

Mental Health Services as a Vital Component of Psychosocial Recovery for Victims of Child Trafficking for Commercial Sexual Exploitation

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There has been a plethora of outcomes associated with child trafficking for commercial sexual exploitation; however little attention has been paid to how outcomes are addressed for children who are placed into residential aftercare recovery programs following their identification as victims. Field-based qualitative research was undertaken in South and Southeast Asia, and involved interviews with 213 representatives from U.N. and governmental agencies, nongovernmental organizations, and residential aftercare recovery programs. Findings highlight the mental health needs of child victims of trafficking for commercial sexual exploitation, describe the availability and quality of mental health services and supports in aftercare programs to address prevailing needs and repair the psychological damage caused by trafficking, and report on lessons learned pertaining to elements of good practice and related challenges associated with the availability and quality of mental health services and supports. It concludes by highlighting the implications of the findings for mental health policy and practice and offers suggestions for further research.

Public Policy Relevance Statement

Child trafficking for commercial sexual exploitation (CSE) has been linked with a range of mental health needs. Nonetheless, little research has focused on mental health care to facilitate their recovery and psychological wellbeing following their identification as victims. Findings from this exploratory study indicate that policymakers should ensure timely access to trauma informed care and culturally relevant mental health services and supports.

When children are trafficked away from their families, friends, and communities, their survival and development are compromised as they are stripped of their basic human rights to safety, security and protection. They are dependent on their traffickers for food, shelter, and other basic necessities, and many fear retaliation against themselves or their families. Health and safety standards in exploitative settings have been described as extremely dismal, further compromising their

wellbeing. The degree of experienced violence ranges from coercive strategies (physical and verbal threats, forced use of drugs, and alcohol) to extreme abuse (physical, sexual, emotional), negative exposure to communicable disease, or torture-like violence (Ijadi-Maghsoodi, Todd, & Bath, 2014; Rafferty, 2013a, 2013b). In response, child victims may develop a range of mental health needs and interpersonal problems, including depression, hopelessness, anxiety, posttraumatic stress disorder, hostility, and irritability (cf. Rafferty, 2013a). Furthermore, children may experience complex trauma, meaning the short and long-term consequences following exposure to multiple traumatic events, as a result of the life-threatening events, persistent stress, and repetitive or chronic dangers associated with trafficking (Cecchet & Thoburn, 2014; Hardy, Compton, & McPhatter, 2013; Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016). In extreme cases, the psychological and physiological symptoms manifested by victims have been compared to those identified in children involved with armed conflict and victims of torture (Conradi, 2013).

In contrast with what is known about the adverse health and mental health implications of being trafficked for commercial sexual exploitation (CSE), little research has focused on the provision of psychosocial recovery and rehabilitation services for

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children in residential aftercare programs following their identification as victims. In addition, the few studies that do exist tend to focus on psychosocial recovery in general, without specific attention to the availability and quality of mental health care to repair the psychological damage associated with trafficking. Existing research also tends to focus on adult victims of trafficking, without distinguishing between the needs of adults and children. Furthermore, much of the focus has been on programs and strategies in developed countries, particularly the United States, with fewer details about their appropriateness for victims elsewhere. Four recent articles have raised concern about this gap in the research literature, and have called for additional studies to guide the development of practice and social policy (Aberdein & Zimmerman, 2015; Ijadi-Maghsoodi et al., 2016; Macy & Johns, 2011; Wilson, Critelli, & Rittner, 2015). Other publications have called for an assessment of mental health and other psychosocial needs (e.g., education, legal, physical) as soon as children are identified (Bokhari, 2008; Brunovskis & Surtees, 2012; McIntyre, 2014; Rigby, 2011).

The current study focuses on the mental health needs of children who are identified as victims of trafficking for CSE and placed into residential aftercare programs for recovery and (re)integration in South and Southeast Asia. As boys are less likely to be identified as victims, residential aftercare programs tend to focus exclusively on girls who experienced CSE (cf. Rafferty, 2016). Three specific open-ended questions guided the research:

Research Question 1: What are the most salient mental health needs of children who have been trafficked for CSE and placed into aftercare facilities in South and Southeast Asia for recovery and rehabilitation?

Research Question 2: What is the overall availability and quality of mental health services and supports to address prevailing needs and repair the psychological damage caused by trafficking for children who have been placed into aftercare facilities in South and Southeast Asia?

Research Question 3: What are the most prominent potentially promising practices and challenges associated with the availability and quality of mental health services and supports for children who have been trafficked for CSE and placed into aftercare facilities in South and Southeast Asia for recovery and rehabilitation?

Method

Field-based interviews were conducted over a 1-year period: January to December 2014. The countries in which the interviews occurred included Cambodia, India, Laos, Nepal, Thailand, and Vietnam. Support was elicited in advance of visits to the respective countries from various U.N. agencies and the major international nongovernmental organizations (NGOs) involved with the provision of aftercare services for child victims. In each case, representatives were informed of my project and asked for their assistance contacting field-based personnel who were involved with child trafficking in the various countries. In response, I was provided with names and contact information for at least one U.N. staff member in each country ($n = 10$) and 20 representatives from NGOs. These representatives ($n = 30$) were subsequently con-

tacted (via e-mail) and an opportunity to meet with them while I was in their respective countries was requested. Meetings were subsequently arranged with each person contacted, or their designated representative. These key informants, in turn, introduced me to field-based staff in various locations. Overall, I met with 213 people from the six countries, including representatives from U.N. agencies ($n = 22$), governments ($n = 12$), and aftercare programs ($n = 179$). Key informants from U.N. agencies included regional and local representatives from UNICEF, U.N. Women, the International Labor Organization, and the International Office for Migration. Government representatives included those who were charged with overseeing aftercare programs for victims of trafficking. Representatives from aftercare programs included executive directors of the major international NGOs that provide aftercare programs for survivors throughout the world, and a variety of staff who work directly with child victims/survivors. The program staff included facility managers, program administrators, housemothers, case managers, mental health counselors, outreach workers, project coordinators, rehabilitation officers, and other support staff such as legal and health care providers.

Interview protocols were developed in advance and focused on (a) identification of victims, (b) service needs, (c) intake and assessment procedures, (d) interim and psychosocial support, and (e) continuing care and (re)integration. Prior to my departure, I had obtained approval for my interview questions from the Institutional Review Board at my university affiliation. One international NGO also required me to obtain approval from its own Institutional Review Board, as well as a background criminal report from the Federal Bureau of Investigation. Although I had hoped to get each key informant to respond to a series of questions and prompts, it was difficult to adhere to the protocol given the time constraints of the interviewees. Some interviews lasted for 10 min; others lasted for 1–2 hr. In some cases, individual interviews were conducted. In other cases, the structure was less formal and involved a group meeting with two or more people. Some interviewees were extremely knowledgeable, with many years of experience, although all interviewees had pertinent information to share. Despite the challenges, everyone was supportive of the research project, and welcomed my quest for information about mental health and psychosocial recovery (and other issues associated with aftercare that are beyond the scope of the current article). The interviews were not recorded, although extensive notes were taken. Ideally, I would have liked to analyze the immense volume of data based on a multistage procedure of combining qualitative analysis with basic quantification of the main themes and dimensions. Unfortunately, this strategy was not possible due to the limited available resources for the project. Interview notes were organized according to the key themes that were identified within the three research questions being explored: (1) mental health needs of program residents, (2) availability and overall quality of mental health services and supports in aftercare facilities to address identified needs, and (3) potentially promising practices and challenges associated with the availability and quality of mental health care for children who have been trafficked for CSE and placed into aftercare facilities in South and Southeast Asia for recovery and rehabilitation.

Results

Mental Health Needs

The first research question aimed to identify the most salient mental health problems experienced by children who have been trafficked for CSE and subsequently placed into residential aftercare program following their identification as victims. Key informants confirmed the mental health outcomes described previously in the research literature, including depression, anger, sadness, tiredness, fear, skepticism about their future, lower self-esteem, drug use, and complex trauma (cf. Rafferty, 2013a). A number of key informants also identified challenging mental health issues that have not been identified previously in the research literature on child trafficking for CSE. They include (a) highly sexualized behaviors of residents within the aftercare program and at school (e.g., provocative dress, flirtatious behavior, offering themselves sexually); (b) sexual harassment from other girls, including the sexual abuse of younger peers by older girls in the facility; (c) acting-out behaviors associated with living in a shelter (e.g., bullying, fights); and (d) self-harm behaviors (e.g., cutting, suicide attempts).

A majority of key informants also expressed concern with stressful environmental characteristics within some aftercare facilities that may compound or contribute to the children's mental health problems. They described, for example, safety concerns pertaining to violent behavior by unscrupulous staff members and outside others (e.g., law enforcement personnel), including sexual abuse and the use of physical and psychological abuse as a strategy to punish and discipline residents. Noted comments included "They tie the girls to the window if they make a fuss, or cry," "They treat them very badly—they keep telling the girls how bad they are," "The shelter is no better than the brothel." Many also expressed concern pertaining to the adverse impact of lengthy shelter stays and, particularly, for international victims who are often detained for several years awaiting their repatriation orders. Both India and Thailand were identified as being particularly problematic in this regard. Key informants also reported that the adverse impact of lengthy shelter stays are compounded in some facilities that detain children in locked facilities, sometimes against their will, and prohibit them from leaving, even if they choose to do so. Sample comments included "It is like a jail" and "Victims are often incarcerated in shelter homes." One key informant in India noted that compliance by NGOs with these government restrictions (high walls, locked doors, closed facilities) violate human rights and international law, and blamed NGO providers for failing to provide adequate protection:

There is a lack of outrage pertaining to closed shelters. NGOs do not take a stand on this. By being passive on this point, they become part of the problem—they are implementing policies that violate the rights of the child. NGOs need to challenge this policy. Children who are living on the streets have open shelters . . . why then are victims of trafficking locked up?

Availability and Quality of Mental Health Services and Supports

The second research question explored the availability and quality of mental health services in residential aftercare programs

to address prevailing needs and repair the psychological damage caused by trafficking. A majority of key informants identified mental care as the most critical component of a comprehensive aftercare service delivery practice for the treatment of the complex psychological and social needs of young victims due to their trafficking and traumatic experiences. In contrast with their positive attitudes and beliefs about mental health care, however, access to mental health services in aftercare programs was frequently described as being scarce, inferior in quality, and inadequate to address prevailing needs and repair the psychological damage caused by trafficking. A director of a large aftercare facility in India described the overall inadequacy of available services as follows: "Capacity to provide emergency response for trauma, illness, attempted suicide, violent behavior, et cetera is sorely needed." Another key informant highlighted the inability of providers to adequately treat trauma: "Children are totally cut off because of the trauma they have experienced. Rehabilitation overlooks the physical and sexual trauma of survivors." Another executive director of a large international NGO with programs for victims of sex trafficking throughout the world reported that "Mental health care is one of the biggest gaps in aftercare services." In Nepal, a director of a large aftercare facility reported, "We do relief work. We have 500 children and one social worker. We operate in a crisis mode."

Key informants also reported that the quality of care in government run facilities was inferior to that provided by privately run NGOs, as well as additional concerns pertaining to the minimal services for children with severe mental health problems. Finally, key informants reported that the psychological-therapeutic interventions offered in aftercare programs varied substantially across a number of dimensions. These potentially promising practices and challenges are discussed below.

Potentially Promising Practices and Challenges Associated With the Availability and Quality of Mental Health Services and Supports

The third research question asked key informants to identify and describe prominent potentially promising practices and challenges associated with the availability and quality of mental health care for children following their identification as victims and placement in residential aftercare programs in South and Southeast Asia. This section reports on lessons learned regarding the two major areas identified by key informants: (a) program capacity to provide quality and culturally appropriate care (trauma informed care, culturally relevant mental health services, incorporate alternatives to traditional therapy, offer comprehensive services and collaborative care, ensure comprehensive case management, individualized care that recognizes a hierarchy of needs, and include mental health assessments to guide the delivery of services), and (b) adequacy of financial and human resources.

Program Capacity to Provide Quality and Culturally Appropriate Care

Trauma informed care. The importance of providing care that is trauma informed and designed to prevent retraumatization

zation of victims by triggering feelings that they had while they were being trafficked and disempowered was repeatedly raised by key informants. Several programs had taken steps to ensure that they were providing exemplary trauma informed care. They described the important role that staff play in creating a climate within the shelter that is based on trauma informed principles and techniques (e.g., supportive, sensitive, empowering) and does not exacerbate the impact of trauma by interventions that may repeat aspects of past abuse. These programs had provided every member of the staff with appropriate training to ensure that they had an adequate understanding about creating trauma informed systems of care and the potential impact of traumatic experiences on children's life, behaviors, perceptions, and reactions (e.g., anger, hostility, irritability, self-harm, withdrawal, dissociative states) and how to apply that understanding at all points of service provision. For the most part, however, key informants reported that program staff was not adequately informed about trauma informed care or potential outcomes associated with traumatic experiences, including flashbacks, persistent fear, hypo- or hyperarousal, and so forth. Program capacity to provide such care was summarized by the executive director of a large international NGO with programs throughout South and Southeast Asia as follows:

That is one of the biggest gaps. There are too few adequately trained social workers. Program staff feels challenged regarding how to support the children, and do not know how to respond to children who have been traumatized. They have not learned about trauma informed care and it is a serious problem. The children present with difficult behaviors and the staff does not know how to provide for their psychological needs. Some victims develop sexualized behaviors and the staff does not have the capacity to deal with these issues.

Culturally relevant mental health services. A majority of key informants highlighted the importance of providing culturally relevant mental health services for the treatment of children with complex psychological and social needs as a vital element of good practice. They cautioned, however, that interventions that are considered to be promising in Western cultures may not be effective elsewhere, or may require substantial modification of their underlying concepts to ensure that they are consistent with local customs and beliefs. They emphasized the importance of transcultural mental health care, meaning services that are culturally sensitive, and involving staff who are culturally competent with the necessary skills and abilities to provide optimal care for the children in their care (e.g., aware of the limitations of Western approaches and the use of alternative approaches for treating diverse populations, able to incorporate cultural traditions into their practice, and understand cultural variations in the expression of emotion). Key recommendations to facilitate holistic and culturally competent care included: the importance of recognizing both cultural and ethnic diversity; ensuring that care programs are culturally relevant, appropriate and consistent with local intervention theory, standards, and best practices; and viewing potentially promising programs and practices within the context of cultural traditions. They further stated that any identification of promising practice must clarify the population for which it holds potential.

Trauma focused interventions such as individual or group therapy and counseling, and other complex psychological interventions used in the Western cultures to address psychological needs, were frequently described by key informants as not always being

individually or culturally appropriate or valid in developing countries, and are not always the most effective or suitable approaches for use in Eastern cultures. Interviewees noted, for example, that many children, particularly those who live in a culture where individuals rarely talk about their feelings, have trouble verbalizing their needs and concerns. They also described how some cultures do not differentiate psychological, emotional, and spiritual reactions from physical ones, but rather, focus on the impact of trauma on the body as a whole. Consequently, emotional and psychological problems manifest through the representation of somatic symptoms and complaints are presented as physiological symptoms. Several key informants also noted that therapies that are popular and gained a lot of empirical support in Western cultures are often viewed differently and lack support in countries where cultural pressures exist to keep mental health problems hidden and stigma and shame are associated with receiving assistance for emotional problems. Some interviewees also noted that terminology might be vital to healing. In Vietnam, for example, it was noted that clients do not comprehend the concept of therapy—but they will listen to terms like “healing practices” or “trauma healing.”

A number of key informants identified trauma-focused cognitive behavioral therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) as being particularly promising for children with complex needs and severe psychological damage from being trafficked, to promote emotional wellbeing and reduce the trauma symptoms associated with trafficking. In one noteworthy initiative in Cambodia, interviewees described a several-year multistep endeavor that was undertaken in collaboration with Johns Hopkins Bloomberg School of Public Health to reduce trauma in girls aged 5–18 who had been sexually exploited and trafficked, and had exceptionally high levels of trauma symptoms, depression, shame, and anxiety. The components of the intervention were similar to a standard TF-CBT model, but slightly adapted to be more culturally appropriate (e.g., psychoeducation was changed to giving information; relaxation was changed to releasing emotion; cognitive reprocessing was changed to changing thoughts). Effectiveness of the treatment was evaluated using the Child Exploitation Psychosocial Assessment Tool (CEPAT; Bass, Bolton, & Bearup, 2010) which yields information on depression (e.g., felt unhappy, sleep problems), function (e.g., ability to complete tasks and activities of daily living), posttraumatic symptoms (e.g., flashbacks of being raped, felt confused, get upset or afraid), shame (e.g., feel dirty, wish to be invisible), and hope (e.g., life is going to get better). Key informants reported an improvement in symptoms, including function (46%), depression (68%), trauma (65%), shame (64%), and hope (51%; cf. Reimer, Arensen, & Seng, 2013). A number of challenges, however, were also identified by key informants, including the reluctance of survivors to discuss their trafficking experiences. They noted, for example, that some girls do not classify their experiences as abuse because they perceive the events as consensual, noting that they had volunteered or agreed to engage in commercial sex in order to make money and to help their families survive. In the writing of the trauma narrative, many girls chose their most traumatic experiences not as their trafficking but as poverty-related issues, divorce, or not going to school. In discussing their trauma histories, the most common thoughts focused on concern about the loss of virginity and its impact on their ability to be married in the future. Other concerns focused on the limitations of TF-CBT for children at different developmental levels, and for children who do not have the verbal capacity to talk

about certain topics or who are unable to describe certain experiences using words. Mental health staff in a few particularly noteworthy programs described the importance of culturally sensitive trauma therapy for younger children who have been traumatized, and reported that they had integrated components of trauma-focused integrated play therapy (Gil, 2012) into their TF-CBT interventions and found them to be particularly helpful for younger children.

Incorporate alternatives to traditional therapy.

A majority of key informants also highlighted the need to reconsider Western methods, practices, and premises as the most effective strategies to address the mental health needs of victims in South and Southeast Asia. They encouraged the use of alternatives to traditional therapies that integrate traditional therapies and holistic healing modalities, while supporting each child as a whole in order to ensure their cultural relevancy. In particular, key informants emphasized the importance of examining the relationship between mind and body in the analysis of mental health problems, treatment approaches that incorporate cultural traditions and community norms, spirituality as a vital aspect of treatment, traditional healing rituals/methodologies, as well as massage therapy, acupuncture, relaxation, deep breathing, meditation, mindfulness, and Buddhist/Hindu teachings and healing rituals, herbal gardening, and yoga practice.

Interviewees often highlighted the use of creative nonverbal therapeutic activities/therapies/healing activities—opportunities/holistic treatment modalities, including art, music, play, and dance movement as playing a vital role in the successful recovery of children who experienced difficulty in the verbal expression of traumatic experiences. Some programs praised art therapy as being particularly instrumental in encouraging children to express themselves, although they also noted that staff was not adequately trained as therapists. Dance movement therapy (DMT) was also used in several programs and identified by some key informants as a vital tool for survivor's psychosocial recovery and rehabilitation. In one noteworthy example, Kolkata Sanved, a DMT program in various shelters in India, aims to help children to focus on mind–body connections, as well as practice coordination, communication, balance and establish trust between the members of the group. In addition to a series of exercises, children also engage in creative dancing and complete their practice with relaxation techniques. Kolkata Sanved works as a train-the-trainer model and its objective is to train survivors to then lead DMT courses on their own. Key informants involved with this program described the development of a more positive attitude, a reduction in self-destructive tendencies, improvements in behavior, and increases in self-esteem. Other programs praised music therapy as showing promise for child victims. In one noteworthy program in Cambodia, for example, an onsite program for the children involved singing, song writing, listening, relaxation, playing instruments, and dance. Key informants praised the program as being an effective strategy for survivors, and especially for those children who found it difficult to talk about the trauma, as well as for children with limited means of verbal expression.

Offer comprehensive services and collaborative care.

Key informants frequently noted the importance of acknowledging the transcultural framework, whereby children in their care are viewed within a broad context and requiring a holistic approach to recovery by addressing both their mental health and social care needs. They noted, for example, how some

cultures connect emotional and social problems and how psychological wellbeing is influenced by multiple interrelated systems (e.g., physical, emotional, spiritual, social). Thus, they indicated that culturally appropriate mental health care is best viewed as one component of a broad range of interventions needed by children to promote their emotional wellbeing, and address their complex social, emotional, and economic needs. They highlighted the provision of comprehensive services to facilitate their recovery, promote their long-term emotional wellbeing, ensure their successful (re)integration back into society, and prevent them from being retrafficked following their recovery and (re)integration. They further noted that the provision of comprehensive care to address the complex problems of child victims may be more effectively handled when program staff works collaboratively with others, requiring a multidisciplinary response by a team of providers, including professionals in the field of mental health. Key informants, however, noted that holistic services at the shelter facilities ranged from nonexistent to outstanding. Some noteworthy promising practices included integrated and multisectorial approaches that incorporate general health and social care to address the children's physical, emotional, legal, social, and spiritual needs, including clinical services for mental disorders and activities to promote their economic empowerment such as education, vocational training, life skills, and job training. Finally, many key informants identified the importance of survivors helping each other by talking to each other and watching out for each other. In one noteworthy example, the Youth Partnership Program at Maiti Nepal empowers children to work with other victims as peer counselors, peer educators or outreach workers providing mentorship and role models in a nonjudgmental ambiance for victims. However, interviewees cautioned that involving peers in the provision of psychosocial interventions needs careful consideration and that peer support models involving children are quite distinct than those deemed to be effective with adults.

Ensure comprehensive case management. In discussing comprehensive and collaborative care, the majority of key informants highlighted the importance of comprehensive case management as an essential program element, and the advantages of working collaboratively with other providers as partners to ensure coordination of the various services being delivered. Some interviewees also discussed how trauma informed case management was vital to empowering survivors as experts of their own lives and to set their own goals and make decisions as part of the process.

In one noteworthy example of outstanding collaboration, Chab Dai (which means “joining hands” in Khmer) has made tremendous strides in raising the standards of care in Cambodia in facilitating coalition-building and case support. Through effective collaboration with organizations that focus on human trafficking and exploitation, Chab Dai brings together the capacities of service providers, researchers and policymakers in order to create support for each other's work. In addition, they help with referrals and support for victims through a 24-hr hotline, follow up with police to ensure prompt reporting of perpetrators, and collaborate with partners to promote services for recovery and rehabilitation. In order to foster collaborative partnerships, Chab Dai have also implemented strong networks in neighboring countries within Southeast Asia, China, and Malaysia to facilitate the timely return

and provision of support for Cambodians who are being exploited on international grounds. In another noteworthy example, World Vision's End Trafficking in Persons Program has developed and shared with partners a case management strategy, including a comprehensive case form outlining the program's action plan for each child in the aftercare facility. The Action Plan and Implementation Form are designed to record children's needs for services, the services provided to assist clients based on the needs identified, the linkages to resources, coordination strategies with partners, and monitoring of the services provided.

Individualized care that recognizes a hierarchy of needs.

During discussions about the limitations of Western models of mental health care and the need for comprehensive, holistic, and culturally competent care using a variety of techniques and modalities, key informants frequently highlighted the importance of providing individualized care to foster healing and empowerment, tailored in accordance with the unique needs of each child. They reported, for example, that although many of the children who are now in care have experienced traumatic events, involving extreme physical and sexual abuse, they have not all had identical experiences. Some children, for example, may be suffering from the psychological damage caused by trafficking and mental health challenges (e.g., depression) and may require services from mental health professionals with specialized skills, while other children may not require any such services. They also noted the existence of individual differences in resilience, how children will not be equally impacted by their trafficking experiences. They also reported that the damage caused by trafficking, and how each child responds to their exploitation, will be influenced by the type, degree, and duration of their experienced violence and abuse. Some key informants placed the need for comprehensive and individualized services within Maslow's (1943) five-tier model of human needs, which recognizes the importance of prioritizing identified needs in order to ensure long-term emotional wellbeing. All children, for example, will require immediate attention to meet their basic needs and ensure their safety and security (e.g., shelter, food, sleep). Some children will do well once their basic needs have been met; other may need more. Some, for example, may need immediate support services, such as psychological first aid, medical care, and legal assistance, while others may not. Some may also need continued psychosocial support to aid their healing, promote their successful (re)integration into the community, and prevent relapse into the trafficking cycle (e.g., ongoing mental health, health, and legal services, as well as education, life skills, job training). This theoretical framework, however, notes that ongoing psychosocial support, including education and learning, cannot be effective until safety is ensured and immediate psychological needs have been met.

Include mental health assessments to guide the delivery of services.

Victims of child trafficking for CSE have diverse backgrounds and needs, and those who have been exposed to complex trauma may potentially benefit from a comprehensive assessment to guide treatment planning and ensure the provision of needed services. In order to ensure that children receive the most appropriate services, key informants reported that mental health needs should be assessed as soon as possible. They also discussed the importance of early screening to identify children most in need of services in view of having limited resources. The majority of key informants reported that an attempt is made to

conduct an assessment of each child's needs as soon as they enter the aftercare facility. In most cases, however, the focus was on obtaining basic demographic information about the child, their trafficker, their experiences, family and community risk factors, and general information about their psychosocial needs. Although the significance of a comprehensive, developmentally appropriate, assessment of each child's needs, including mental health, was often identified as playing a vital role to guide the delivery of services, the majority of key informants indicated that this was rarely, if ever, conducted. In many cases, the actual strategies used by interviewees to identify mental health needs were quite limited in scope, and consisted primarily of observational strategies (e.g., "We notice that she looks sad, doesn't talk, stays alone, cries a lot"). Key informants also described a number of challenges associated with the assessment of mental health, including the lack of culturally valid instruments and insufficient staff who are adequately trained to use them. Some key informants further noted that there are a number of risks associated with the use of standardized Western assessment instruments, including the lack of norms for local populations, language barriers and issues related to translation, and applicability of diagnostic categories. For example, some staff who had administered the CEPAT reported that it has been effective in assessing children's needs. However, they also raised a number of concerns, including the failure to address emotional distress that is expressed in somatic ways, the amount of time it takes to administer, the excessive detail, the amount of verbal ability that is required to answer and understand questions, and its unsuitability for very young children.

There were, however, some noteworthy examples of the use of comprehensive mental health assessments. In Cambodia, for example, Transitions Global (now Hope for Justice) developed and implemented an assessment process that is comprehensive, multi-pronged, and ongoing. In this impressive program, the case manager obtains information about each child's psychosocial and emotional state and maturity. The onsite psychologist and social worker conduct an assessment of mental health and psychosocial needs when they enter the program. The comprehensive needs assessment also includes a complete physical, eye examination, restorative dental exam, and regular follow-up for all of the medical issues identified during the assessment. In addition to these screenings, which are conducted at the medical center, employees assess the child's educational needs within the school environment. They conduct a family and community assessment to gain insights into options post recovery. Mental health providers at the shelter further explained how they rely on these assessments to inform treatment goals, develop a care plan (e.g., education, physical health, mental health), and review progress in accordance with Maslow's hierarchy of needs (Maslow, 1943), as well as the Inter-Agency Standing Committee (2007) guidelines on mental health and psychosocial support. Finally, they assess the mental health needs of the children as they leave the aftercare program in order to determine if their needs have been adequately addressed.

Another noteworthy example is the World Hope Emergency Assessment Center in Cambodia (now operated by Hope for Justice). This program serves as both a safe house/shelter program and an assessment facility. Full-time mental health staff at the facility (e.g., counselors, social workers, clinical supervisors) conduct comprehensive mental health assessments for each child in the program using a variety of measures (e.g., the Harvard Trauma

Tool, Hopkins Checklist–25, Achenbach Child Behavior Checklist, CEPAT Template). The assessment results are used to initiate basic recovery therapy, including intensive and holistic psychological and physical health care. Likened to an emergency room in a hospital, the center was designed to address the paucity of adequate mental health support (and holistic and well-coordinated services) in aftercare programs, the lack of mental health professionals in shelters for clients, and to provide critical care for children in need of immediate trauma recovery and stabilization. In addition to providing onsite assessments, the facility also provides individual and group therapy designed specifically for victims of sexual trauma. They also offer art, music, play, and drama programs, basic educations, and a small onsite health clinic. After a 90-day maximum stay, children are referred to appropriate medium or long-term care aftercare facilities, or to their families or guardians, whenever viable.

Adequacy of Financial and Human Resources

Financial resources. One significant factor identified as having a major impact on the provision of mental health care for child victims pertained to the adequacy of governmental responses and financial resources that are made available for psychosocial recovery. Key informants often noted that their governments have not yet taken full ownership of their responsibilities under international law, leaving the vast share of the responsibility to U.N. agencies, NGOs, and private donors (Rafferty, 2016). Some interviewees also described severe understaffing and limited services in government-run public facilities, as opposed to those that were privately funded. Some key informants also discussed how mental health has generally been identified as a lower priority in South and Southeast Asia, and the limited efforts made by governments to create mental health services that are affordable and available. Many further commented on the lower priority for funding for the provision of mental health services, in contrast with other psychosocial services (e.g., physical health care, legal services). Key informants also reported that even when mental health staff is available, many are not willing to work in aftercare facilities, and particularly in those that are government run. Some interviewees also reported that counselors in government-run facilities are rarely, if ever, fully qualified or trained to work with child victims, in addition to being underpaid, overworked, and undervalued. In some noteworthy promising initiatives run by major international NGOs, however, counselors are sent into government homes to address program deficiencies and provide counseling services. These initiatives provide much needed psychological services for survivors, but sustainability is dependent upon NGO funding.

Human resources. Key informants frequently linked the overall availability and quality of culturally appropriate and essential mental health interventions to repair the psychological damage caused by trafficking, and associated abuse, to the adequacy of human resources, and particularly to the educational background and overall lack of adequate training in both counseling and psychological support. In one particularly impressive program, the onsite mental health worker, with a graduate degree in clinical social work and many years of experience, discussed the importance of having providers with the following qualifications

and levels of experiences: (a) a graduate degree, with clinical therapy training, or a therapist specializing in trauma; (b) clinical therapy experience, with an emphasis on trauma and work with adolescents; and (c) experience working in residential settings (e.g., rape/domestic violence), with survivors of trafficking (torture, sexual exploitation, or related field), and in international settings or cross-cultural contexts.

In contrast with these recommendations, however, key informants reported that providers of mental health services are drawn from varied educational backgrounds, with wide-ranging qualifications (from secondary school education to, in very rare cases, graduate training). Some providers had received education in social work or psychology (e.g., bachelor's or master's degree), and, in very rare cases, services were provided by trained personnel with knowledge of trauma healing (master's or doctoral degree in social work or psychology) who were employed by privately run NGOs. In some cases, a professional counselor or psychologist visited the program at least once a week; in rare cases, there was a counselor or psychologist on site and available on a daily basis. Some had technical support available (either in person or via Skype). Key informants also reported that providers tend to have little or no clinical training or experience; some had received a basic introduction to social work or psychology, some were trained on the job, or through intermittent trainings provided by various organizations (e.g., International Organization for Migration, World Vision, Transcultural Psychosocial Organization). In Cambodia, for example, the Transcultural Psychosocial Organization trains local people from the community to become mental health workers, often those who have previously been involved with providing some kind of mental health guidance. In addition, they have adapted training materials to the local context.

In addition to the paucity of qualified mental health providers, concern was frequently expressed by interviewees about the shortage of staff trained in trauma or trauma healing, therapeutic crisis intervention, or other emergency response measures. Some informants noted concern with staff with no psychology or mental health background, clinical training, or knowledge of trauma counseling, providing therapeutic services. In some cases, the mental health counselors who were interviewed acknowledged their lack of knowledge and expertise, as well as their frustrations at not having adequate training and support to address the complex needs of the children.

To address this serious shortfall in human resources, key informants often called for effective action to be taken in order to ensure that program staff receives appropriate education and training to ensure that they have the appropriate skills to meet the unique needs and problems of the children. Respondents particularly noted the need for greater awareness of the psychological damage caused by trafficking, the impact of trauma, including the trauma bond that some children have with their traffickers, as well as the ongoing stressors associated with living in a shelter facility and the potential for further harm from staff and peers. Some were quite perplexed about how to handle both typically developing sexual behaviors and oversexualized behaviors, including the abuse of younger children by the older girls. Another key issue involved the need for those who provide mental health services to have appropriate training in diagnostic and therapeutic skills, including the ability to conduct appropriate needs assessments and child friendly interviewing techniques, to ensure their competence

and not cause the children any further harm. Finally, many noted the need for training to ensure their competence to provide culturally competent mental health care, including an awareness of sociocultural issues, the challenges when working with children from diverse cultures and ethnicities, as well as effective culturally relevant therapeutic interventions to work effectively with younger children, specifically those with poorer abstraction skills to address the complex needs of children following trauma. Lastly, some key informants reported that caregivers tend to overidentify with victims negatively influencing survivors' healing and coping processes, noting that many of the latter have been victims of gender-based violence in their own lives. Some also expressed concern about vicarious traumatization and secondary traumatic stress. They reported feeling drained, not being able to stop thinking about what was discussed with victims, somatic symptoms, and visualizing the experiences of the children.

Discussion

Child trafficking for CSE is a complex phenomenon, requiring multifaceted programs and policies by various stakeholders. Responses focus on three overarching strategies, including prevention, prosecution and protection. This article focuses on protection, and aims to contribute to the knowledge base on the mental health needs of children who have been trafficked for CSE and the provision of quality and culturally appropriate mental health care by presenting the perspectives of key personnel with frontline experience with this population. This is an area of research with a paucity of robust and reliable data, with few practices and interventions that have been identified, evaluated, or shown to be effective.

The overarching aim of the current study is to facilitate the successful recovery of child victims by improving the provision of psychosocial services, strengthen policy mechanisms and institutions that are designed to assist them, and promote future research on appropriate mental health interventions. It adds to the existing literature in a number of ways. First, it highlights the mental health needs of children who have been trafficked for CSE and who have been placed into residential aftercare programs in South and Southeast Asia, where they are provided with temporary accommodations and remain pending their return to their communities (reintegration) or integration into new communities. Next, it describes the availability and quality of mental health services and supports to facilitate their recovery and rehabilitation. Finally, it reports on lessons learned pertaining to elements of good practice and related challenges associated with the availability and quality of mental health care.

Recommendations for Social Policy, Practice, and Future Research

A number of international and regional declarations, conventions and treaties, as well as various guidelines and international mechanisms for protection have been adopted that incorporate the principles of human rights to child trafficking, physical health, and mental health. In addition, the World Health Organization (WHO) has recognized the importance of mental health since its origin, and noted that it is fundamentally interconnected with health

outcomes as well as physical and social functioning. More recently, the WHO's (2013) *Comprehensive Mental Health Action Plan 2013–2020* was adopted by the World Health Assembly and symbolizes a formal recognition for WHO's 194 member states of the vital importance of mental health and their commitment to take specific actions to meet the global targets (Saxena, Funk, & Chisholm, 2013). As noted by WHO (2013), "the action plan has, at its core, the globally accepted principle that there is no health without mental health" (p. 6). In addition, the Recommended Principles and Guidelines on Human Rights and Human Trafficking from the Office of the High Commissioner for Human Rights includes a number of principles that include the need for governments to ensure access to adequate psychological care: "States shall ensure that trafficked persons are protected from further exploitation and harm and have access to adequate physical and psychological care" (Robinson, 2001, p. 1). Findings from the current research, however, suggests that we are lacking in several areas and that governments must work to fulfill their obligations to ensure children's rights to protection; the concept of a "right" means that it is a legally enforceable entitlement, which governments are obliged to respect, promote, protect, and fulfill.

Mental Health Needs

Findings from this study confirm some of the earlier findings pertaining to the psychological damage that may result from being trafficked for CSE (cf. Rafferty, 2013a). Key informants, however, identified additional mental health issues that have not been previously identified in the research literature on child trafficking (cf. Rafferty, 2013a). They include sexualized behaviors and sexual harassment and abuse from older girls at the facility, violent behavior by unscrupulous staff members and outside others, including sexual abuse and the use of physical and psychological abuse as a strategy to punish and discipline residents, and policies that detain children in locked facilities.

These findings suggest that the mental health outcomes associated with child trafficking for CSE cannot be overstated, and that every effort should be made to ensure that programs and policies are equipped to ensure developmentally and culturally appropriate mental health services for those who need them, and consistent with the commitments that governments have made on their behalf. In addition, future research is warranted to explore whether or not the additional mental health needs reported here prevail in other facilities and countries, as well as the extent to which they are consistent with issues discussed in related research involving other populations. For example, related research has identified peer sexual abuse, harassment, and violence in other types of residential settings for children (Barter, Renold, Berridge, & Cawson, 2004; Euser, Alink, Tharner, van IJzendoorn, & Bakermans-Kranenburg, 2013; Farmer & Pollock, 1998; Gibbs & Sinclair, 2000). In addition, reports of inadequate services are consistent with related research in other settings and may provide vital guidance for social policy, practice, and research involving children who have been trafficked for CSE. In a noteworthy review of the literature on sexual abuse in residential care from 1945 to 2011, for example, Timmerman and Schreuder (2014) found that although peer sexual abuse is one of the most common types of abuse, it is habitually ignored.

Availability and Quality of Mental Health Services and Supports

Findings from this exploratory study paint a dismal picture of the overall availability and quality of mental health services to address prevailing needs. They also report on additional barriers and challenges that confront children in government-run facilities (as opposed to those that were privately funded), victims with severe mental health problems, and those with long-term needs as a result of exposure to complex trauma. In addition, findings identified noteworthy elements of good practice and related challenges associated with high quality and culturally relevant psychological–therapeutic interventions with important ramifications for programs, policy and research.

Promising Practices and Challenges

One key finding pertained to the important role that staff plays in creating a climate within the shelter and providing services that are culturally relevant and consistent with trauma informed principles and techniques, and particularly for children with complex psychological and social needs. Key informants highlighted the importance of the transcultural framework, whereby children in their care are viewed within a broad context and their complex needs are addressed through a holistic framework that addresses their range of needs. They noted, for example, how some cultures connect emotional and social problems, and how psychological wellbeing is influenced by multiple interrelated systems (e.g., physical, emotional, spiritual, social). Thus, they indicated that culturally appropriate mental health care is best viewed as one component of a broad range of interventions needed by children to promote their emotional wellbeing. They cautioned, however, that interventions that are considered to be promising in Western cultures may not be effective elsewhere, or may require substantial modifications to ensure their cultural relevance. They highlighted the use of alternatives to traditional therapies, including creative nonverbal therapies, such as art, music, play, and dance movement as playing a vital role in the successful recovery of children who experienced difficulty in the verbal expression of traumatic experiences.

These findings indicate that future research is warranted to assess the availability and quality of mental health services for children who have been trafficked for CSE in order to promote the availability of timely and appropriate mental health care. One key issue pertains to a lack of data on the proportion of child victims who are receiving the mental health services to which they are entitled to under international law. A second issue pertains to the need for program monitoring to address abusive practices within shelters that do not have strong programmatic and evaluation frameworks and appropriate monitoring to hold staff accountable. A third issue pertains to the effectiveness of the services that are being provided, including the factors associated with effective programming for children on their trajectory of recovery from CSE, including support services designed to address re-trafficking (secondary prevention interventions). Finally, future research might aim to identify the appropriate procedures and unique protection and support strategies when victims are children and not adults, as well as the required changes when programs that have been shown to be effective in the United States and other devel-

oped nations are being implemented elsewhere. For example, although TF-CBT has been shown to reduce trauma symptoms, there is a need to assess this treatment option for child victims of CSE, and particularly for those outside the United States. Ideally, future research will enable us to identify any necessary modifications and implementation strategies for child victims in international settings.

Although the topic of culturally relevant interventions for children who have been traumatized as a result of being trafficked for CSE has not yet been explored, related research has reported concern with the nature of mental health programming being rooted in Western psychology and the need for culturally sensitive approaches (Bryant & Njenga, 2006; Moghaddan & Taylor, 1986), the need for a global community psychology (Marsella, 1998), traditional and indigenous treatment and healing methods (Moodley, Gielen, & Wu, 2011), and critical issues to be considered when working with ethnoculturally diverse populations (Verdeli, 2016). Related research also supports the use of alternatives to traditional therapies benefits for survivors of trauma. Meditation and relaxation therapy, for example, are useful in reducing trauma symptoms among children affected by civil war (Catani et al., 2009), combat veterans (Rosenthal, Grosswald, Ross, & Rosenthal, 2011), and children who have been sexually abused (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010). The use of play and other developmentally appropriate creative therapies have also been shown to support healing and development in young children, adolescents and adults (Prendiville & Howard, 2016). Other research on mindfulness and meditation has found it to increase positive wellbeing and to decrease the somatic responses of several physical and mental disorders (Walsh & Shapiro, 2006). Finally, there have been practices for trauma sensitive yoga in order to be mindful of the symptoms and possibility for re-traumatization within this population (Emerson & Hopper, 2011). Future research might focus on assessing the effectiveness of the alternate forms of healing identified above for child victims in diverse cultures, including creative psychotherapies and spiritual practice as an autonomous intervention, or in combination with trauma informed treatments. Longitudinal research might also assess the effectiveness of different interventions in ensuring successful (re)integration and reducing the prevalence of being re-trafficked.

Findings from the current study suggest that research on the use of Western instruments for this population is warranted. Currently, there are not many assessment tools that are reliable, valid, and usable with several populations. Related research also highlights competences for mental health professionals providing services to culturally diverse populations that emphasize the need for research and modifications to standard interventions and assessment, and how they can be adapted for other cultural groups (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). Ager, Robinson, and Metzler (2014), for example, compiled several tools that are utilized for psychosocial assessment and identified three main challenges, including (a) cultural validity (many assessments do not clearly reflect how mental health is understood in certain cultures), (b) reliability (since assessments are influenced by culture, an assessment measure may be reliable in one setting and not in another), and (c) feasibility (difficult to find competent people who have time to administer comprehensive assessments).

Adequacy of Financial and Human Resources

Key informants routinely identified the lack of financial and human resources as major impediments to the provision of timely and appropriate mental health care. The overall shortage of human resources for mental health, and especially in lower and middle-income countries has also been described in the literature (cf. Kakuma et al., 2011). According to Maramis, VanTuan, and Minas (2011), for example, "Greatly improved education and training capacity, and re-orientation of training curricula to community-based practice, will be necessary to prepare professionals to work in new way and in unfamiliar settings" (p. 701).

The inconsistency in the education and training of the providers of mental health services highlights the dire need for quality education and training. The dearth of suitable training in both counseling and psychological support undoubtedly has an adverse impact on the quality of mental health care and services. Interventions are clear: Training programs need to be developed to ensure that individuals working with the children are providing quality and appropriate care. Related to the issue of education is the fact that some countries have no schooling in psychology, and training in social work is only recent. Future research may focus on education and training standards for staff who provide mental health and other psychosocial services for child victims in aftercare. There is a need for training centers for clinical psychology, an increase in training curriculums, education for mental health professionals, and the incorporation of mental health training into preexisting health professions.

Study Strengths and Limitations

One major strength of the current study is that it draws attention to the mental health needs of child victims of trafficking for CSE and the availability and quality of mental health services and supports following their identification as victims. Research has documented that identified child victims have a range of needs, but little research has focused on available services and mental health interventions for children to help them recover from their traumatic experiences and rebuild their lives. In addition, the transcultural study of mental health services for children who have been trafficked is relatively new and the present study represents a small step into this emerging body of research. In contrast with most research in this area, which is based on a review of reports or single programs, the current study incorporates the perspectives of participants from various settings in six different countries, including experts on the ground who are in the trenches of the work. In addition, it draws attention to the broader social policy context in which children are placed and aims to facilitate the implementation of appropriate and effective culturally relevant interventions. Finally, it draws attention to the need to develop standards for monitoring the quality of services that are being provided.

Notwithstanding the strengths of this study, the findings are limited in several ways. First, the approach was exploratory and further qualitative and quantitative studies are needed to promote an effective response. In addition, since the sample of key informants and program sites were not random, the results cannot be generalized to the larger population. Furthermore, it focuses only on those child victims who had been placed in aftercare programs for recovery and (re)integration following their identification. It

does not address the psychosocial needs of children who were not identified as victims, and those who were wrongly placed in juvenile justice facilities or simply deported (cf. Rafferty, 2016). Additional qualitative and quantitative research is needed to identify vital mental health program elements that facilitate the successful recovery of child victims. Finally, longitudinal research and interventions are required to identify effective strategies to facilitate the successful (re)integration of children into their home communities or integration into new communities following their recovery and rehabilitation. Children who were trafficked for CSE may also suffer stigma in their families and communities if and when they return home. Despite these limitations of this exploratory study, it is hoped that the information collected and presented in this article will provide a base for social policy and future research on this overlooked topic involving the psychosocial recovery of child victims of trafficking for CSE.

Conclusion

In conclusion, recognizing the importance of both physical and mental health for all children, a number of international and regional declarations, conventions, and treaties aim to safeguard human rights in general, as well as to protect children from the harms associated with trafficking for CSE. In addition, other international mechanisms for protection recognize the need for psychological support when children are exposed to traumatic events, including CSE, and provide guidelines on interventions to effectively address the mental health needs of child victims of trafficking. Findings from the current study suggest that greater attention must be paid to ensuring that the mental health needs of child victims are addressed in residential aftercare programs, including ensuring that adequate financial and human resources are made available to ensure the provision of quality and culturally relevant mental health care, governmental accountability, and ongoing monitoring and evaluation of existing programs and services. Furthermore, although the primary focus of this article is on the protection of children and mechanisms pertaining to the repair of the psychological damage caused to victims of child trafficking, it does not negate the importance of preventing this heinous crime, including the social, economic, and political factors associated with its tolerance and development (cf. Rafferty, 2013a), the improvement of effective strategies to ensure that all young victims are identified (cf. Rafferty, 2016), and immediate action to combat violence against girls and related violations of their human rights (cf. Rafferty, 2013b, 2013c). In addition, the specific barrier to timely and appropriate culturally relevant mental health services must be addressed.

Keywords: child trafficking; commercial sexual exploitation; mental health services and supports; psychosocial recovery; aftercare services

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Call for Papers: Special Issue on Psychiatric Rehabilitation for Veterans

Guest Editor: Richard Goldberg, Ph.D.

Submission Deadline: June 15, 2018

The Editors of *Psychiatric Rehabilitation Journal* are soliciting papers for a special issue devoted to the topic of advances in psychiatric rehabilitation in the Department of Veterans Affairs (VA) and other agencies serving Veterans. High quality research is sought on the range of psychiatric rehabilitation practices improve the functioning and quality of life of Veterans. We welcome treatment studies, including randomized controlled trials and quasi-experimental studies that demonstrate advances in the psychiatric rehabilitation of Veterans with psychiatric disabilities across the continuum of services, including vocational rehabilitation and peer support. We would also welcome rigorous research in the application of psychiatric rehabilitation approaches to novel populations, such as Veterans with posttraumatic stress disorder, traumatic brain injury and polytrauma. Manuscripts on implementation and evaluation of psychiatric rehabilitation training and practice efforts are also encouraged.

The Guest Editor overseeing this special issue is Richard Goldberg, Ph.D., Professor, Division of Psychiatric Services Research-Department of Psychiatry, University of Maryland School of Medicine and Director, VA VISN 5 Mental Illness Research, Education and Clinical Center (MIRECC).

All papers will be peer reviewed, and authors should note that submission to this special issue does not guarantee acceptance.

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Questions regarding the special issue should be directed to the Guest Editor, Dr. Richard Goldberg (Richard.Goldberg@va.gov), or to the Incoming Editor, Dr. Sandra Resnick (Sandra.Resnick@yale.edu).