permanent policy and governance frameworks that will endure beyond the lifetime of the programme.

Qatar has accepted and adopted the WHO Mental Health Action Plan 2013–20 (World Health Organization, 2013) and the National Mental Health Strategy closely aligns with its key domains. The Strategy sets out a series of initiatives to create an environment that protects the dignity of people with mental health problems. So far, the provisions of common law have enabled mental health professionals to provide appropriate compulsory care. The imminent introduction of the country's first mental health law will be a landmark and it will enshrine in law the rights of patients (Abou-Saleh & Ibrahim, 2013). El-Islam (1995) emphasised the major role of the family in decisions concerning patient admissions and follow-up care, and the role of the family will be woven into the new legal framework.

Much progress has been achieved since the launch of the Strategy but there is still a long way to go. Leaders, decision makers, professionals, patients, relatives and civil society have been able to work collaboratively towards the achievement of a shared vision where the people of Qatar can experience good mental health and well-being, supported by integrated mental health services. The country will undoubtedly achieve its vision of less stigma for those seeking help, and their access to effective care and treatment in the most appropriate settings.

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SPECIAL PAPER

Mental health and human trafficking: responding to survivors' needs

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Mental health professionals have opportunities to intervene and provide care for trafficked people. Research shows that mental health problems – including depression, anxiety and post-traumatic stress disorder – are prevalent among trafficked people, and that at least some trafficked people come into contact with secondary mental health services in England.

What is human trafficking?

Human trafficking is the recruitment and movement of people using means such as deception and coercion for the purposes of exploitation (United Nations, 2000). Men, women and children are trafficked across and within international borders for exploitation in forced sex work, domestic servitude and in a variety of industries, including fishing, agriculture and construction, as well as for forced criminal acts. Human trafficking is a global problem, with an estimated 11.7 million people exploited in the Asia-Pacific region, 3.7 million in Africa, 1.8 million in Latin America and the Caribbean, 1.6 million in central and south-eastern Europe, 1.5 million in the European Union and developed economies, and 600 000

in the Middle East (International Labour Office, 2012).

This article summarises research on mental health and human trafficking and how mental health professionals can respond, including recent research conducted to inform the UK health service response to human trafficking. There are an estimated 13 000 victims of human trafficking in the UK (Silverman, 2014), trafficked from more than 80 countries, notably including Romania, Poland, Albania and Nigeria.

What mental health problems are associated with trafficking?

Research from various countries shows that depression, anxiety, post-traumatic stress disorder (PTSD), and self-harm and attempted suicide are common among survivors in contact with refuge services (Ottisova *et al*, 2016). Oram *et al* (2016) found that symptoms of depression, anxiety and PTSD were reported by 78% of women and 40% of men survivors in England. Similarly, a study of trafficked people in Greater Mekong sub-region found that 61% of men and 67% of women, as well as 57% of children, reported probable depression (i.e. symptoms indicative of depression as measured by a standardised screening tool) and probable PTSD was reported by 46% of men, 44% of women and 27% of children (Kiss *et al*, 2015).

Evidence of severe mental illness, including schizophrenia and psychotic disorders, has also been detected among trafficked people in contact with secondary mental health services in England (Oram *et al*, 2015). The study also found an increased risk of compulsory psychiatric admission and longer duration of psychiatric admission among trafficked versus non-trafficked patients who were matched for gender, age (within 2 years), diagnosis, in-patient status at first contact and year of most recent contact. Seven per cent of trafficked patients had a history of psychiatric admission prior to trafficking.

Although traumatic experiences while being trafficked may induce or exacerbate mental disorders, poor mental health may also increase vulnerability to trafficking, due to factors directly associated with poor mental health, such as reduced decision-making capacity or understanding and increased dependence on others. Trafficked individuals' risk of mental disorder appears to be influenced by multiple factors, including: pre-trafficking abuse; duration of exploitation; violence and restrictions on movement while trafficked; greater numbers of unmet needs; and lower levels of social support following trafficking (Ottisova *et al*, 2016).

Importantly, recent findings from the UK show that trafficked people may come into contact with mental health services (Oram *et al*, 2015), and this offers mental health professionals opportunities to intervene and provide care.

What are indicators of trafficking?

Mental health professionals may encounter trafficked people who are still being exploited or, more commonly, who have escaped (Zimmerman & Borland, 2009). Research conducted in the UK found that up to one in eight mental health professionals working in areas known to have higher numbers of trafficked people (e.g. London) had been in contact with a patient they 'knew or suspected had been trafficked' (Ross *et al*, 2015). Trafficking may be disclosed by the patient or another professional involved in the patient's care, or mental health professionals may detect signs that suggest possible experiences of trafficking. Suspicions may be raised, for example, if patients present with signs of physical or psychological trauma and are unable to speak the local language or to provide basic identity documents (Hemmings *et al*, 2016). Patients still experiencing exploitation may be accompanied by a dominant or controlling companion or minder.

What should mental health professionals do if they suspect trafficking?

When assessing and caring for patients who may have been trafficked, mental health professionals should, whenever possible, see them without companions or minders present, use an independent interpreter, and be prepared to provide extended consultations (Hemmings *et al*, 2016). Professionals may also try to schedule a further appointment to create a better opportunity for disclosure.

Trafficked people may fear disclosing information about their experiences due to threats of harm to themselves or their family members, because of a risk of detention or deportation, or they may be inhibited by feelings of shame or guilt (Zimmerman & Borland, 2009). Others may have difficulty recalling and recounting their experiences; trauma can affect recall of the details and chronology of events. Mental health professionals may need to provide crisis care with little background information and accept that patients may not wish or be able to return for follow-up care (Zimmerman & Borland, 2009). However, professionals should also be prepared to provide information about referral options, and should familiarise themselves with local and national support services and referral pathways (Hemmings *et al*, 2016).

Many trafficked men, women and children experience physical and sexual violence while being trafficked. A recent study conducted with survivors in England found, for example, that 66% of trafficked women reported forced sex while being trafficked; 95% had been trafficked specifically for sexual exploitation and 54% had been trafficked for domestic servitude (Oram *et al*, 2016). Research also suggests that many experience physical and sexual abuse from partners, family members and other perpetrators prior to trafficking and that vulnerability to violence may continue after escape from exploitation (Ottisova *et al*, 2016).

Mental health professionals should routinely enquire about current and historical experiences of abuse when working with trafficked patients. Survivors will benefit from psychological support to address their experiences of multiple traumatic

events. They will also require careful risk assessments and safety planning, including risk of re-trafficking. Trafficked patients should whenever possible be offered a choice regarding the gender of their healthcare professional and, where used, their interpreter. During assessment, professionals should try to explore common post-trafficking reactions such as fearfulness, sadness, guilt, shame, anger, memory loss, hopelessness, reliving experiences, emotional numbing, feelings of being cut off from others, being 'jumpy' or easily startled, and risk of suicidal ideation and self-harm. Assessment should also include substance misuse; it is not uncommon for trafficked people to be forced to use drugs or alcohol or to use them as coping mechanisms.

Trafficked people are likely to be unfamiliar with how mental health services are provided and with the treatments available to them. Care should be taken to explain care plans, care coordination and duration, to ensure informed consent and, whenever possible, to allow individuals to participate in decision-making about their care. Professionals should also be cognisant that cultural differences can affect the presentation and understanding of psychological symptoms and treatment preferences. It is often necessary to consider the acceptability of psychological interventions and potential stigma associated with them for trafficked patients from other countries and cultures (Zimmerman & Borland, 2009). All relevant members of the care team should be aware of the patient's history, health and social needs, and need for follow-up, while maintaining strict confidentiality of patient information.

What interventions should be offered?

To our knowledge, no research evaluating the effectiveness of interventions to support the recovery of trafficked people has yet been conducted (Ottisova *et al*, 2016). Treatment should be provided in line with clinical guidelines for working with victims of trauma (World Health Organization, 2013). Evidence-based interventions for PTSD such as narrative exposure therapy (NET), trauma-focused cognitive–behavioural therapy (TF-CBT) and eye movement desensitisation and re-processing (EMDR) may be suitable for survivors who are ready to talk about their trauma, and should be evaluated in future research. If evidence-based psychological therapies are not available or patients do not wish to engage or have ongoing severe stressors, antidepressants may also be a treatment option (Abas *et al*, 2013). Evidence on responses to human trafficking in low-resource settings remains largely absent.

Studies exploring risk factors for mental disorder among trafficked people suggest that psychological interventions will need to take account of abuse experienced both prior to and during exploitation and the potential for ongoing harm. Broad approaches to stabilising physical and psychological health are likely to be needed before commencing trauma-focused psychological therapy. Social stressors (e.g. unstable housing, insecure immigration status) are likely to exacerbate distress and psychological symptoms. Patients may need assistance accessing social, financial and legal support as well as help with techniques to regulate emotions and to cope with dissociation (Domoney *et al*, 2015).

Conclusions

Mental health problems are prevalent among trafficked people and survivors often require support to recover from the psychological impact of their experiences. Mental health professionals have a key role to play in responding to human trafficking. Awareness raising and training are required to ensure professionals are prepared to respond to trafficking and to safely identify and refer trafficked people to the care that they need and deserve.

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