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The Mental Health Aspects of Trafficking in Human Beings

A Set of Minimum Standards

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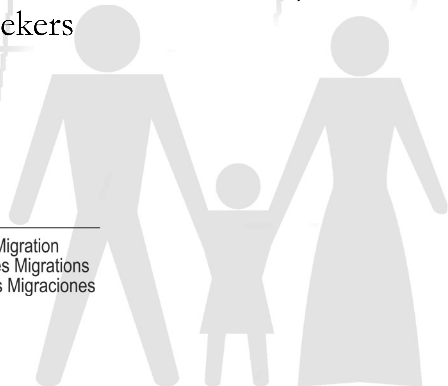

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OIM Organisation Internationale pour les Migrations
OIM Organización Internacional para las Migraciones

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The front and back cover pictures of this publication manual were drawn by trafficked persons assisted by IOM.

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FOREWORD

In a continued effort to emphasize the important links between health and trafficking of human being, the IOM Regional Mission in Budapest, Hungary, upon the initiative of the US Ambassador to Budapest, HE Nancy G. Brinker, organized a conference in March 2003, to which were invited health and counter-trafficking experts from across the region. Of the many different health concerns that were highlighted during the conference, psychological problems were an important and recurring theme. The subsequent Budapest Declaration, adopted by the participants of the conference, effectively noted that, "minimum health care standards should be established for trafficked victims. These standards should be developed through a partnership of governments, inter-governmental and non-governmental organizations, and academic institutions, and should be based on comprehensive research and best practices." Following this initiative, as part of a long process to promote the discussion of health care for trafficked persons and with the generous financial support of the US Department of State, Bureau for Population, Refugees and Migration (PRM) IOM invited an expert team from various backgrounds, to develop and run a curriculum and compile a training manual on mental health assistance for trafficked persons. In accordance with the Budapest Declaration's advices, a set of functional minimum standards of care in the area of mental health has been developed to supplement the Training Manual as well.

The Minimum Standards presented in that booklet, recognize the fact that a significant number of trafficked persons are traumatized by their experiences, and psychological scars often take much longer to heal than physical scars. However, this is not to say that other health issues faced by trafficked people, such as sexual and reproductive heath, and a broad range of physical traumas are of any less importance. On the contrary, minimum standards must be established in these and other areas as well, in order to ensure that the health care assistance offered to trafficked persons is truly comprehensive, beneficial and appropriately designed to their specific health problems.

These Minimum Standards aim to provide a guiding tool for all types of organizations who are already acting or are intending to develop programs in the field of combating trafficking. Furthermore, the standards aim to help the implementation of comprehensive and co-ordinated psychosocial care of trafficked persons from the time of their rescue to throughout their reintegration process. We hope you will find these Standards useful and that the work on mental health care of trafficked persons will continue to progress.

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INTRODUCTION

This document publication seeks to help managers, planners and caseworkers of the International Organisation for Migration (IOM), its partner organisations, as well as governmental bodies and institutions and NGOs develop and implement effective and high-quality psychosocial support programmes for trafficked persons and groups, in a standardised and co-ordinated way. The document summarizes a series of baseline standards for comprehensive and co-ordinated psychosocial care of trafficked persons throughout the process of their rescue from forced labour, slavery, torture, and humiliation. These Minimum Standards are intended as a supplement to the recently compiled and published *Training Manual* focusing on mental health aspects of counter-trafficking (IOM, Budapest 2004), and expand on other related sources and training materials aiming at counter-trafficking.

DEFINITION

The notion of "standards" hereby should be interpreted as a series of *measures* or *evaluation criteria* for the establishment, development, functioning, and monitoring of mental health aid programmes for **trafficked persons**, in general.

The term "beneficiaries", used throughout this text refers to those trafficked persons being assisted in short-, mid- and long-term shelters either by the IOM or by other organizations.

PURPOSE

As in many other fields of human services (e.g. medical services), standards for mental health care of trafficked persons are meant to regulate and harmonize investments in the following three sectors of resources and contribute to their rational use:

1. The promotion of co-ordinated organisation development in counter-trafficking on both national and international level;

2. The meaningful and uniform development of staff training in counter trafficking both at single country and cross-country level

3. The definition of evaluation criteria for the assessment of new action projects in the field of counter trafficking.

TAXONOMY OF STANDARDS

Given the fact that the mental health needs of trafficked persons are multi-dimensional in nature and origin, and owing to the fact that they are *changing* over time depending on the resources available, the standards outlined below offer a two-axial approach to resource development (A x B).

The first (A) axis, *Structural-operational standards*, provides a classification scheme for eight major clusters of standards. The second (B) axis makes each of these eight sets of standards specific to *Functional units* of service provision, taking into account the approximate length of the needs at various locations and/or organisation units of IOM and/or its partners. The grid for this two-way classification of standards is shown in the follo-wing table:

Table 1. Two-axial taxonomy of standards for mental health care of trafficked persons

(A) *Standards*	*(B)* *Functional units (levels) of services provision*		
	Short-term care (up to 72 hours)	*Mid-term care (2-3 months)*	*Long-term care (> 3 months)*
1. Environmental Standards			
2. Staffing and Team Composition			
3. Staff Training and Development			
4. Job Assignments			
5. Management			
6. Programme Activities			
7. Record keeping and Reporting			
8. Ethical Standards and Professional Conduct			

Each chapter of this publication is preceded by its respective grid and **all eight Minimum Standard grids are available at the end of this publication as a reference tool.**

1. ENVIRONMENTAL STANDARDS

1.1 DEFINITION

Environmental Standards refer both to physical and psychosocial conditions that should provide trafficked persons with a safe place for accommodation in a physical and social setting. This includes free access to selected resources which are necessary and indispensable for the maintenance and promotion of physical, mental and social well-being.

1.2 RATIONALE

Victims of trafficking are persons , who arrive at IOM or other humanitarian organization supported transit and/or rehabilitation centres after lengthy deprivation from a full range of basic human rights to adequate housing, security, personal identity and dignity. Consequently, appropriate environmental conditions represent one of the most powerful tools in the mental health care and rehabilitation of trafficked persons. This holds true even in circumstances when no specific mental health assistance services are momentarily available or do not seem urgently necessary.

1.3 SHORT-TERM SHELTERS

Short-term shelters are expected to provide accommodation for a temporary stay of up to three days, although this may vary from shelter to shelter depending on country and needs (e.g., prolonged process of evidence gathering). Given the emergency purpose of their existence , short-term shelters typically provide only a minimum of indoor space and material assistance. This particular type of shelter accommodates up to 8 persons in a dormitory-style arrangement. Short-term shelters are expected to have the following facilities, as minimum requirement:

- *One multi-purpose room for daily activities*, where encounters with other beneficiaries and with support staff can take place , as well as the use of telecommunication facilities.

- *A separate room for interviewing, counselling, and office work*. The room may be used also for storage of first aid medical equipment, files and other documents.

- *Sleeping room(s)* which should not accommodate more than three occupants. (smaller shelters may have up to eight beds in a single room). Occupancy of a sleeping room should, as much as possible, be left to the mutual choice of the beneficiaries. The beneficiaries must be allowed to keep their personnel belongings.

- *A kitchen* for shared use, including satisfactory facilities for the preparation and cooking of food, a sink supplying hot and cold water, a dinner table of appropriate size, table ware etc.

- *Hygiene facilities*, including a bath or shower, toilet and washing facilities for daily use by all beneficiaries.

1.4 MID-TERM SHELTERS

Mid term shelters should be suitable for a wide range of activities, and cover most of the trafficked person's physical, psychological and social needs, as well the needs of the staff. Housing conditions must provide accommodation for a period of 2 to 3 months. The building should be suitable for both indoor and outdoor activities. The following facilities meet these requirements

- *Counselling room* for multi-purpose activities, large enough to provide space for 5-10 comfortably seated occupants . In addition to focus programme activities (e.g., group counselling), the room could be used for a wide variety of leisure-time social, recreational, cultural and/or religious activities as well, if appropriate and needed.
- *Sleeping room(s)* accommodating from 2 to a maximum of 5 persons/room. Shelter managers must do their utmost to avoid crowding based on the number of beds at their disposal. , However, the availability of beds, but also the number of the available staff, the range of programme activities, and budget considerations will also determine shelter occupancy rates.
- *Child friendly room*, arranged and maintained on a regular or a temporary basis, according to needs. This room is specifically designed for children and caters to their recreational and educational needs... It should be equipped with toys, educational materials, as well with facilities for physical exercise. In addition, the shelter should provide a secure outdoor area for children with suitable play facilities.
- *Separate mother-child room* for that can accommodate up to two mother-child dyads. The accommodation of women and children should aim to normalize the situation as far as possible and provide an opportunity for individualization, participation and culturally sensitive parental care. Adequate privacy for breastfeeding should be preserved and baby change tables should be available.
- *Kitchen* for joint use by the beneficiaries and the staff with satisfactory facilities for the preparation and cooking of food, including a sink with running hot and cold water. The kitchen must have sufficient space for mothers to prepare food for their infants and be equipped with the necessary utensils.
- *Hygiene facilities*, including a bath or shower, toilet and washing facilities for shared daily use.
- *Work station* for the staff equipped with adequate furniture, telecommunication facilities, and providing storage area for storage of first medical aid, files and other documents.
- *Sick room* for beneficiaries with infectious diseases, both for urgent medical health assistance and/or continuous treatment and care.
- *Outdoor space* for providing fresh air activities. As a minimum requirement, beneficiaries of the shelter should have free access to the use of a small-size garden, safe balcony, especially if the length of stay exceeds 3 months.

The following optional standards should be considered in order to provide mental health and therapeutic benefits and improve the subjective well being and quality of life of beneficiaries:

- Leisure room to listen to music, watch TV or video, use a telephone and fax
- Physical activity room with some sport equipment to maintain and/or recover fitness levels
- Reading room with a small-size library
- Vocational training room.

1.5 LONG-TERM SHELTERS

Long-term shelters accommodate trafficked persons during a phase of reintegration and, in many cases, also function as rehabilitation centres in the country of origin. The length of stay can extend over 3 months. The major difference between long-term shelters and the previously described short- and mid-term shelters is that beneficiaries are now free to enter and leave the premises without permission or supervision. Long-term shelters may be independent housing unites (operated, for instance, by local NGOs), or constituent parts of larger state or privately operated social and/or health institutions, such as state or county hospitals. As far as physical facilities are concerned, long-term shelters are requested to meet nearly the same minimum standards as mid-term shelters, and these are the followings:

- *Counselling room or large living room for group- and workshop activities* (large enough to accommodate 5-10 persons, as minimum)
- *Sleeping rooms*
- *Child friendly room*
- *Mother with child/children room*
- *Staff Work* station
- *Kitchen*
- *Hygienic facilities* (separate for women and men, if needed)
- *External support services room* for the use of special services provision (e.g., individual counselling, medical examination)
- *Outdoor space* for rest and leisure time activities
- *Sick room* (unless available in nearby hospital complex or other local health facilities)

2. STAFFING AND TEAM COMPOSITION

2.1 DEFINITION

By definition, *staff* refers to the corps of employees of a certain work organisation, whose individual jobs may or may not be interrelated. At a higher level of staff organisation, however, the notion of *team* refers to a group of people, whose work activities are necessarily interrelated and based on partnership.

2.2 GENERAL RULE

Given the fact that mental health is *not*, and should not be considered the province of any single profession (psychiatry, psychology or any other discipline) , the mental health care of trafficked persons should be entrusted to *multidisciplinary teams*. By rule, such teams are consisted of persons of different formal (professional) qualifications, of paraprofessional helpers (volunteers), staff management and technical (support) personnel.

2.3 TYPES OF WORKING TEAMS AND THEIR COMPETENCIES

2.3.1 Core teams

Core teams are typically small-size multidisciplinary work groups, organized in shifts, providing direct (person-to-person) services with around the clock coverage. The composition of core teams should be the same or similar at all levels of services (short-, mid-, and long-term care) in order to ensure fluid and coordinated information sharing within teams and throughout the cross-country counter-trafficking network. The size of the core teams may vary between 3 to 5 persons. With a 5-member core team, the following posts should be filled by qualified professionals.:

1. *Case manager*. The first-contact resource persons for small groups of beneficiaries, s/he co-ordinates service provisions on a personal basis (up to 5-6 beneficiaries/month). Case managers are expected to share all needed information on beneficiaries with other team members via regularly arranged daily case conferencing.

2.1 *Medical doctor* (usually with a specialization as a General Practitioner). In addition to case management, s/he takes responsibility for physical check-ups, screening for infectious diseases, conducting clinical diagnostic interviews, providing first aid interventions, as well as for planning and coordinating more complex and specialised treatment plans and referrals, if appropriate and needed.

3.2 *Nurse*. This staff person with a formal training in nursing, in addition to case management, takes responsibility for the physical well-being of beneficiaries, and provides technical support in particular to the Medical doctor and in general to other team members (e.g., in administration, networking and communication).

4.3 *Staff manager*. Preferably a qualified social worker, s/he is responsible for monitoring the work and social conditions at the facility; and provides professional support (peer counselling) to all other case workers in data gathering and solving social problems of beneficiaries (e.g., gathering background data on family conditions of victims).

5.4 *Security guards*. These staff persons are assigned by local law enforcement authorities to provide ad hoc security both for the beneficiaries and services providers at given facilities and sites of services provision, as well as during times of transportation.

2.3.2 Extended teams

The expression refers to interacting networks of mental health and other professionals recruited and hired by core teams, on a case-to-case basis, to provide specialised health and mental health services to individual and/or groups of beneficiaries with special needs for clinical and/or legal intervention. Members of such teams may include:

1. Psychiatrist/psychotherapist
2. Clinical psychologist/psychotherapist
3. Legal advisor
4. Epidemiologist/infectologist
5. Gynaecologist
6. Paediatrician
7. Interpreter/translator
8. Accountant
9. Facility manager
10. Technical support staff.

The psychiatrist/ psychotherapist and/or clinical psychologist/psychotherapist of the extended team may also provide supervision back-up for core staff and in administer the mental and physical health of all care personel in the facility, ensuring that burn-out and fatigue is minimized (see Section 5.3.2).

A vocational or educational trainer/specialist may also be included as an optional member of an extended team at long-term shelters.

The size and composition of extended teams may vary, according to local needs and financial resources. Their job assignments should be set to an on-call (case-to-case) basis. However, the recruitment criteria and on-the-job training programmes for professional members of extended teams should be the same that apply for the recruitment of the core staff (see Section 5).

3. STAFF TRAINING AND DEVELOPMENT

3.1 DEFINITION

Staff's specialized training and development in general constitutes a continuous process of enhancing specific knowledge, understanding, specific interpersonal helping skills, work habits, attitudes, self-confidence, self-help skills, and on-the-job behaviour of *all* care personnel, regardless of former qualification, in order to meet minimum standards of professional and ethical competence for tasks they are expected to accomplish in given settings, under given circumstances, and with available resources at hand.

3.2 CRITERIA FOR TRAINING PROGRAMME DEVELOPMENT

Given the fact that counter trafficking is a stage-wise, multi-plan process, staff training and development may have different goals, contents, varied audiences and applicability to different organisational settings and available resources. The basic thematic framework of training and all levels of care is expected to closely follow the thematic structure of the IOM *Training Manual*, with necessary adjustments and adaptations according to specific needs of local audience and teaching-learning resources. However, the fundamental criteria for training programme development at all levels and types training should be the same, and these are the following:

- *Standardisation.* Ensuring international networking in counter trafficking, with its "grass roots" in commonly agreed standards of organisation and staff development.

- *Applicability to different audiences.* The training programmes should benefit the interest and learning needs of rather heterogeneous audiences, ranging from lay community volunteers to mental health professionals.

- *Applicability to varied needs.* The programmes are expected to be comprehensive, yet flexible and open-ended in order to meet different types of training: initial, follow-up, refresher or remedial, and advanced.

- *Applicability to various teaching/learning methods.* Training programmes should make effective use of diverse teaching/learning methods and technologies: lecture, case study, video, role playing, etc. The may also be implemented in different training formats, according to needs and circumstances: weekend seminars, workshops, self-paced reading or experiential learning.

- *Effectiveness.* Programme developers and trainers should empirically assess and monitor the effectiveness of their programmes in major domains of training objectives, such as, knowledge, attitudes, and practical helping skills.

3.3 TYPES OF TRAINING PROGRAMMES

IOM mental health and educational experts propose two types of training programmes for care personnel working with trafficked persons:

1. *Training of Trainers (ToT) programmes* on regional levels of IOM activities. The aim of these programmes is to enable multidisciplinary teams of potential trainers from different countries (general practioners, psychiatrists, social workers, psychologists, nurses etc.) in the acquisition of a common knowledge base for effective transfer of helping competencies to local care personnel working with trafficked persons. The first such training workshop was implemented and checked for general acceptability and viability in May 2004, in Budapest, Hungary, with the participation of 25 mental health professionals from 13 countries of Central, South East, and Eastern European countries.[1] Similar ToT training programmes should be developed and organized for teams of potential trainers in other regions of IOM activities, either as introductory courses for new teams of potential trainers or advanced courses for trainers already involved with the implementation and/or supervision of training activities countrywide. It is recommended, that the length of ToT-type training workshops be spread over 10 working days (6 hours per day), and that their content be based on the thematic framework of the IOM *Training Manual* and the present series of *Minimum Standards*. It is also recommended that the ToT-level trainees be a mixed groups of professionals with formal qualification (general practitioners, mental health specialists, psychologists, nurses, social workers, etc.) and with previous experience in work with trafficked persons at varied sites (IOM shelters, transit centres, rehabilitation centres or other health and social services in their home countries). As participants of the training, these professionals play a dual role of trainer and local resource persons. Post training, they are expected to act as one of the main organizers and promoters of local, Country Level Training programmes, as well as main facilitators of public awareness raising about public health and mental health aspects of trafficking in humans in their home countries.

2. *Country Level Training (CLT) programmes* are intended to raise the qualifications of care personnel working with trafficked persons countrywide, at different sites and facilities. According to the current proposal, the length of the CLT-type courses should be the same as set for the ToT-type courses (60 hrs intensive training), spread either over 10 working days (6 hours per day) or several consecutive weekends, depending on the availability of participants, local conditions of accommodation of the participants, transport, etc. CLT-type courses should be offered continuously, thereby educating and training as many local-level care personnel as possible, from all levels of mental health assistance, and in participants' native language. If an international expert is invited to give a presentation, then an interpreter should be hired or bi/tri-lingual participants may act as interpreter on an ad hoc basis.

The core curriculum of all CLT-type training programmes should be, basically, the same as that of the ToT-type courses, i.e., based on the IOM *Training Manual* and the hereby-specified *Minimum Standards*. Within this structure, the training should be in part theory, in part experience sharing, and in part experiential learning (e.g. problem-based learning and creative problem solving). Formal lectures on mental health issues can be delivered by either the participants of a regional ToT-type training, by local experts on trafficking, local experts and health care professionals from related fields (e.g., general medicine, psycholo-

[1] See "Mental Health and Trafficking: Training of Trainers Workshop: Daily Schedule. May 16-24, 2004. Budapest, Hungary.

gy, psychiatry, social work, and/or nursing) and/or by international experts[2]. The teaching-learning activities should be segmented and should range from initial (basic) to more advanced (special) skills training curricula, as listed below. Local training staff would be recruited from various sources, including but not limited to, ToT trained individuals. The ToT trained staff will be core members of the local training personnel, whereas other members would be selected among local professionals familiar with mental health issues, trafficking issues, gender issues etc., not necessary specialized in mental health care of trafficked persons. It has been recommended, that each CLT team to be composed of:

- 3 core trainers (with completed regional TOT training), present for the entire duration of the training who introduce core topics and facilitate small group discussions, etc.
- 5 co-trainers, each covering one of the five core topics (chapters) outlined in the *Training Manual* (see Section 3.4, below).
- 1 international expert as an external resource person, as a suggested minimum, preferably from the IOM Regional Co-ordination team (RCT)

3.4 LEVELS OF TRAINING

The following core programmes are outlined in some detail. They are conceived as series of self-contained "training packages" (modules) that should be developed and implemented sequentially, and continuously checked for effectiveness.

3.4.1 General introductory course

Goal: To advance understanding of the mental health aspects of trafficking of human beings in modern society, and to advance knowledge of basic standards that IOM (and its NGO partners) offer as resources and strategies for counter-trafficking, including care for helpers themselves.

Audience: The programme should address both professional and non-professional personnel providing personal (direct) care of trafficked persons in any form or purpose.

Methods: Seminar combining various teaching/learning activities (reading, lecturing, experiential case studies etc.).

Length: 2 workdays (12 hours)

Thematic structure:

1. Roots and paths of trafficking in national and international perspectives
2. Health and mental health consequences of the trafficking process from the perspective of trafficked persons
3. Providers' perspective in counter-trafficking

[2] Szilárd, I. (October 2004): Country Level Training (CLT) Skeleton. (Draft)

4. Theoretical framework of mental health assistance to trafficked persons: case management and programme implementation

5. Role stressor, compassion fatigue, "burn out", and helping the helpers in the process of counter-trafficking

6. IOM Minimum Standards as basic guidelines and criteria for quality assurance in providing mental health assistance to trafficked persons (as outlined in this document).

Specific training goals:

At the end of the course, trainees are expected to be able to demonstrate:

- an understanding of the basic facts on the magnitude, trends, and causal factors of trafficking in countries and regions of prime interest for the audience.

- knowledge of a wide variety of criminal acts, techniques of coercion and violence, "typically" used by traffickers at different phases of the trafficking process.

- factual knowledge of major categories of mental health impairments due to the trafficking experience, including basic knowledge of sign and symptoms of PTSD and related acute and chronic mental disorders.

- basic knowledge of major principles and strategies of mental health assistance and protection of persons and groups affected by the trafficking experience, with an emphasis of IOM minimum standards for support.

- basic knowledge of major risk factors endangering helpers' physical and mental health, as well a sound knowledge of minimum standards of self-care in combating chronic stress and early "compassion fatigue" and "burn-out" at their sites of professional activity and in their social and familial environment.

3.4.2 Basic-level skills training

Goal: To advance basic interpersonal helping skills for caseworkers responsible for the mental health protection of trafficked persons and groups held in law enforcement facilities or under the supervision of governmental (police stations, shelters, detention centres etc.).

Audience: The programme should address both professional and non-professional personnel providing personal (direct) care of trafficked persons in any form or purpose.

Methods: Small-group workshops combining modelling, role-playing, and experiential case studies (e.g., on video when possible).

Length: 3 workdays (18 hours)

Thematic structure:

1. The art of effective communication with persons and groups in distress
2. Basic interviewing skills in different settings (probation office, shelter, doctor's office, hospital, community agency, etc.)
3. Basic skills for effective group work in enclosed settings (shelters, transit centre, hospitals, etc.)
4. Strategies and techniques of effective stress management and crisis intervention
5. Record keeping and case reporting skills.

Specific training goals:

At the end of the course, trainees are expected to be able to demonstrate:

- (a) skills for planning and preparing a first-contact interview with a person who may have been subject to the trafficking experience, (b) greeting skills, (c) rapport building skills, (d) interviewing skills, (e) listening and observation skills, and (f) interview termination skills.
- effective use of selected assessment tools in standard use by the local team (e.g., check lists, rating scales), excluding the use of specialized and copyrighted psychological tests and other clinical diagnostic instruments.
- adequate leadership skills for organising and facilitating small group activities for various purposes (e.g., leisure time activity groups, self-help groups), excluding group-therapy activities at this stage of casework.
- appropriate behaviour in acute crisis situations, including specific interviewing skills, situation control, assessment and referral.
- transfer skills of at least two simple, easy-to-use techniques of relaxation and stress reduction (e.g. breathing exercise & progressive relaxation), and their "know-how" for implementation in every-day case work, whenever needed and appropriate.

3.4.3 Intermediate level skills training

Goal: To facilitate the acquisition, rehearsal, and transfer of specific professional competencies necessary to meet minimum standards for the development, implementation and monitoring of mid-term rehabilitation and reintegration programmes at IOM associated institutional or community settings.

Audience: Mixed groups of case workers and extended team members providing mental health assistance and psychosocial support to trafficked persons at facilities designed for mid-term care (2-3 months).

Methods: Small-groups workshops (7-15 persons) using a combination of problem-based learning with experiential modes of training, including role-playing, modelling, peer coaching and mentoring.

Length: 3 workdays (18 hours)

Thematic structure:

1. Screening and diagnosing minor and major mental health impairments
2. Planning and conducting problem-solving interviews
3. Communicating health information, advice and guidance
4. Basics of client-centred psychological counselling and psychotherapy
5. Basics of group counselling and creative problem-solving
6. Strategies and techniques of helping to cope with chronic stress and crisis situations
7. Strategies and techniques of social skills training.

Specific training goals:

At the end of the course, trainees are expected to be able to demonstrate skills in:

- conducting standardized clinical (screening) interviews
- planning and carrying out problem-solving interviews
- conveying (potentially) threatening medical diagnosis
- giving advise, direction and guidance on a personal basis
- the effective use of non-directive techniques of counselling
- planning and conducting a group counselling session
- planning and implementing a short-term psychotherapy programme, in free use and combination of varied techniques of verbal and non-verbal therapies (optional).

3.4.4 High-level skills training

Goal: To facilitate the transfer and dissemination of specific skills necessary to meet minimum standards for the development, implementation and monitoring of long-term rehabilitation and reintegration programmes in favour of trafficked persons and groups upon their resettlement in countries of origin.

Audience: Mixed groups of case workers and extended team members providing mental health assistance and psychosocial support to trafficked persons at facilities designed for long-term care (over 3 months).

Methods: Small-groups workshops (7-15 persons) using a combination of problem-based learning with experiential modes of training, including role-playing, modelling, peer coaching and mentoring.

Length: 2 workdays (12 hours)

Thematic structure:

1. Creating small-scale social programmes for reintegration and community support
2. Empowerment and enabling through self-help and mutual aid
3. Specific therapeutic techniques fostering effective coping and recovery
4. Dealing with social exclusion, hostility and aggression

Specific training goals:

- At the end of the course, trainees are expected to be able demonstrate adequate knowl edge and effective use of:
- Empowerment and enabling skills
- Negotiation skills
- Contracting skills
- Networking skills
- Social skills training competencies
- Mediation skills
- Advocacy skills
- Skills in dealing with interpersonal- and/or community violence against ex- formerly trafficked persons and groups
- Skills in organising and conducting simple creativity and/or vocational training workshops
- Leadership skills in organising and facilitating self-help/mutual aid groups
- Job training and staff management skills
- Organisational skills in media work (health education and public awareness raising)
- Designing and organising small-scale, local community-focusing action research projects.

3.4.5 Time structure of daily course a/ctivities

Experience shows that structuring the daily schedule of activities is most convenient both for the trainees and the trainers, if organized in the following optional manner:

Activity	Duration
1. Theoretical presentation: Part I.	30-60 minutes
2. Questions and Answers plenary	30 minutes
3. Experience sharing/skills training in small groups: Part I.	90 minutes
4. Plenary discussion: Part I.	30 minutes
5. Rest hour (lunch)	60 minutes
6. Theoretical presentation: Part II.	30 minutes
7. Experience sharing/skills training in small groups: Part II.	90 minutes
8. Plenary discussion and evaluation: Part II.	30-60 minutes

3.4.6 Course evaulation

On a short-term basis, the administration of a standardised achievement tests is recommended as an end-of-course evaluation tool, in combination with subjective assessments of its effectiveness, acceptability and appropriateness from the participants' perspective. However, skills take time and application to develop. Thus, a delayed evaluation conducted 2 to 6 months after the completion of the training is recommended. This second evaluation would focus the observation and analysis of trainees' reactions and communication skills in real-life situations.

4. JOB ASSIGNMENTS

4.1 DEFINITION

In the broadest sense, "*job assignments*" means matching: (1) job requirements with (2) personal assets/capabilities of a candidate to accomplish certain tasks under (3) given circumstances. To put it simply, "job assignment" means *authorization* or *positioning* of persons to accomplish certain tasks under certain working conditions, taking into account their formal educational background (qualification) and personal characteristics (fitness and aptitude).

4.2 RATIONAL

Due to the fact that mental care is a multi-disciplinary field for social action, particularly in the context of counter-trafficking, IOM standards of job assignment to different tasks, at varied work conditions, and with different staff composition (core vs. extended teams), should be regarded as one of the most complex responsibilities of staff management and staff development. Consequently, job assignment at IOM supported facilities call for clear-cut standards and accountability.

4.3 GENERAL RULE

In general, the criteria and practice of job assignment (nomination, authorization) rests on clearly defined job requirements (task descriptions) in terms of prescribed duties that an employee with an appropriate educational background (or on-the-job training) is expected to accomplish at a given position. Hence, task descriptions usually include clear-cut statements about:

- Input situations job holders "typically" face in a given work environment (tasks)
- Decisions they have to make (or should make)
- Actions they have to take (or should not take)
- Tools or job aids they should (or can) use
- Expected outcomes of each action
- Specified quality standards for each action and/or outcome.

Due to the considerable complexity of tasks in the realm of mental health care, including multiple roles assigned to single caseworkers, job requirements in counter-trafficking programmes cannot be expected to be as specific as those in other settings. Only general guidelines for day-to-day activities, duties and responsibilities of staff members formulated for mental health assistance of victims at diverse sites of service provision. This strategy leaves room for local initiatives to recruit and develop human resources, according to needs. Hence, the following standards have been recommended by the IOM experts regarding job assignment issues at different levels of mental health care for trafficked persons.

4.4. JOB ASSIGNMENT PROCESS

4.4.1 Job assignment in short-term care

All psychosocial staff at short-term transit facilities are expected to pass the first two IOM's training programmes, i.e., general introductory (theoretical) module and basic skills training (see Section 3), as a minimum prerequisite for job assignment. At this level of care the following basic tasks are expected on a daily basis:

1. Intake interviews
2. Health assessment
3. Stress and crisis assessment
4. Information support and personal guidance
5. Referrals (if needed and appropriate) to more specialized professionals.

In principle, all members of the core-team of a facility for short-term care should pass the first two basic IOM training courses, as a minimum standard before or during her/his assignment to a certain job (see Section 3). Accordingly, management should respect the following standards in staff positioning:

- *Intake interviews* usually means conducting "first encounters" with newly arrived trafficked persons at the facility. An intake interview generally means fact-finding of two different types: (a) compiling non-clinical information, and (b) gathering health related information, including clinical data. Whereas all trained staff can assemble non-clinical data, health related and clinically relevant fact-finding should be entrusted only and exclusively to health professionals (e.g., general practitioner, clinical nurse, clinical social worker, clinical psychologist, etc.).
- *Health assessment:* "Assessment" on its own is not a diagnostic procedure. It refers to the process of collecting, validating, organizing, recording and communicating data (facts) about a person's physical, social and mental health functioning as part of the admission procedure. Whereas a medical examination can only be provided by a professional trained in medicine (i.e., a medical doctor or, in some instances, by a nurse), other core team professionals trained in mental health (psychologists, nurses, social workers) can assess social and mental health functioning.
- *Stress and crisis assessment* usually represent an integral part of the health assessment procedures. Accordingly, the same job assessment criteria should apply in terms of having mental health professionals conduct the acute (active) crisis assessments and stress management. However, in emergency situations when no mental health professional is available (e.g., during late-night admissions), non-professional staff members with appropriate training and specific job descriptions at hand (e.g., trained volunteers or security guards), should accomplish the task and undertake necessary measures, including situation control, psychological "first aid", and referral as needed and appropriate.

- *Information support and personal guidance.* One of the basic expectations from all trained caseworkers, regardless of differences among them in formal vocational background, is to be well-prepared in providing beneficiaries with information on both general and personal matters (including basic legal advice) and guidance to alleviate disorientation, situational anxiety, blocks in communication, and increase the ability to cooperate and to make informed decisions. The goal is to enable and empower trafficked persons as early as possible for full participation in the case management process, including awareness raising on legal matters. This is a complex and sensitive task, which in conventional health services setting is referred to as "*patient (or client) education*". Hence, information support and guidance should be *not* entrusted to care personnel with no specific (IOM sanctioned) training for work with trafficked persons. Conveying potentially unwelcome medical and/or mental health information should be entrusted to health professionals, if asked for and appropriate.

- Referrals: Referral to specialists' care should be made or approved by professionals, who are either members of the facility's core team or members of a hired extended team. Prescription of medication of any kind is the sole and exclusive responsibility of medically trained health professionals (i.e., medical doctors or, in some instances by nurses following medical orders).

4.4.2 Job assignment in mid-term care

All psychosocial staff at transit centres and/or other facility providing mid-term care (up to 3 months) are expected to participate in all of IOM's training programmes up to intermediate level skills training (see Section 3). At these functional units, the following tasks are expected on a daily basis:

1. Intake interviews (optional if the beneficiary is transferring from a different facility)
2. Health assessment and follow-up (optional if the process was completed elsewhere)
3. Diagnostic procedures (optional, as needed and appropriate)
4. Brief psychotherapeutic care and counselling (if needed and appropriate)
5. Referrals (if needed and appropriate).

Most of the above listed task requirements are the same or similar to those listed for the short-term care facilities. However, there are two specific job descriptions and related job assignment criteria that ask for special attention at the level of mid-term care:

- *Diagnostic procedures*. All diagnostic procedures should be entrusted to health and mental health professionals, matched with their basic and specialist educational background.

  - *Medical* diagnostic procedures should be accomplished by medical personnel (general practitioners, specialists), both at the level of screening and more in-depth clinical diagnostics.
  - *Psychiatric/psychological screening and diagnostics* should be entrusted to staff members specialized in clinical psychiatry and/or clinical psychology; in using generally acknowledged international standards and criteria for mental health diagnostics (preferably WHO's ICD-10).
  - *Psychological testing* must be assigned exclusively to a clinical psychologist.
  - *Nursing diagnostics*, a component of medical diagnostics and treatment plan, must be carried out by a clinically trained nurse with sound knowledge and experience in applying international acknowledged standards of nursing diagnosis and procedures.

- *Brief psychotherapy*, including client-centred therapy (the IOM expert team's preferred approach), should be entrusted only to mental health practitioners (clinical psychologists, psychiatrists, and, in some instances, clinical social workers) who have specialized beyond regular academic training, and who have sound prior experience in the use of these techniques in caring for other vulnerable groups with similar mental health problems, including victims of violence (e.g., family violence, rape, incest, battered women, victims of terrorism or victims of wars). Practitioners specialized in psychotherapy should have trained *supervisors* as external resource persons for their own personal psychosocial support. Organization and facilitation of psychosocial support programmes, such as *art therapy* workshops, *group counselling* sessions, *mutual aid* group sessions and the like, can be assigned to other mental health practitioners (e.g., psychologists, nurses, social workers), who may have only on-the-job training (e.g. basic training course).

4.4.3 Job assignment in long-term care

All psychosocial staff are expected to successfully complete all of IOM's training programmes, including high-level skills training (see Section 3). At this level of care the following basic tasks are expected:

1. Intake interviews (optional if the beneficiary is transferring from a different facility)
2. Health assessment and follow-up (optional if the process was completed elsewhere)
3. Diagnostic procedures (optional, as needed and appropriate)
4. Psychotherapeutic care and counselling (if needed and appropriate)
5. Occupational training/ counselling (optional, as needed and appropriate)
6. Creating and managing small scale social programmes
7. Referrals (if needed and appropriate).

Most of the above-listed task requirements are the same or similar to those listed for staff working at short- and mid-term care facilities. However, two additional specific job descriptions and related job assignment criteria are necessary for long-term shelters. These are:

- *Occupational training/counselling* assumes organisation of short-term in-service or outreach job-training courses for the beneficiaries of needed rehabilitation and/or reintegration programmes, including aid in job seeking in the local community or elsewhere. This task can be assigned to *vocational education specialists* working as consultants to the facility's staff. These adjuncts staff may be hired periodically from local vocational schools and provide services on an on-call basis.
- *Creating small-scale social programmes* as an integral part of the rehabilitation and the reintegration process. Essentially, it refers to choosing and developing of local action programmes of different formats, according to needs and resources, including public education programmes (e.g., media work), outreach and fund-raising programmes, organising time-limited or open-ended groups such as in-service (or community based) support or self-help groups (e.g. Alcoholic Anonymous model groups), task-focused or problem-solving groups (e.g., job-creating groups), social or recreational groups, etc. The creation and maintenance of such programmes should be the shared responsibility of all psychosocial staff at a given site, with the main role of coordination and management assigned to trained *social workers* and/or *community nurses*, if any available amongst the core- or extended team members on the board.

5. MANAGEMENT

5.1 DEFINITION

In the domain of mental health care for trafficked persons, the management aspect of short-, mid- and long-term care involves overseeing the running of the facility and ensuring that the minimum standards set out in this document are effectively met. Management in this context encompasses not only the act of managing but also the body of managers or senior staff in charge of a facility. With this in mind, management should be multi-disciplined in its focus and attempt to disseminate to all staff as much knowledge and understanding of the issues concerning the mental health care of trafficked persons as possible. The scope of good management will range from the local (the supervision of the functional aspects of the shelter, the assistance offered to trafficked persons) to the universal (setting up communication systems and networking partnerships in the area and the region, lobbying and advocacy work and providing overall accountability to donors and organizations).

5.2 MULTI-DIMENSIONAL GUIDELINES

The minimum standards of management presented in this document are multi-dimensional in nature and are guidelines applicable to all levels of assistance to trafficked persons. No distinctions are made between the management of short-, mid- and long-term assistance or care facilities.

5.3 SCOPE OF MANAGEMENT ACTIVITIES

5.3.1 Staff recruitment and development

As a general rule, both the recruitment of new staff and compensation for staff turnover should be transparent, socially non-discriminative, and closely supervised by IOM authorities and/or partner experts.

The *recruiting process* itself should follow a stage process, and be entrusted to a team of experts in counter-trafficking. The main components of the hiring process should include:

1. Needs assessment
2. Preparation of position description and job requirements
3. Application procedure (via public announcement)
4. Selection procedure (including interviews with applicants)
5. Candidate notification and hiring.

The following *selection criteria* should apply:

- Educational/professional qualification of candidates matched with job requirements
- At least two-years work experience in human services (preferably in mental health)

- Major motivations and personal incentives leading to the application for work with trafficked persons
- The breadth of personal knowledge on trafficking in humans
- Cross-cultural competence, including fluent command of a foreign language (optional).

Psychological testing should *not* be conducted as part of the selection process. Instead, various dyadic interviews should lead to the best candidate's selection.

The recruitment of staff is one of the primary tasks of management. Depending on the needs of the facility, but also with reference to the minimum standards set forth under Section 2, management should ensure that the following staff is recruited on a full and part-time basis:

- Medical doctor (preferably a general practitioner);
- Nurse;
- Social worker and/or a psychologist; and
- Psychiatrist, legal advisor, other specialist as seen fit.

In recruiting staff, it is paramount that management be aware of the ever-changing needs of the facility, and ensure that the recruitment of staff cover all the needs of the trafficked persons. The following recommendations are encouraged:

- Offering the option of female health care staff and general practitioners;
- Guaranteeing the availability of translation services;
- Providing a multi-cultural framework of understanding and sensitivity; and
- If needed, hiring external experts.

5.3.2 Human resource development

Beyond the task of recruiting highly trained and competent staff and insuring their integration into seamless team work, management must also ensure that all service providers receive all necessary additional training or continued education in a variety of fields. Human resource development focuses broadly on:

- the acquisition and improvement of knowledge with regard to specialized areas of expertise that relate to the delivery of services to trafficked persons. Hence, training should periodically be proposed on advances in victimology and the health and mental health effects of trauma, in particular as it relates to phenomena of violence and sexual violence towards women, men, children and sexual minorities,
- the development of skills fostering cultural competence and sensitivity as the beneficiaries often stem from a range of countries and unfamiliar cultures,
- the training necessary to enhance professional team-building skills witth due attention to limit-setting, time management, communication between team members and with supervisors and management, and

- the increased awareness of an overarching ethical framework set in the respect for human rights and professional codes of conduct (see Section 8).

Additionally, it is primarily management's responsibility to protect the health and mental health of each staff member by ensuring that continuous attention is given to the potential untoward effects that affect service providers to trauma victims. This well documented scientific field should be familiar to management which must be able to recognize subordinates exhibiting reactive stress signs of so-called "Compassion Fatigue", Secondary Traumatization Stress Disorder or Burnout. To effectively contribute to the prevention of these conditions, to favour job satisfaction and reduce high turnover rates, management should also invest in:

- the organization of peer support groups in which staff members under strain can seek psychological support,
- the provision of optional individual supervision for all staff by mental health professionals, psychiatrists and psychologists, specialized in this delicate service, and
- setting up staff development workshops designed to enhance the resistance of the professionals working in direct contact with trafficked persons.

5.3.3 Maintenance of facilities

The purview of management also encompasses the oversight of the care facility on a long-term and day-to-day basis. This includes guaranteeing that the highest hygiene standards are maintained, that the rules and regulations of the facility are followed, that both staff and assisted persons are fully aware of their tasks and responsibilities, and that a consistent level of quality is provided, in such matters as food, shelter, clothing, training, etc. Within this sphere, management should consider such issues as providing effective guardianship for minors and/or mentally impaired beneficiaries and meeting the specific needs of mothers with children.

5.3.4 Communication and networking

For the growth and strengthening of the facility and for the continued productivity of the staff, communication and networking are essential on the following multiple levels:

1. Between International reporting systems and databases and the care facility: Management should take all efforts for co-operation with and access to health databases (e.g., global counter-trafficking health databases), counter-trafficking databases (e.g., MIMOSA), and international reporting systems and statistics.
2. Between management and staff: Data concerning the facility (e.g., the figures shared with international reporting systems, developments in the field, etc.) should be shared with staff. The aim is to make the role of the facility as transparent as possible and to engender a sense of responsibility and inclusion for all staff.

3. Between the care facility and any specialised staff/care personnel: A system of ongoing contact, especially in the case of emergencies, must be in place to make sure that on-call health care specialists such as a psychiatrist or legal advisor are easily accessible and available when needed.

4. Between beneficiaries, care personnel and the public/governments/hospitals: The highest standards of confidentiality with regard to the transfer and sharing of data of trafficked person should be stressed by management. The interests and rights of the beneficiaries are paramount. Staff should be made aware of the importance of informed consent, and of the need for confidentiality at all levels, especially when personal beneficiary data is shared between facilities (short-term to mid-term for example) and/or with hospitals. In the case of minors or the mentally impaired, a guardian or legal representative must be made available.

5. Between management and local/regional/national bodies: management should also strive to set up networks of expertise and knowledge in the area and in the region. This networking also enhances advocacy on issues regarding trafficked persons and is a powerful tool to lobby for change with governments, IGOs, NGOs, etc., for the benefit of counter-trafficking and mental health care initiatives.

6. Between the care facility and medical facilities in the region: In case of labortory needs or further medical or surgical management that cannot be met by the facility, contracts or connections with university clinics, private clinics and laboratories is helpful.

7. Between Country of Destination/Transit (CoD/T) care facility and Country of Origin (CoO) care facility: A recommended minimum standard in this area would be to have some system of back reporting in place, with emphasis on client privacy. If there are no IOM systems of care in place in the CoO, the IOM care facility in the CoD/T should attempt to set up partnership relationships with respected, recommended local NGOs in the CoO.

8. Between various care facilities: Ensure that communication between care facilities and centres in the area, region and country are maintained so each can learn from the other and continually improve on their ability to provide quality services.

9. Between management and donors/partner organizations: It is vital that management is operationally transparent and facilitates full accountability to donors and partner organizations.

5.3.5 Financial Management:

When drafting budgets, management should take into consideration the costs associated with meeting the mental health needs of assisted trafficked persons in the facility and of mental health care personnel. Ideally, mental health activities and costs on a country level will be reflected in the programme's budget.

6. Programme Activities

6.1 Definition

The expression refers to daily and/ weekly activities that are intended to assist in the physical and psychological recovery of trafficked person. Whenever possible, the ultimate goal is to reach full reintegration in the community of origin of the beneficiary. Programme activities should have a holistic approach in addressing the mental health needs of the trafficked persons.

6.2 Rational

The physical and mental well being of trafficked persons during their stay at any type of facility greatly depends on the activities developed by the assistance providers. Any assistance programme should provide different activities as part of the centre/facility/shelter's schedule.

While the emphasis on the initial stage of the assistance should focus on meeting the immediate basic needs of the trafficked person, in the long-term, providers should develop comprehensive assistance programmes tailored to address, on one hand, the specific needs of each person, and, on the other hand, those factors/aspects that decrease the vulnerability of the person in the trafficking cycle.

6.3 Standards for short –term care activities

Usually the first 72 hours up to 2 weeks are critical in order to ensure the co-operation and participation of the assisted person within the overall assistance programme. As such the approach should be gradual, non-intrusive and focused on building the trust between the assistance providers and the beneficiary.

6.3.1 Initial intake and accommodation

At every stage of assistance, and especially at initial point of contact, the safety and security of the trafficked person should come first. Safe accommodations are provided for newly referred cases whether or not they are clear or potential trafficked persons.

At the initial point of contact, it is recommended to postpone a direct inquiry as to the beneficiary's history/situation, especially if police or another agency's worker has already interviewed her/him. In this case, the assistance provider should obtain in advance some basic information from the person or agency making the referral.

Any direct inquiry should prudently focus on addressing and meeting the immediate basic needs: food, sleep and rest. Verification should be made of any specific or urgent health complaints that require immediate assessment by a health professional. Additionally, caseworkers should facilitate contact or communication between the trafficked person and her/his family or close friends (only if safe and requested by the trafficked person).

The caseworker should be able to observe and note the trafficked person's status at the initial point of referral, as well as provide simple, clear and concise information about the shelter and the assistance process. This should be repeated in greater detail the following days, as well as whenever the trafficked person requests additional information.

Alternatively, a basic observation check-list should be filled out by the initial caseworker on aspects related to the trafficked person's general appearance, emotional status, level of awareness and interaction. This should not be carried out in front of the trafficked person and should never replace the crisis assessment performed by a trained professional.

6.3.2 Crisis Assessment and Intervention

Given the severe impact of the trafficking experience, assessment and crisis interventions are closely interrelated procedures and are part of a more complex procedure which includes: ensuring immediacy and control, assessment, intervention, referral and follow-up as presented in more detail in the *Training Manual*.

It is highly recommended to use checklists of the most common crisis-related indicators. These are also to be completed (along with other paperwork) after the initial personal encounter with the trafficked person. Such check-lists for the assessment of acute crisis states may include tools for crisis assessment, stress assessment, assessment of impact of traumatic events, family support resources vs. family conflict assessment, and for screening (eventual) alcohol and/or drug dependency (see the section on "Recommended Assessment Tools and Techniques" in the *Training Manual*).

The timing and setting of the crisis interview should always be adjusted to the physical and mental conditions of the trafficked person.

In emergency situations, only basic-data should be collected. Later on, a more in-depth interview and more elaborate case-reporting should be arranged.

Experience dictates that most of the trafficked persons require some form of psychological first-aid intervention. Please refer to the *Training Manual* for specific steps/rules that must be taken into consideration when providing psychological first-aid interventions.

6.4 STANDARDS FOR MID -TERM CARE ACTIVITIES

6.4.1 Initial intake and accommodation

If the trafficked person will ultimately be assisted by a different organization, all relevant data/information gathered on the beneficiary, including evaluations of his/her further needs and further recommendations or actions, must be transferred to the other agency/mission. This should be done with the informed consent of the beneficiary and only after all the procedures have been fully explained to her/him (e.g., how and to whom the data will be transferred).

Aspects and principles of crisis assessment and intervention equally apply at this stage. This holds true especially when a trafficked person has been repatriated to her country of origin (CoO) after s/he went through a very traumatizing experience or after a long period of time outside of his/her CoO.

If the trafficked person already participated in an either an IOM/NGO/Government based assistance programme before being transferred to a mid-term assistance process, and if the relevant information has been transferred to the follow-up agency, the initial intake phase should also focus on explaining the new assistance framework as well as the following steps that apply to the beneficiary.

6.4.2 Needs and mental health assessment

An in-depth mental health assessment should be performed if the trafficked person has returned to his/her CoO. Indeed, standardized tests/questionnaires should be made more readily available on the trafficked person's language. Also, the observation period of the trafficked person affords a more comprehensive evaluation of his/her mental functioning.

A thorough assessment should always begin with an open-ended interview during which the client should have the opportunity to speak about his/her situation freely with minimal interruption from the mental health professional.

In addition to the current mental status that the trafficked person is presenting, the initial needs assessment should also include a more systematic/detailed questioning on the family structure and history, family life and relationships, temperament or personality attributes, as well as the person's mental health functioning prior to having entered the trafficking cycle.

Additionally, an ecological approach to assessing and intervening puts a strong emphasis on social functioning rather than on mental dysfunctioning and is considered particularly useful in the daily practice of assisting trafficked people.

An ecologic approach relies on three basic areas of assessment and intervention:

- Needs assessment (both former and present) – in the context of available resources;
- Assessment of personal aspirations (both former and present) – in the context of available opportunities; and
- Assessment of personal assets (capacities and strengths) at the time being – in the context of personal or general (societal) expectations for change.

6.4.3 Counselling and support

Individual counselling sessions/psychotherapy sessions should follow the assessment phase. The approach should be gradual and adapted to the beneficiary's individual needs and attitudes. A therapist/counsellor should never impose a form of treatment that suits only the provider interests or capacity.

In order to ensure a holistic approach, counselling and support should be integrated in the multi-disciplinary team approach. The counsellor/therapist also seeks to gradually facilitate the integration of the beneficiary in regular programme activities, including group work if the opportunity is provided at the facility.

Regarding group counselling, it is important to avoid lumping heterogeneous populations together. Indeed, when for example minors are also beneficiaries, if the age difference is too great with the adult trafficked persons, separate treatment groups should be set up.

6.4.4 Occupational and recreational activities

In order to ensure a multi-dimensional approach, the assistance framework should include regular occupational and recreational programmes. These programmes may be offered in alternative secure facilities.

As at the early stages of assistance, beneficiaries are accommodated in closed facilities, it is essential to provide an in-house regular set of and recreational activities. Group activities should be an essential part of the overall assistance programme, as they are inherently therapeutic and take place in a non-threatening environment made up of the trafficked person's peers.

Group activities can be scheduled either as:

- Daily type of activities, e.g., reading, listening to music or watching movies, if possible even gardening. These are activities that can be organized in an unstructured, simple and friendly manner.
- Bi-weekly activities, e.g., art and crafts, music/dance, poetry/drama/role play. These activities are usually implemented in an organized manner and coordinated either by a qualified therapist or by a trained caseworker. Trafficked children tend to respond well to these activities which can be psychotherapeutic.
- Weekly activities (especially under conditions of long-term care), e.g., specific vocational workshops like sewing, cooking, knitting. These activities offer the advantage of helping trafficked persons recover practical skills and may lead to some form of professional certification. A qualified vocational trainer should act as supervisor for these activities.

6.4.5 Education and guidance

Education, which is extremely relevant when dealing with trafficked children, as they are likely to have missed important periods of formal learning, must be at the centre of the beneficiaries' schedule.

As soon as possible, it is necessary to foster learning opportunities by offering educational classes, tutorials, or entering children in local schools programmes (when safe and appropriate). Teaching basic literacy and algebraic skills is an important step in empowering children. The same principles also apply in the case of adults who are illiterate and have never had the opportunity to study before.

6.4.6 Preparation for reintegration

This phase should take place only after the trafficked person has completed the initial rehabilitation process and must be a focus of the psychotherapeutic intervention/counselling programme.

It should include an assessment of the beneficiary's community in order to identify the presence of risk factors. Indeed, the caseworker must survey further potential for violence, the risk for the beneficiary of returning to the trafficking cycle, the degree of likely stigmatisation the beneficiary may have to endure, and the overall and an analysis of the family dynamics and its socio-economic conditions.

A preliminary reintegration plan should be developed with the active participation of the trafficked person and, if at all possible, with supportive family members.

6.4.7 Facilitating faith-based support and/or self-help groups

Any assistance and reintegration programme should be able to identify and include a community-based component in order to ensure a sustainable re-insertion of the trafficked person into society. The importance of this component rests on the fact that most assistance aid programmes are typically run with limited funds and over limited periods of time. But it is also well known that community support groups are buffers to the heightened risk of social exclusion and stigmatisation that typically hit ex-victims of trafficking after their resettlement in their CoO. Finally, both community-based faith and secular self-help groups provide one of the most promising avenues to help in the resettlement phase, nurturing the beneficiary's ability to regain trust and confidence in self and others, and to learn from others appropriate and effective coping strategies to deal with personal problems.

6.5 STANDARDS FOR LONG-TERM CARE ACTIVITIES

At this stage of assistance, all efforts and programme activities should concentrate on preparing the trafficked persons for an independent and self-sustained life.

6.5.1 Initial Intake and Accommodation

Sometimes the long-term assistance is provided by the same organization. It is also possible that the trafficked person is transferred to a semi-independent living facility or to another more community-based organization. As such the recommendations listed in the section dealing with the medium-term stage equally apply for the long-term assistance.

It should be underscored that the transfer process from one stage to another and often times from an organization to another and from a region to another has to be carefully prepared, considered and the subject of careful liaison between different facilities and colleagues.

6.5.2 Needs and mental health assessment

The recommendations listed in the section dealing with the medium-term stage equally apply for the long-term assistance. The emphasis at this stage must be on the monitoring and re-evaluation of the status of the trafficked person. This task should preferably be carried out by the same professional that made the past in-depth assessment and use the same psychological tests and assessment principles.

6.5.3 Counselling and support

Even if an initial contract has been set between the counsellor/therapist and the trafficked person, at this stage of the assistance process, it particularly appropriate to evaluate the progress that the beneficiary has made in order to be able to set future goals of the counselling and assistance programme.

6.5.4 Occupational training/guidance

The recommendations listed in the section dealing with the medium-term stage equally apply for the long-term assistance.

At this stage, the focus should be on including the trafficked person into a regular vocational programme based on her/his professional interests and skills, in accordance with the available employment opportunities (prior to vocational training, a vocational needs assessment must be conducted).

At this stage, the occupational and vocational components of the assistance programme are an important part of the preparation for reintegration.

6.5.5 Recreational activities

The daily and bi-weekly types of activities as presented in the section dealing with the medium-term stage equally apply for the long-term assistance stage.

Assistance providers should also include within their bi-weekly or monthly schedule activities that take place in the community rather than inside the centre (e.g., country side trips, theatre or cinema shows). The beneficiaries should also be given the opportunity to gradually take responsibility for organizing their free/leisure time.

6.5.6 Educational activities and guidance

Once more, these types of activities are extremely relevant when dealing with children or people that did not have the opportunity to study.

At this stage of assistance, the providers should make every attempt to organise the inclusion of the trafficked person within the mainstream educational system.

6.5.7 Preparation for Reintegration

It should include first of all an assessment of the person's progress and achievements. This has to be done with the active participation of the trafficked person and has to be linked with the initial reintegration plan.

Preparation for reintegration has to be connected with all other components of the programme and at this stage of the assistance process, it should include at least: facilitating life

skills training programmes (especially in the case of children), occupational skills or vocational training, job referral and gainful employment, as well as assistance in finding alternative accommodation.

6.5.8 Facilitating faith-based support and/or self-help groups

The recommendations listed within the medium-term stage equally apply at this stage of assistance.

7. RECORD KEEPING AND REPORTING

7.1 DEFINITION

By definition, *record keeping* means a continuous, step-wise process of gathering, organizing, filing (achieving), storing and saving data collected by *case managers*, as prime informants, for each individual "case" (person) taken into the process of mental health assistance at different points of time and sites, from different sources (observation records from intake interviews, medical diagnostic findings, mental health assessment documents etc.). Ideally, there should be three major components of a global, comprehensive record-keeping system both on national and international levels (yet to be constructed for international use, see Section 5.3.4):

1. Filing (archiving) personal ID data on trafficked persons taken into care at the time of admission to-, and at the time point of her/his transfer or release from a certain organisational unit;
2. Filing base-line data on physical and mental health functioning of persons taken into care at the time of admission-, during-, and at closing points of time to a particular mental health assistance centre;
3. Filing personal ID data on all caseworkers and their recorded interventions (helping services), who were (if ever) in personal contact with a given person (victim) at any point of time in the course of admission-, stay-, and/or release from the given facility, whether a transit centre or elsewhere.

On the other hand, *reporting* means transfer of client-centred databases (files) from one caseworker to another within the same organisational unit for care, or vertically, from local shelters and transit centres to higher level organisational units of counter-trafficking (e.g., local governments, IOM regional support centres etc.). Transfer of any personal database on trafficked persons should be strictly protected from abuse from different sites, and for different purposes (e.g. abuse for local corruption, social exclusion, or re-trafficking), according to ethical codes of conduct with trafficked persons themselves, and according to ethical codex of practice, that should be well-known and familiar to all professionals involved with providing mental health assistance for trafficked persons (see Section 8).

7.2 HEALTH INFORMATION SYSTEMS AND THEIR COMPONENTS

In the realm of counter-trafficking, the IOM-supported Health Information System (e.g. MIMOSA, in progress of development), asks for the establishment and standardization of record keeping and reporting standards, the components of which should be compatible with internationally accepted codes and comply with rules of contemporary epidemiological research.

It is envisaged that as a module of MIMOSA a Global Counter Trafficking Health Database (CTHDB) would be developed. This could provide unique possibility for a data collection / transfer and sharing system according to standardised manner, based on specific protocols and templates. The data entry accuracy and consistency should be secured

through training of those staff members who are included into the data entry procedure. The database and the standardised, secure data transfer system would serve the interest of both the trafficked persons' (improving the appropriateness and quality of the follow up treatment and care upon repatriation/ re-integration), and the CT programme planners', public health officers' and researchers' as well (providing a better understanding on the health impact and consequences of the phenomenon).

The information that is gathered should cover:

7.2.1 Basic personal/administrative data

This database comprises vital information to be included in all medical records and administrative files for each trafficked person.

7.2.2 Basic health data

This database covers all physical, mental and social health status information collected regarding the trafficked person from the moment s/he enters the facility until her/his departure. This particular database should include:

- Initial and monitoring notes from case managers or other care providers, any physical and/or mental health problems identified, any medical and psychosocial treatment or procedures carried out and results of any treatment provided, regular updates on current/future plans of care for each individual;
- Documented correspondence with partner institutions/agencies and referral letters regarding the beneficiary's condition and specific health and social care needs;
- Liaison documentation with legal authorities; and
- Any known information about the individual's relationship with family or other outside personal contacts especially in the case of minors or persons with special needs.

7.2.3 Discharge Summaries

In preparation for the transfer or departure from the facility's care, the designated case manager must prepare a concise Discharge Summary that captures all significant health information and plans of treatment and follow up. Specific attention must be taken to ensure that the assisted person, or the parent or legal guardian in the case of a minor or persons with special needs, understands what s/he is told and to how well equipped the assisted person is to address her/his own health needs once released from the care of the facility. Copies of medical records (such as laboratory results, x-ray results, specialist's consultation notes, etc.) and/or any other records including legal documentation that will be needed by the beneficiary must be provided, preferably in a language that is understood by the person and/or guardian.

7.2.4 Follow- up and referral notes

To facilitate and ensure that continued health care and psycho-social support is available or carried out, the designated case manager is responsible for preparing referral notes and for corresponding with the receiving facility and/or family member and/or health practitioner on the individual's condition and specific care needs. Whenever possible, a list of contacts that are able to meet the health and psycho-social needs of the trafficked person should be

offered/included in both the local and the departing beneficiary's native language. Where possible and with the explicit consent of the trafficked person, it is recommended that the case manager facilitate the referral to an outside organization or another health care facility through direct phone or letter contact.

7.2.5 Data file security and confidentiality

Because a trafficked person may have multiple files and be under the care of several team members as well as external consultants, there are risks to the security and confidentiality of all the health information. To avoid the loss or misplacement of vital information, care must be used at all times when handling records, even in situations when this may seem unimportant or innocuous. All documentation must be kept in a secure location and should never be left unattended. All facilities are highly encouraged to provide code numbers for beneficiaries in lieu of names. These code numbers should appear, in lieu of names, on top of every page of the file in case the documents are separated.

7.3 USE OF PSYCHIATRIC DIAGNOSTIC SYSTEMS

It is highly recommended that health practitioners use international standards to define diagnoses and treatment, e.g., the International Classification of Diseases 10 (WHO, ICD 10).

7.4 ROLE OF CASE MANAGERS IN DATA GATHERING, RECORD KEEPING AND REPORTING

It is the responsibility of the designated case manager to discuss the past/current mental and physical health status with the trafficked person in an appropriate language. It is imperative that no risk be taken that any health problems identified while in the care of the facility, any medical treatment procedures carried out (and the results thereof), any remaining health problems and the plans of action or treatment not be appropriately addressed.

7.5 SHARING OF DATA

Six key points on when and how to share the data of trafficked persons:

1. Communication about beneficiaries between staff members, or between staff and partner organizations/consultants should only take place on a "need-to-know" basis, and with the explicit consent of the trafficked person.
2. Information about cases should never be revealed to persons outside the facility (such as the police, or other outside providers) unless there has been specific permission from the trafficked person, and in consultation with the case manager and/or Facility Manager.
3. Communication about the trafficked person must not be shared between staff members in a public location.
4. Details of a trafficked person case should never be discussed with another trafficked person.

5. Staff members may discuss details of their work with the trafficked person they assist during (peer) supervision or in staff meetings, such as during mental health team meetings, supervisory meetings with a senior health worker or an outside health care professional

6. Staff members are forbidden to discuss cases and case details with the trafficked person's family and or friends, unless that the trafficked person gives her/his consent; or except in cases of minors when the family member is also their official legal guardian. However the child should be consulted to find out if, by revealing information about the child, s/he may be put in any danger or at risk for some form of hardship. In such cases, the assistance provider must seek legal advice from a legal officer.

7.6 STAFF REPORTING, MONITORING, AND EVALUATION

The staff manager, in collaboration with other team members, takes the responsibility to document and monitor the flow of major programme activities, the quality of organisational and work conditions, and the financial management of the facility. The staff manager prepares and submits annual reports to the IOM regional authorities and donors. The report should cover the following chapters, as a minimum:

1 Executive summary of major programme activities carried out thought the particular calendar year (status report as of December 31);

2. Summary statistics on services users, including background statistics, basic health information, and services provision for specific conditions;

3. Lists of staff and collaborators hired/employed on specific positions, including staff turnover;

4. Evaluation of major strengths and weaknesses (gaps) in the operation of the facility; and

5. Financial report on major expenditures (salaries and benefits, operational costs, etc.).

The comprehensive evaluation of the facility's operational characteristics and programme activities should represent by far the most important chapter of the staff reporting. In this respect, the involvement of *informal authorities* in the evaluation process is highly recommended (e.g., invited experts, representatives of local NGOs), as an independent reference group for quality assurance of services.

8. ETHICAL STANDARDS AND PROFESSIONAL CONDUCT

8.1 DEFINITION

In providing health and mental health services to trafficked persons, *all* staff carry out their duties to the best of their abilities within an intricate framework respecting human rights and obeying guiding moral principles, ethical standards, professional codes of conduct, legal directives, as well as institutional rules. This framework enhances the quality of services and ensures that each trafficked person is treated with the utmost regard for his/her human rights. Ultimately, ethical standards and professional codes of conduct (including attention given to the occupational mental health of staff) create the conditions for the provision of effective psychosocial care and thus enable trafficked persons to reintegrate the process of fulfilling their personal development.

8.2 GUIDING MORAL PRINCIPLES AND THE RESPECT FOR HUMAN RIGHTS

Generally accepted guiding moral principles in the provision of health and mental health services set aspirational goals (as opposed to binding regulations), and represent the overarching structure for meaningful professional action:

- Beneficiance and Nonmaleficence. In conducting professional duties, staff strives to benefit the welfare and rights of those with whom they work and take care to do no harm.

- Fidelity and Responsibility. Staff seeks to establish relationships of trust with the beneficiaries of their work and clarify their roles and interventions. They are aware of their responsibilities and of the impact of their professional behaviour, particularly when it can lead to potential harm and exploitation.

- Integrity. Professional assistance promotes accuracy, honesty and truthfulness. Unwise or unclear commitments must be avoided.

- Justice. Duties are carried out with equal fairness to all beneficiaries who are entitled to the same levels of quality.

- Respect for the worth and dignity of each person. Staff respects cultural, individual and role differences. Privacy, confidentiality and self-determination require deliberate attention. Special safeguards are implemented to protect the rights and welfare of persons whose vulnerabilities impair autonomous decision making (for example, minors, the mentally ill, etc.)

- Adherence to human rights as they are set forth in numerous declarations and conventions ratified by supranational organizations. Of particular relevance, among many instruments, are the *United Nations Declaration of Human Rights*[3], the *United Nations*

[3] G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948).

Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the *United Nations Convention Against Transnational Organized Crime*[4], *the United Nations Convention on the Rights of the Child*[5].

8.3 ETHICAL GUIDELINES SET BY PROFESSIONAL ASSOCIATIONS

Responsible professional practice demands personal and professional competence. This is strongly expressed in the *Budapest Declaration* (2003)[6]: "*Health care should be provided by trained professionals in a secure and caring environment, in conformance with professional codes of ethics (…)*".

The very nature of the multidisciplinary team approach (see Section 2.3.1) to assisting trafficked persons implies, at a minimum, that each staff member has completed formal professional training in his/her field of expertise. As such, in addition to applicable laws, s/he is committed to follow the ethical guidelines and the professional code of conduct designed by the association that regulates his/her profession within the community in which the professional duties are carried out. If no association regulates the profession s/he belongs to, the staff person should remain informed about the professional codes of conduct and ethical standards devised for his/her discipline at an international level. It is the staff person's responsibility to know precisely which ethical charts and which codes of conduct apply to his/her specific situation.

The following examples are illustrations of the situations faced by colleagues in different national settings. In addition to the ethical codes set by country associations, international standards are often also relevant, and there may be additional specialized guidelines for specific groups of beneficiaries (such as children, vulnerable populations, etc.) Each staff member must analyse his/her situation within the national context of his/her professional practice:

- A social worker trained or working in Great-Britain is bound to the *Code of ethics for social work* set by the British Association of Social Workers. S/he must also abide by the *International Declaration of Ethical Principles of Social Work* and the *International Ethical Standards for Social Workers* devised by the International Federation of Social Workers.

- A psychologist trained or working in Switzerland must abide by the *Ethical standards of psychologists and Code of conduct* of the Federation of Swiss Psychologists, as well as by the *Ethical principles* set by the European Federation of Psychologists' Associations.

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4 G.A. res. 55/25, annex II, 55 U.N. GAOR Supp. (No. 49) at 60, U.N. Doc. A/45/49 (Vol. I) (2001).

5 G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force Sept.2 1990.

6 Regional Conference on Public Health & Trafficking in Human Beings in Central, Eastern and Southeast. Regional conference hosted by U.S. Embassy Budapest, with funding from USAID, in cooperation with the International Organization for Migration (IOM), March 19-21, 2003, Budapest, Hungary.

- A psychiatrist trained and working in the United States of America must follow the *Principles of Medical Ethics* of the American Medical Association, the *Principles of Medical Ethics with Annotations especially applicable for Psychiatry* of the American Psychiatric Association, the *Code of Ethics* of the World Medical Association, and the *Declaration on Ethical Standards for Psychiatric Practice* of the World Psychiatric Association.

8.4 PROFESSIONAL CODES OF CONDUCT AND GUIDELINES FOR DIRECT ASSISTANCE

Professionals working for IOM or affiliated with IOM programmes must be familiar with and follow the organization's *Standards of Conduct* (2002), as well as the more specific *Principles of conduct for IOM staff members providing health services to migrants subject to involuntary movements, use of force or other forms of coercion* (2001) and the relevant sections of the *WHO ethical and safety recommendations for interviewing trafficked women* (2003) and the *IOM Handbook. Direct Assistance for Victims of Trafficking* (2004). The latter document stresses the most fundamental guidelines for ethically sound assistance to trafficked persons:

- Informed Consent. All assistance by IOM and/or by any other organization in charge of the programme is to proceed on the basis of the victim's full and informed consent.

  From the initial admission of the trafficking victim to the assistance programme up to the victim's full reinsertion into society, it is incumbent on the organization-in-charge's staff and any partner organizations and their staff, to explain relevant actions, policies and procedures in such a way that the victim can understand them before seeking consent to any proposal or action.

  At some stages in the assistance process, it will be necessary for the victim to indicate her consent in writing.

  If staff cannot communicate in a language the victim understands, all necessary efforts must be made to secure the assistance of an interpreter for oral and written communication.

- Non-discrimination. Staff must provide the best possible assistance to victims of trafficking without discrimination on the basis of gender, age, disability, colour, social class, race, religion, language, political beliefs or status.

  Staff shall take care to ensure that partner organizations and their staff observe the same obligation in regard to trafficking victims.

- Confidentiality and Rights to Privacy. All information and communication regarding the victim must be treated with due regard for the victim's right to confidentiality and privacy. From the first meeting with the victim up to the completion of the assistance process staff should assure the victim that all personal information regarding the person and the particular case will be kept confidential.

Confidential information includes, but is not limited to: information provided by the victim, information provided by health and other service providers and information regarding the victim's legal status.

Staff must handle all victim data responsibly, only collecting and sharing information related to the victim within the limited of the "need-to-know" principle and with the victim's informed consent. No information is to be released without the prior knowledge and informed consent of the victim concerned, except where the victim's safety and the safety of others are at issue.

- Self-determination and Participation. All care programme staff should recognize the right and need of victims to make their own choices and decisions, and encourage them to participate as much as possible in the decision-making process regarding themselves.

  Staff shall always work together with the victims towards the restoration of their self-respect and autonomy and to strengthen their confidence to assume responsibility for themselves and regain control over their lives and their future.

- Individualized Treatment and Care. While acknowledging that trafficking victims share a number of common experiences and circumstances, staff should acknowledge the individuality of victims and, to the extent possible, provide personalized care and assistance.

  Throughout the assistance process, staff should strive to provide the most appropriate protection, assistance and support measures appropriate to the needs and circumstances of individual victims.

- Comprehensive Continuum of Care. The services provided by IOM and/or by any other organization in charge of the care programme, should be part of a holistic approach to aiding the recovery of trafficking victims, thereby offering a comprehensive continuum of care in accordance with their physical, psychological and social condition.

  In order to ensure the appropriate nature and quality of the particular assistance offered to trafficking victims, IOM staff should collaborate with the other experiences assistance providers and establish cooperation agreements regarding the provision of appropriate and comprehensive services to victims.

- Equitable Distribution of Resources. Care staff should distribute and provide all services, materials and resources equitably and according to the need of the victims.

  IOM staff should facilitate access to all available resources and services for victims, including services provided by non-governmental, intergovernmental and state organizations.

- Best Interests of the Child. All assistance and protection shall be based on the principle that the best interests of the child will always be the paramount consideration.

8.5 PROFESSIONAL KNOWLEDGE AND CULTURAL SENSITIVITY

Professionals working with trafficked persons share the same requirements for specialized knowledge regarding health and mental health issues as colleagues working within the field of trauma, in particular as it relates to phenomena of violence and sexual violence towards women, men, children and sexual minorities. In addition, their skills must be honed to allow the provision of services with the utmost cultural sensitivity and competence. It is incumbent upon all staff and the organization to ensure that appropriate training and staff development take place to ensure cultural competence and that staff remain abreast of new knowledge emerging within their field of expertise.

8.6 STRESS, COMPASSION FATIGUE, BURNOUT: STAFF HEALTH

Stressful working conditions, undoubtedly the case for direct assistance providers in contact with trafficked persons, have the potential of generating many untoward effects on staff morale and personal functioning, as well as on the organization's effectiveness. It is therefore incumbent on management and on each professional to identify stress factors in the personal, professional and environmental/organizational dimensions, as well as to put in place corresponding action plans to ensure staff satisfaction, avoid high turnover rates due to compassion fatigue and burnout, and maintain the focus on the effective provision of services:

- In the personal sphere, staff must become self-aware of the positive and negative personal outcomes that stem from their lifestyle choices and act on these choices in order to better resist sources of stress. This covers many areas such as remaining engaged in family and social support networks, relaxing through creative expression, seeking skills development, paying attention to nutrition and sleep requirements, etc.
- In the professional sphere, staff must make adjustments to the manner in which tasks can be approached with different strategies and yet increase efficiency and the positive impact on beneficiaries. Examples of areas touched on are time management, setting appropriate boundaries with beneficiaries, building reasonable expectations with regard to personal investment and job commitment, the need for cooperation to carry out complex tasks, etc.
- Finally, in the environmental sphere, staff must develop a realistic understanding of the organization's functioning and strive to bring about changes that improve working conditions, such as clarifying task descriptions, better communicating between professionals and supervisors, etc. This is the context in which peer support groups and supervision (as it is practiced in mental health settings by experienced and specially trained mental health professionals) should be proactively organized.

The successful occupational health and mental health management of all care personnel and of colleagues serving in affiliated organizations ultimately amplifies the action in favour of the beneficiaries, i.e., the trafficked persons.

1. Environmental Standards - Right to shelter as basic human right Length of stay determined by country and needs - Security system - General shelter rules - Additional space recommendations for mid and long term care.	**Short-term (emergency response) Shelter** **Up to 72 hours/2 weeks** A. Space requirements: Enclosed and limited level of space provided B. Multipurpose room – daily activities C. Sleeping rooms D. Support staff room – interviewing, counselling, file storage E. Kitchen F. Hygiene facilities	**Mid-term Shelter** **2-3 months** A. Space requirements: Indoor and outdoor space provided B. Sleeping rooms C. Staff/Work Area/Stations D. Counselling room E. Mother with Child room /dyad F. Child friendly room G. Sick room H. Kitchen I. Hygiene facilities	**Long-term Shelter (Reintegration and sometimes rehabilitation phase)** **> 3 months** A. Space requirements: Indoor and outdoor space and supervise/permitted departure B. Sleeping rooms C. Staff/Work Area/Stations D. Counselling room E. Mother with Child room F. Child friendly room G. Sick room H. Kitchen I. Hygiene facilities K. External support staff room

2. Staffing and Team Composition	**Short-term Shelter** **Up to 72 hours/2 weeks**	**Mid-term Shelter** **2-3 months**	**Long-term Shelter** **> 3 months**
General Advice: - ensure 24 hours coverage - working hours by shifts - Assistance to Guardianship matters (for minors, persons with special needs) - Multi-disciplinary approach **Services by function** 1. Medical services 2. Psychosocial services 3. Legal services 4. Logistics support 5. Accountancy 6. Management	**Core team:** 1. Case manager 2. Medical Doctor (GP) – part time [with MH care training] 3. Nurse staff 4. Accountant/cashier 5. Staff manager 6. Security guards **Extended team:** 1.Psychiatrist/Psychotherapist 2. Clinical psychologist (The above two members may provide supervision back-up for core staff) 3. Legal advisor 4. Epidemiologist/infectologist 5. Gynaecologist 6. Paediatrician 7. Interpreter/translator 8. Accountant 9. Facility manager 10. Technical support staff Access to Extended Team (on-call, case to case basis)	**Core team:** 1. Case manager 2. Medical Doctor (GP) – part time [with MH care training] 3. Nurse staff 4. Accountant/cashier 5. Staff manager 6. Security guards **Extended team:** 1.Psychiatrist/Psychotherapist 2. Clinical psychologist (The above two members may provide supervision back-up for core staff) 3. Legal advisor 4. Epidemiologist/infectologist 5. Gynaecologist 6. Paediatrician 7. Interpreter/translator 8. Accountant 9. Facility manager 10. Technical support staff Access to Extended Team (on-call, case to case basis)	**Core team:** 1. Case manager 2. Medical Doctor (GP) – part time [with MH care training] 3. Nurse staff 4. Accountant/cashier 5. Staff manager 6. Security guards **Extended team:** 1.Psychiatrist/Psychotherapist 2. Clinical psychologist (The above two members may provide supervision back-up for core staff) 3. Legal advisor 4. Epidemiologist/infectologist 5. Gynaecologist 6. Paediatrician 7. Interpreter/translator 8. Accountant 9. Facility manager 10. Technical support staff Access to Extended Team (on-call, case to case basis) Recommended: Vocational/educational trainer/specialist

3. Staff Training and Development			
Criteria for all training programmes 1. Standardisation 2. Applicability to varied audiences 3. Applicability to varied needs 4. Applicability to varied teaching/learning methods 5. Effectiveness **Types of training programmes** 1. Training of Trainers (ToT) 2. Country Level Training (CLT) **A General Introductory Course** *can also be offered to provide advance knowledge of basic MH standards and strategies for counter-trafficking.*	**Short-term Shelter** **Up to 72 hours/2 weeks** **Basic Skills Level Training** A. Goal B. Audience C. Methods D. Length - 3 work days (18 hours) E. Themes F. Specific Goals	**Mid-term Shelter** **2-3 months** **Intermediate Skills Level Training** A. Goal B. Audience C. Methods D. Length - 3 work days (18 hours) E. Themes F. Specific Goals	**Long-term Shelter** **> 3 months** **High Skills Level Training** A. Goal B. Audience C. Methods D. Length - 2 work days (12 hours) E. Themes F. Specific Goals

4. Job Assignments (functional aspects)	**Short-term Shelter Up to 72 hours/2 weeks**	**Mid-term Shelter 2-3 months**	**Long-term Shelter > 3 months**
- Important need to recognize the emergency/critical cases (e.g., Psychotic, intoxication, aggression, suicide)	1. Intake interview 2. Health Assessment 3. Stress and crisis Assessment - refer to Crisis Assessment Summary Report Form p 110 of Training Manual 4. Information support and personal guidance 5. Referrals	1. Intake interview (Optional if transferring from a different facility) 2. Health Assessment and Follow up (optional if transferred and completed) 3. Diagnostic procedures (optional, as appropriate) 4. Brief psychotherapeutic care and counselling (optional, as appropriate) 5. Referrals (if needed)	1. Intake interview (Optional if transferring from a different facility) 2. Health Assessment and Follow up (optional if transferred and completed) 3. Diagnostic procedures (optional, as appropriate) 4. Psychotherapeutic care and counselling (optional, as appropriate) 5. Occupational training/counselling 6. Creating and managing small scale social programmes 7. Referrals (if needed)

5. Management			
- Multi-disciplined and multi-dimensional in focus - Recruiting process and Selection criteria should be transparent, socially non-discriminative and monitored by IOM, other organizations and/or partner experts - **Optional:** Female health care givers and GPs Translation Services Multicultural Framework of understanding Engaging external experts	**Short-term Shelter** **Up to 72 hours/2 weeks** **A. Recruitment of Staff** - GP or medical doctor - Nurse - Social Worker and/or psychologist - Psychiatrist, legal advisor, other specialist as needed **B. Human Resource Staff Development:** - Effective training on MH for TPs - Use of Training Manual - Protect health and mental health of staff **C. Maintenance of Facilities**: - hygiene, protection of minors, tasks and responsibilities of staff **D. Communication and Networking between:** - International reporting systems and care facility - Management and Staff - Beneficiaries, care personnel and public/government/hospitals; ETC. **E. Financial Management:** - mental health needs in budget	**Mid-term Shelter** **2-3 months** **A. Recruitment of Staff** - GP or medical doctor - Nurse - Social Worker and/or psychologist - Psychiatrist, legal advisor, other specialist as needed **B. Human Resource Staff Development:** - Effective training on MH for TPs - Use of Training Manual - Protect health and mental health of staff **C. Maintenance of Facilities**: - hygiene, protection of minors, tasks and responsibilities of staff **D. Communication and Networking between:** - International reporting systems and care facility - Management and Staff - Beneficiaries, care personnel and public/government/hospitals; ETC. **E. Financial Management:** - mental health needs in budget	**Long-term Shelter** **> 3 months** **A. Recruitment of Staff** - GP or medical doctor - Nurse - Social Worker and/or psychologist - Psychiatrist, legal advisor, other specialist as needed **B. Human Resource Staff Development:** - Effective training on MH for TPs - Use of Training Manual - Protect health and mental health of staff **C. Maintenance of Facilities:** - hygiene, protection of minors, tasks and responsibilities of staff **D. Communication and Networking between:** - International reporting systems and care facility - Management and Staff - Beneficiaries, care personnel and public/government/hospitals; ETC. **E. Financial Management:** - mental health needs in budget

6. Programme Activities	Short-term Shelter Up to 72 hours/2 weeks	Mid-term Shelter 2-3 months	**Long-term Shelter > 3 months**
- Daily, weekly activities - Intended to assist physical and psychological recovery - Holistic approach - Goal is for full reintegration into CoO community	**- First 72 hrs to 2 weeks critical.** **A. Initial Intake and Accommodation** **B. Crisis Assessment and Intervention**	**A. Initial Intake and Accommodation** **B. Needs and Mental Health Assessment** **C. Counselling and Support** **D. Occupational and Recreational Activities** **E. Education and Guidance** **F. Preparation for Reintegration** **G. Facilitating Faith-based Support and/or Self-help Groups**	A. Initial Intake and Accommodation B. Needs and Mental Health Assessment C. Counselling and Support D. Occupational Training/ Guidance E. Recreational Activities F. Educational Activities and Guidance G. Preparation for Reintegration H. Facilitating Faith-based Support and/or Self-help Groups

7. Record Keeping and Reporting	**Short-term Shelter Up to 72 hours/2 weeks**	**Mid-term Shelter 2-3 months**	**Long-term Shelter > 3 months**
or "Health Information System Management" - Guidelines applicable to short-, mid- and long-term care facilities	A. Health Information Systems and their Components: - Personal/Administrative Data -Health Data - Discharge Summary - Follow-up and Referral Notes - Data File Security and Confidentiality B. Use of Psychiatric Diagnostic Systems C. Role of Case Managers in Data Gathering, Record Keeping and Reporting D. Sharing of Data E. Staff Reporting, Monitoring and Evaluation	A. Health Information Systems and their Components: - Personal/Administrative Data -Health Data - Discharge Summary - Follow-up and Referral Notes - Data File Security and Confidentiality B. Use of Psychiatric Diagnostic Systems C. Role of Case Managers in Data Gathering, Record Keeping and Reporting D. Sharing of Data E. Staff Reporting, Monitoring and Evaluation	A. Health Information Systems and their Components: - Personal/Administrative Data -Health Data - Discharge Summary - Follow-up and Referral Notes - Data File Security and Confidentiality B. Use of Psychiatric Diagnostic Systems C. Role of Case Managers in Data Gathering, Record Keeping and Reporting D. Sharing of Data E. Staff Reporting, Monitoring and Evaluation

8. Ethical Standards and Professional Conduct	**Short-term Shelter** **Up to 72 hours/2 weeks**	**Mid-term Shelter** **2-3 months**	**Long-term Shelter** **> 3 months**
- Guidelines applicable across the board for short-, mid- and long-term care facilities - Duties must be carried out within an intricate framework of human rights, moral principles, ethical standards, professional codes of conduct, legal directives as well as institutional rules.	A. Guiding moral principles - Beneficience and Nonmaleficence - Fidelity and Responsibility - Integrity - Justice - Respect for dignity of individual - Adherence to human rights B. Ethical guidelines set by professional institutions C. Professional Codes of conduct and guidelines for direct assistance D. Professional Knowledge and Cultural Sensitivity E. Stress, compassion fatigue, burnout: Staff health	A. Guiding moral principles - Beneficience and Nonmaleficence - Fidelity and Responsibility - Integrity - Justice - Respect for dignity of individual - Adherence to human rights B. Ethical guidelines set by professional institutions C. Professional Codes of conduct and guidelines for direct assistance D. Professional Knowledge and Cultural Sensitivity E. Stress, compassion fatigue, burnout: Staff health	A. Guiding moral principles - Beneficience and Nonmaleficence - Fidelity and Responsibility - Integrity - Justice - Respect for dignity of individual - Adherence to human rights B. Ethical guidelines set by professional institutions C. Professional Codes of conduct and guidelines for direct assistance D. Professional Knowledge and Cultural Sensitivity E. Stress, compassion fatigue, burnout: Staff health