider any problems the trafficked persons may have in being reintegrated back into their family. In some cases, a trafficked person may have

left the country owing to a domestic problem or other abusive situation. Another problem is that government officers often fail to share information or contact other organizations that may be able to provide immediate or on-going assistance for trafficked persons. For example, the organization Acting for Women in Distressing Circumstances (AFESIP) Vietnam opened a rehabilitation centre in Ho Chi Minh City in 2001. Since then, it has been able to integrate the establishment of a garment factory for former residents as part of the AFESIP Fair Fashion extension also based in Ho Chi Minh City.

AFESIP Vietnam has established an on-going local partnership with the National Women's Union of Viet Nam, various ministries and organizations. Of its staff members, 12 are located in Ho Chi Minh City: the National Coordinator, Social Coordinator, a team of social workers, an administrative coordinator and a communications and project officer. A representative also works to sensitize policymakers in Hanoi. The main objectives of AFESIP Vietnam are as follows:

- To visit persons involved in prostitution in the different red-light districts of Ho Chi Minh City in order to disseminate information about safe sex;
- To distribute condoms and sexual hygiene products;
- To gather information and promote alternative income-generating activities;
- To provide rehabilitative care in Ho Chi Minh City through a holistic structure;
- To facilitate the repatriation of Vietnamese trafficked persons from Cambodia, Thailand or any other location;
- To reintegrate the residents into society and follow each case for three years;
- To cooperate and train collaborative partners through outreach.

Respondents' Reported Issues/Constraints

- A lack of government resources to assist trafficked persons;
- Front-line government officials need further sensitization on trafficking, such as that related to identification and the varying needs of trafficked persons;
- Stigma and discrimination against trafficked persons is still strongly entrenched and this problem needs to be addressed;
- Very few competent NGOs are assisting trafficked persons in Viet Nam;
- Very few specialist services are available to trafficked persons with moderate to severe psychological problems.

Chapter 9

Overall Summary, Conclusions and Recommendations

Psychosocial Support

The research study revealed that some quite positive actions are taking place in the Greater Mekong Subregion and beyond to assist trafficked persons in their return, recovery and reintegration into their own societies. However, it is apparent that there are significant variations in the level of support provided and the technical capacity of those providing support across each of the economies comprising GMS. Economies such as China and to a lesser degree Viet Nam and Myanmar have less developed return, recovery and reintegration processes, but some positive steps forward seem to have been taken as these issues are highlighted for attention in the national plans of action. In Thailand, which is predominantly a destination country, the services available to trafficked persons are quite extensive, as they are in Cambodia. The Lao People's Democratic Republic has also made large inroads in this regard, with a functioning multidisciplinary network within five provinces and a multisectoral case management team that regularly meets to discuss cases.

Non-governmental and governmental organizations function well together and there is a growing referral mechanism in place in Thailand and Cambodia, but in the Lao People's Democratic Republic referral between agencies is limited. In most instances, interviewees described the use of best practice principles for the case management of trafficking cases. Very few internal guidelines or standard operating procedures are available, although a number of organizations did report that they were developing these for future institutionalization.

All the respondents in this research study clearly defined and interpreted "psychosocial" and "mental health". Most followed a similar interpretation as outlined in the Inter-Agency Standing Committee (IASC) guidelines on psychosocial and mental health, which define "psychosocial" care as involving a continuum of support and "mental health" care as providing specialized services when basic services and care are insufficient for normalizing a person who suffered a traumatic experience. IASC issued these guidelines to enable humanitarian actors to plan, establish and coordinate a set of minimum multisectoral responses aimed at protecting and improving people's mental health and psychosocial well-being in the midst of an emergency. The focus of the IASC guidelines is on implementing minimum responses, which are essential, high-priority responses that should be implemented as soon as possible in an emergency situation. Minimum responses are the first things that ought to be carried out; they are the essential first steps that lay the foundation for the more comprehensive efforts that may be needed later. However, even though these guidelines were originally developed for emergency situations, they are applicable to, and form a good basis for, the development of guidelines on psychosocial and mental health which are contextualized to suit in-country situations for anti-trafficking and support agencies and departments. As previously indicated, this research study found that there is a general lack of international best-practice guidelines in place across the GMS economies for the psychosocial and mental health support of trafficked persons.

Mental Health

With regard to mental health, there are a number of institutions and organizations that provide more in-depth treatment for those traumatized to a level beyond the capacity of the service provider to heal. The formal and informal referral networks in each country seem to be working effectively, although many countries suffer from a lack of trained psychologists and psychiatrists, which is problematic as those in need may not be receiving the skilled care they require. The majority of respondents stated that traditional healers were not always used or accessed, although this may not ultimately be the case. Once the trafficked persons have been reintegrated, they may in fact utilize these more traditional methods to deal with any on-going issues. Some possible strengths of traditional healers include the following:

- The cultural characteristics of some traditional therapies have been found to include some of the same “active ingredients” that account for the success of psychotherapy. Positive results in interpersonal, intrapsychic and physiologic terms have been demonstrated;
- Traditional healers usually treat patients while they are residing with family or are receiving the support of their families. They provide culturally understandable answers and healing techniques. However, there is an obvious risk with some so-called traditional healers who do in fact provide advice or treatment that is counterproductive to the healing process.

Key informants responded that the incidence of serious physical and psychological trauma experienced in GMS is quite low, but it does happen. Unlike in many European countries, the trafficking situation in GMS is predominantly opportunistic and facilitated by persons related or well known to the victim. In European countries and other parts of the world, crime syndicates operate in very sophisticated ways to ply their trade and thereby use more complicated measures to intimidate, subdue and control trafficked persons. These cruel and inhumane techniques are less common in the majority of cases in GMS. Physical and psychological trauma is however reported in varying degrees. Trafficked persons, as previously mentioned, have problems in re-establishing trust, because in many cases friends and family had facilitated or been directly involved in the trafficking situation. The ways individuals cope with violence and trauma are always varied. In GMS, Buddhism plays a major role in how people evaluate or predict their fate. Trafficked persons often put the trafficking experience down to bad luck and frequently believe their fate will be better the next time. A degree of “acceptance” of their fate and an ability to move on rather than dwell on the past are often the case.

Labour migration should always be seen as a viable reintegration option if trafficked persons are provided with safe options and information that would reduce their susceptibility to be deceived. Western societies generally have a very individualistic approach to dealing with traumatic experiences; people often choose either to deal with things alone or to seek support from outside specialist sources. In many Asian cultures a “collectivist” approach to life is followed and family networks are seen as the first support network to be utilized when a trauma has been experienced. Both approaches can have positive and negative effects in respect of how trafficked persons cope with their emotional pain and how they progress through the healing process. An individualistic approach can leave people isolated without friends or family to assist. A collectivist approach may facilitate healing, provided trafficked persons are able to disclose their experiences and if their immediate support network is understanding and does not maintain predetermined negative aspersions towards the trafficked persons or the subsequent physical or psychological problems they may be experiencing.

Trafficking is a complex phenomenon with many dimensions. The trafficked person's personal background, repeated experiences of violence and abuse, socio-economic constraints and the behaviour modifications made in order to adjust to the trauma of being forced to work in poor, abusive situations, all must be considered in order to gain a psychological perspective of that person. The recovery and reintegration of trafficked persons also requires a coordinated approach by all the actors involved at different levels. The different stages of assistance that the trafficked person is provided call for different priorities. Both the physical and the psychological needs of the victim need to be addressed throughout the process, which moves from the initial crisis intervention to long-term support services. One recent study⁴⁶ stated that the human rights of trafficked persons must be respected; all interventions must be measured on the scale of their ability to protect and ensure the following rights of trafficked persons:

- Dignity
- Not to be re-traumatized
- Confidentiality
- Judicial redress
- Access to trained care and protection, and to professionals who can facilitate their healing
- Self-determination and participation
- Choices
- Information
- Education, shelter, health and a vocation

Psychosocial assistance covers the immediate needs of the trafficked person, such as safe shelter, and their means of existence as well as long-term assistance programmes aimed at helping the participants to achieve reintegration and inclusion. Such programmes may be implemented in the country of origin or destination, or any other country where the trafficked person might settle. Governments therefore should create adequate structures for providing social assistance and protection. These may include, among others, safe accommodation, health care, legal assistance, vocational training and education. Some essential standards should be observed in terms of social assistance; for instance all services must respect the right to privacy of the trafficked person and observe the principles of confidentiality and freedom of movement. Assistance programmes must be tailored to the individual and start with an in-depth needs assessment of the trafficked person. The assistance offered must be oriented towards the individual needs and wishes of the trafficked person. The assistance programme should be designed in such a way that it will enable the trafficked person to make well-informed, pressure-free, autonomous decisions about his or her own life, now and in the future. The assistance services provided must offer a real and viable opportunity for trafficked persons to escape trafficking, violence and exploitation. They should take into view overall the full social integration and labour inclusion of the trafficked person.⁴⁷

⁴⁶ SAARTHAK, *Outgrowing the Pain: Individual Psychological Intervention for Survivors of Trafficking* (UNIFEM and USAID, New Delhi, 2006)

⁴⁷ IOM Kosovo. *A General Review of the Psychological Support and Services Provided to Victims of Trafficking*, September 2003. <http://www.reliefweb.int/library/documents/2003/iom-kos-19sep.pdf>

In August 2007, IOM facilitated a psychosocial and mental health workshop in Bangkok as a means to bring together service providers from GMS to establish some common principles for psychosocial and mental health service provision across the Subregion (see annex II). This was an important step in standardizing procedures and standards of care across economies in GMS, as trafficking generally involves and requires cross-border cooperation for the recovery, return and reintegration of trafficked persons.

The following shortcomings are evident in this study:

1. The results are based on direct feedback from organizations providing various forms of psychosocial assistance/care and mental well-being/health services for trafficked persons. Feedback from beneficiaries is also needed to compliment the information provided.
2. Psychosocial and mental well-being/health service provision in economies such as China and Viet Nam is in its relative infancy, so there is essentially very little to report. Positive steps forward are however being made in these economies, which are reflected in the relevant national plans of action. Non-governmental organizations, such as AFESIP and Save the Children/United Kingdom, are doing some very good work in China and Viet Nam to assist trafficked persons and in building the capacity of counterpart agencies.
3. Most organizations/agencies interviewed stated that their service provision is voluntary and that the trafficked person is able to make direct inputs to the planning process. However, some other organizations disagree that this is the case. It is very difficult to measure the degree of input from the trafficked persons without actual feedback from those beneficiaries. However, this report was not intended to rate each organization's adherence to international best practice principles, but instead focus on constructive ways that service provision and case management practices could be improved.

Key recommendations*

1. The profiles of the trafficked person developed by the sending countries form an excellent foundation on which the receiving countries can build and provide a good example of the positive effects of increased collaboration. While maintaining respect for each person's anonymity and individuality, the entire framework of assistance would be rendered ineffective if sufficient follow-up work is not ensured in the trafficked person's home country. Once that person has been repatriated, care should be focused on the broader reintegration needs of the trafficked person, with assistance plans tailored to meet his or her individual circumstances. It is critical that sending and receiving countries increase their levels of cooperation and information exchange in order to meet the specific needs of trafficked persons. Some problems are still evident with regard to the transfer of information and the usability of the information being transferred between countries of destination and origin. Further strengthening is required in this area.

* Implementation of some recommendations is dependent on current legislation, resources and technical capacity, among other factors.

2. Recovery and rehabilitation programmes need to have a more comprehensive understanding of the reality of a trafficked person's life. If focus remains on only part of the reality, i.e. the trafficking situation, then it forces the trafficked person to reconstruct the trauma and not outgrow it. Forcing persons to conform to the rules of a recovery and rehabilitation programme may also give the institutions/organizations cultural precedence over the individual needs of the trafficked person.
3. It is crucial that trafficked persons be consulted when developing any return and reintegration programme or project. Currently there are very few, if any, projects or services that are evidence-based. More research needs to be undertaken to further explore the real needs of trafficked persons. The only way to do this is through direct consultation with the beneficiaries.
4. A significant gap across countries is the lack of a multisectoral, interagency framework that would enable effective coordination, identify useful practices, flag potentially harmful practices and clarify how different approaches to mental health and psychosocial support complement one another.
5. Any provision of services needs to recognize that trafficked persons have experienced a situation in which they had totally lost control over their lives and in many cases they endured psychological disempowerment as a means of control at the hands of the trafficker. Therefore, it is crucial that trafficked persons regain some semblance of control and ownership, or at the very least, be an active participant in the planning of the recovery and reintegration process. Being able to do this is in itself therapeutic and a means for rebuilding lost self-esteem and self-confidence.
6. Any provision of services needs to recognize that people react differently to adverse experiences. Likewise, people respond and recover at different rates. Focus should therefore be on the individual person because all people have the ability to think, feel and act differently.
7. It is important that programmes recognize, at some stage in the recovery and reintegration processes, that persons who had been trafficked must be allowed to regain their own self-identity and not be labelled as either victims or survivors. Being labelled can be unintentionally negative and disempowering and a constant reminder of what people have experienced or endured. The trafficking situation or related trauma is an important part of their reality; it is however not their complete reality. Persons that have been trafficked need access to strength-based programmes that are individualized and receptive to their personal and social needs.
8. The crime of trafficking recognizes no borders; many cases of trafficking involve several countries. In the best interest of the trafficked person, it is extremely important that psychosocial services and case management practices be relatively consistent in each country and across borders. Current systems and service provision vary greatly among the GMS economies. Many bilateral MOUs have been signed, but unless there are complimentary guiding principles on return and reintegration that compliment these agreements and are enforced or institutionalized, they will in fact remain pieces of paper rather than powerful instruments to further improve and standardize the return, recovery and reintegration systems.

9. More research needs to be undertaken to determine the feasibility of more community-based recovery and rehabilitation options. An accepting and sympathetic community would greatly improve the effectiveness and speed of a trafficked person's recovery and reintegration. In most cultures in GMS, the family and community are integral to a person's well-being and connectedness. Being ostracized or separated from such communities can exasperate existing problems for a trafficked person and cause further anxiety or depression. Re-trafficking, stigma and confidentiality remain significant constraints to community-based options but these factors still warrant more attention. Caution and selectivity would be crucial as, in most cases in GMS, family or community members are responsible or complicit in the trafficking of their own.
10. As outlined in the results, in several countries very few agencies/organizations provide psychosocial and mental health support for trafficked persons. Although this can be seen in a negative light, it could also be an opportunity and a catalyst for the creation of a programme that would assist in the integration of psychosocial and mental health into other social systems, such as community-based organizations and/or public and primary health care systems. Health care professionals play an important role in the identification of a trafficking case, as individuals may present certain physical and psychological symptoms that are characteristic of a trafficked person. The information they collect is an important part of any prosecution case. Broader protection frameworks are needed to ensure that assistance mechanisms exist at the national, provincial, district and community levels.
11. There is very good justification to propose the development of a psychosocial training package that incorporates cognitive behavioural therapy and counselling techniques and case management practices that are based on best practice principles but tailored to the cultural diversity of each country. A major consideration that would be incorporated into such a package would be the utilization of traditional support networks that enhance both short- and long-term recovery and sustainability. Another focus of such a programme/project would be to assist in building technical networks that facilitate knowledge and skill transfer among organizations and agencies. Furthermore, the construction of standardized instruments, such as psychological screening tools and case management checklists, would also benefit organizations in GMS. To be effective, all the instruments so developed would need to be as culturally sensitive as possible, be contextualized, practical and relatively simple in nature. It is also very important to recognize the limitations evident in each economy and to provide practical assistance that compliments and builds on existing structures/frameworks and avoids overburdening and setting systems up for failure. To accomplish the above, the facilitating organization would need to possess technical expertise, resources and regional reach. Importantly, to guarantee effective implementation and cooperation, the organization would need to have a sound reputation and the trust of Governments and non-governmental agencies in GMS.

Annex I:

Baseline Questionnaire

General

1. What do you consider to be “psychosocial support” and how do you (your organization/department) provide such support, if at all?

Type of Assistance Provided

2. Please indicate what assistance your organization/department provides to victims of trafficking? (please tick)
 - Basic health needs (such as clean water, adequate nutrition, clean environment, etc.)
 - Family support/mediation
 - Secure environment
 - Education (formal and informal)
 - Housing
 - Medical assistance (access to health services, if needed)
 - Psychological assessment
 - Counselling
 - Life-skills education
 - Psychotherapy
 - Community education
 - Traditional healing
 - Reintegration support
 - Vocational skills
 - Family assessments and family tracing
 - Follow-up visits (including further counselling sessions and check-ups by a mental health professional or doctor/nurse; family members allowed)
 - Seed grants
 - Legal aid
 - Others (please indicate)
3. At what point in time do you bring the trafficked person to a nurse/doctor/clinic?
4. If a person is identified as having been trafficked but has not been harmed and wishes to return home immediately, what do you do?

Organizational Orientation

5. What guides you with regard to your service provision for trafficked persons?
6. Does your organization/department provide services to all trafficked persons or specific groups such as women and children? Are there any special institutional policies/guidelines in place? If so please elaborate/provide.
 - Do trafficked persons receive the same services/assistance as other persons?
 - Does the assistance offered to trafficked persons from destination countries and countries of origin vary? If so, in what way?
7. In your opinion, is there a clear understanding as to the roles and responsibilities of the governmental and non-governmental sectors in relation to providing assistance and services to trafficked persons? Does a formal agreement exist (such as an MOU) or is this an ad hoc arrangement?
 - Has any national or local system of coordination and monitoring been established for governmental organizations and NGOs offering recovery and reintegration services to trafficked persons? Is this linked to individual and/or family needs?

Assessment Methodology

8. Do you use a specific assessment method or tool when making the initial basic needs assessment of a victim of trafficking? Please describe/provide the initial assessment process/tool/checklist, etc., if available.
 - In general, what are the immediate needs of trafficked persons or does this vary (keeping in mind that children have different needs from adults)? Do agencies really make a distinction in most situations?
 - Does more in-depth (psychological) screening take place at a later stage?
 - Is translation available for trafficked persons and persons providing assistance?
 - Is information on the mental/emotional well-being of the trafficked person also collected in this initial assessment? If so, how is this done?

Case Management

9. How do you process your cases? Is a personalized case management process put in place to provide on-going care for trafficked persons? Please describe this process. How is this monitored? If you have a form, please provide this.
 - Is case management information made available if a referral to another agency takes place?
 - Does the trafficked person need to provide consent before information can be transferred?
 - How is the security of these files ensured?
 - Are trafficked persons themselves counselled on their own case management process, and are translators accessible?

Standards of Care/Guidelines

10. Does your organization/department have minimum standards of care in place for trafficked persons? If so, please provide a copy of these.
 - How were these guidelines formulated?
 - If minimum standards guidelines are not in place, do you think they would be helpful to you in your work and beneficial to trafficked persons? What do you currently use to guide your work?
11. Do trafficked persons actively take part in outlining the care they would like to receive? If so, how?
 - Is the assistance offered oriented to the individual needs and wishes of the trafficked person?
 - Are there avenues for trafficked persons to provide feedback on the services offered?
12. Do persons from the community also assist trafficked persons in the recovery process? If so, please describe how. What community resources are available?
 - What are the difficulties that you experience in forming linkages with the community, if any?
 - Do you see the potential for community networks in assisting in the recovery and sustainable reintegration of trafficked persons?
 - How is the confidentiality of the trafficked person protected?

Mental Health

13. Do you think there is a difference between “psychosocial support” and “mental health support”? If so, why?
14. Are the trafficked persons suffering from mental health problems receiving assistance?
15. If your organization/department offers more specialized mental health services, are there any specific guidelines in place for the provision of these services? Please provide a copy if available.
 - Are clinical screening tools used to make an assessment?
 - If used, do you believe that these types of tools are culturally applicable, reliable or effective in making an accurate diagnosis?
 - Is counselling available (provide definition of counselling)? If so, who provides this and what training have they had?
 - Is the counselling service term fixed or flexible (dependent upon the emotional state of the trafficked person)? Is the service effective in improving the emotional well-being of trafficked persons?
 - Are these programmes tailored to suit the needs of each trafficked person?
 - What strategies are in place to prevent the re-traumatization of the trafficked person?

- Are there other (less formal) ways a trafficked person can be assisted in the healing process if they have emotional problems? If so, please describe these and the way they are used. In your opinion, are they effective in helping the trafficked person in both the short and long term?

16. If a trafficked person is brought to your organization/department with on-going mental/emotional problems due to domestic violence or a marital break-up etc., which initially forced the person out of the family home and led to the trafficking situation, does this person's recovery and reintegration plan differ from the plan for a person who also experienced some mental/emotional anguish (as a result of having been trafficked) but who ended up in a trafficking situation due to their desire to find more suitable employment?

Does your agency/department provide follow-up services/assistance for persons reintegrated into their communities? If so, please provide information.

- Are any support networks/mechanisms established in communities to assist the mental/emotional well-being of returning trafficked persons?
17. How is the emotional well-being of your staff looked after (i.e. care for the caregivers or stress management)? Would you welcome regular training/capacity-building sessions on psychosocial/emotional well-being?
18. On a scale of 1 to 5 (5 being highly effective) how would you rate your services in assisting the recovery and reintegration process for trafficked persons?

Would you like to provide any other information that you think is relevant?

Annex II:

Report of the Workshop on Mental Health and Psychosocial Assistance for Victims of Trafficking in the Greater Mekong Subregion

Issues of trafficking in the Greater Mekong Subregion are known to have far-reaching effects on both the trafficked individual and the greater society. With this in mind, IOM convened a regional psychosocial and mental health workshop in Bangkok from 15 to 17 August 2007. The specific aims of this workshop were to bring together governmental and non-governmental practitioners from the Subregion to discuss psychosocial/mental health concepts, to exchange experiences and information on good practice in GMS on the provision of psychosocial and mental health care for trafficked persons and to draft some important fundamental and practical principles that are applicable to GMS in order to ensure that trafficked persons receive the best care possible.

Participants also noted that as part of the recovery process, persons that have overcome a trafficking situation want to move on with their lives and regain their unique identities within the community as soon as possible. Therefore, the participants strongly noted that trafficked persons should be regarded as "individuals" and should not be directly labelled by support agencies as "victims", "survivors", or the like.

The gravity and severity of the crime of trafficking in persons and its effect on individuals and society call for sustained, committed and coordinated efforts among Governments and relevant non-governmental stakeholders to bring to justice the perpetrators and to provide appropriate protection and recovery services for trafficked persons. The participants felt that it was essential that such efforts encompass and promote the basic principles of human rights for all concerned in accordance with international conventions and covenants.

In responding to the challenge, Governments should take the lead in enacting measures aimed at promoting a "rights-based" approach to the provision of services for trafficked persons and all concerned with the pursuit of justice in the legal process.

The establishment of a comprehensive "protection framework" for trafficked persons should be prioritized through efforts to build cooperation, reduce inequality and increase access to good-quality services among countries of origin, transit and destination. Equality under the law and the right to citizenship should be considered fundamental to this objective. Governments also have a shared responsibility in providing recovery assistance for trafficked persons and in addressing the psychosocial and mental health care needs of those in need of support.

The workshop participants agreed to suggest the following guiding principles and values relating to the provision of psychosocial and mental health care services. These principles and values serve to inform and guide the efforts to establish comprehensive protection frameworks for the recovery and social integration of trafficked persons. The participants also agreed to participate as members of an "ad hoc technical working group on psychosocial and mental health care for victims/survivors of human trafficking", which would be facilitated by IOM.

Principles and Values for the Provision of Psychosocial and Mental Health Care Assistance to Victims of Trafficking

1. All services offered to trafficked persons should be rights-based and holistic in approach, including physical, mental, social and spiritual aspects. The key considerations are as follows:
 - Services should be voluntary, take into account the best interests of the individual, and be responsive to the individual's expressed needs;
 - Equal opportunities and access should be ensured for all trafficked persons regardless of gender, age, ethnicity, disability, language and religion;
 - Responses should be rights-based according to international conventions, including the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).
2. All trafficked persons have the right to receive comprehensive; high-quality-, age-, gender-, language- and culturally-appropriate services provided by adequately trained psychosocial and mental health service providers and/or para-professionals and professionals.
3. Governments should enact measures and referral mechanisms to provide for comprehensive, professional, high-quality services for trafficked persons in partnership with non-governmental service providers.
4. Regionally accepted minimum standards of quality care, including psychosocial and mental health services, should be established for all trafficked persons/survivors.
5. Services should be participatory, collaborative and consultative processes, with the aim being to restore dignity and decision-making power to the trafficked person.
6. Regional ethical standards and practices should be established and adopted at the country level (in particular, relative to issues such as confidentiality, informed consent, research and training)
7. Governments and key stakeholders should take increasing responsibility for ensuring that psychosocial and mental health care services are mainstreamed in all prevention, protection and recovery support, including throughout the legal process.
8. Recognize the role of psychosocial services in helping trafficked persons to create healthy "family" and "community" relationships that build resilience and support for the trafficked person's healing and integration processes.
9. Recognize the need for raising public awareness about the psychosocial impact of trafficking on the victim, and that awareness raising activities should be conducted in a way that is non-stigmatizing and culturally and linguistically appropriate.

10. Comprehensive mental health and psychosocial research and “good” practices as well as ethical integrity should form the basis of policies and services as well as resource mobilization.
11. Governments, non-governmental organizations and other stakeholders should increase cooperation among themselves and across borders by coordinating and linking psychosocial and mental health care services offered to trafficked persons in countries of destination, transit and source.
12. Securing justice and compensation for damages can be considered an important part of the healing process and should be pursued in a timely and voluntary manner, without hindering or delaying the recovery and integration of the trafficked person.

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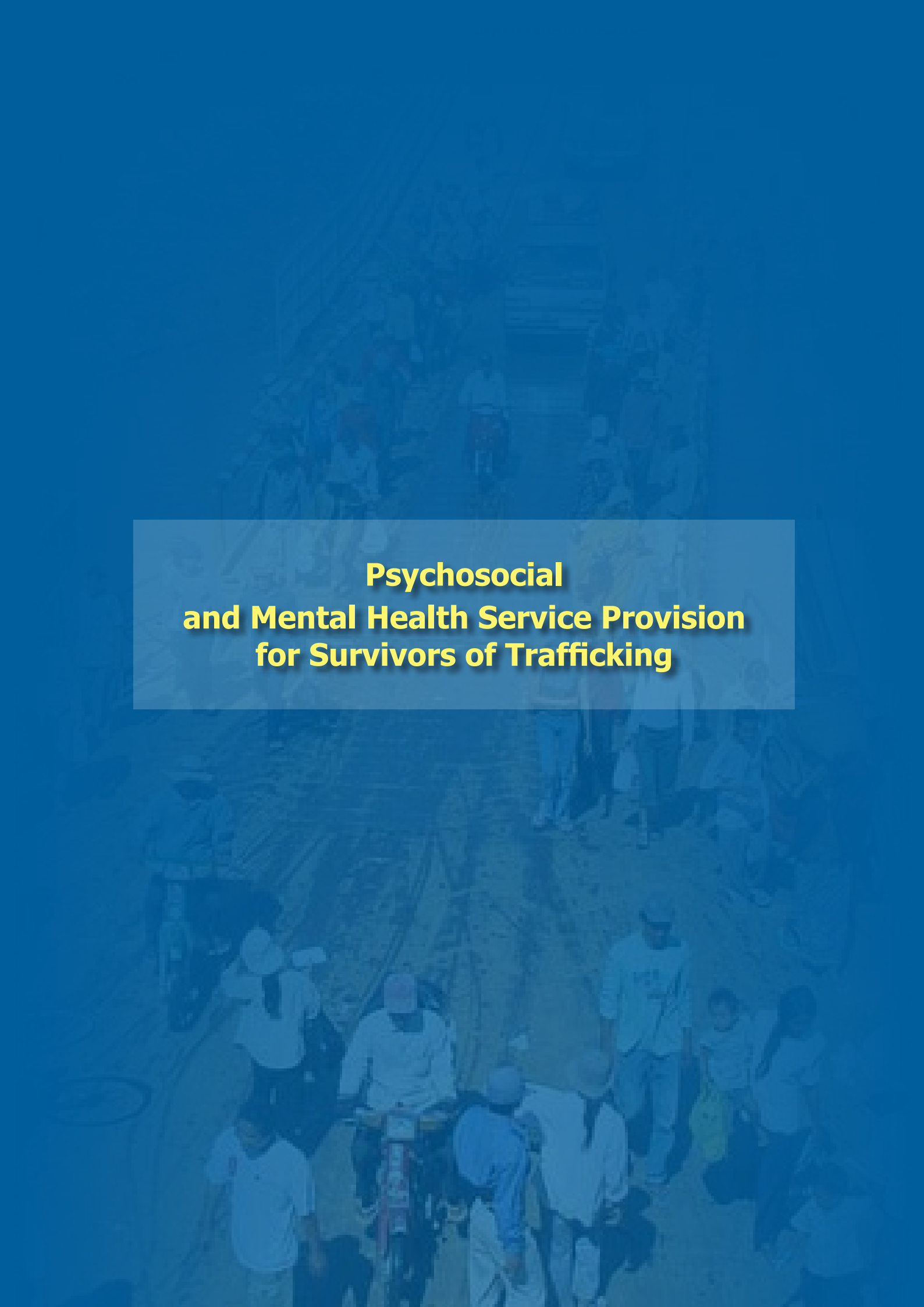
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An aerial, high-angle photograph of a busy street market. The street is paved and lined with numerous people, many of whom are carrying items on their heads or backs. The scene is filled with activity, with people walking in various directions. The overall atmosphere is one of a bustling, everyday marketplace. The image is overlaid with a semi-transparent blue rectangle containing the title text.

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