Supporting the mental health of trafficked people

Trafficking of people represents a gross violation of human rights that carries serious health consequences, including an increased risk of HIV, sexually transmitted infections, and violence. Although research on trafficking and health has primarily focused on HIV and sexually transmitted infections, much less information is available regarding other aspects of trafficked people’s health, including mental health issues relating to the trauma, violence, and human rights violations trafficked people often experience.

In The Lancet Psychiatry, Sian Oram and colleagues report prevalence of mental health morbidity among trafficked people in South London using data from a clinical registry of secondary mental health services. Although previous research has suggested a high prevalence of depression and post-traumatic stress disorder in populations receiving health and social services after trafficking, few studies have examined the mental health of trafficked people in broader populations. The use of routinely collected clinical records is a particularly important feature of the study by Oram and colleagues, in view of the complex ethical and practical challenges associated with the collection of primary data on trafficking and health.

In the study by Oram and colleagues, 103 (77%) of 133 trafficked people were female, and over half were trafficked for sexual exploitation. Although trafficking of people occurs across diverse occupational sectors—including the sex industry, domestic work, agriculture, and manufacturing—trafficking for sexual exploitation has often been singled out. The UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (the Palermo Protocol) defines trafficking of people as involving actions by a third party (e.g., recruitment and transportation); use of force, deception, or other fraudulent means; and purposes of exploitation (e.g., forced labour). However, trafficking for sexual exploitation has often been conflated with sex work (i.e., the sale or exchange of consensual adult sexual services) for ideologically and politically motivated reasons and because of challenges in defining and identifying trafficking. The Palermo Protocol definition remains complex and challenging to apply within health research, in part because of its criminal justice origins and emphasis on the actions of traffickers, rather than the experiences of trafficked people. Additionally, trafficking for sexual exploitation and sex work are often conflated on ideological and political grounds, as exemplified by the anti-prostitution pledge in the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, which required all recipients of funding from the US President’s Emergency Plan for AIDS Relief to explicitly oppose sex work, its legalisation, and sex trafficking until its repeal in 2013. Posing additional concerns to the accurate identification of trafficked people is the fact that health and social services providers in many contexts rarely receive evidence-based training in accurately screening and assisting trafficked people; indeed, previous work suggests that sex workers are often assumed to be trafficked by service providers and law enforcement, in part because of institutional policies and media messages that conflate sex work and trafficking.

Future efforts to ensure that trafficked people are accurately and safely identified and supported must remain a priority within both research and service provision. Research done in partnership with sex workers and trafficking survivors would be especially useful for establishing the most relevant and accurate means of identifying trafficked people in diverse settings. Additionally, continued efforts to train front-line workers (e.g., health-care providers, law enforcement, and social workers) using evidence-based methods for identifying and assisting trafficked people are needed.

Trafficked people who were receiving secondary mental health services in the study by Oram and colleagues experienced several severe traumas over their lifecourse. A large proportion (69 [52%] of 133) reported abuse during childhood before trafficking and ongoing violence and threats after trafficking. 60% of trafficked adults experienced some form of physical or sexual abuse during adulthood; 14% of trafficked adults also reported physical abuse and 10% sexual abuse after trafficking, thus showing the complex and cyclical nature of violence in trafficked people’s lives, which is rarely restricted to the trafficking experience alone. The fact that trafficked people were more likely to be compulsorily admitted into mental health care (adjusted odds ratio 7.61, 95% CI 2.18–26.60; p=0.002) and had longer admissions once in care (1.48, 1.01–2.15; p=0.045) than those who had not experienced trafficking calls attention to the need
for trauma-informed mental health services that are appropriately responsive to trafficked people’s unique needs and experiences. A large proportion of trafficked people were migrants from other countries, representing 17 diverse countries of origin among children and 33 among adults—suggesting the importance of the effects of migration when providing health and social services for trafficked people. Migration experiences are crucial determinants of mental health; for example, migrants often experience severe trauma related to the migration process (eg, detention or smuggling experiences, or stress related to adjustment to a new sociocultural context) and face disparities in access to mental health care. Finally, the multitude of human rights violations reported by trafficked people in the study by Oram and colleagues4 (eg, violence before trafficking and occupational abuses after trafficking), remind us of the need to incorporate human rights considerations into clinical interactions with trafficked people. To improve the wellbeing of trafficked people, the development, assessment, and financing of community-based health and social services that meaningfully involve trafficked people in their design should be pressing priorities.

Shira M Goldenberg
Simon Fraser University, Gender and Sexual Health Initiative, BC Centre for Excellence in HIV/AIDS, St Paul’s Hospital, Vancouver, BC V6Z 1Y6, Canada sgoldenberg@cfenet.ubc.ca

Genetic vulnerability in antipsychotic drug-induced diabetes

Studying a complex disease such as type 2 diabetes in patients uniquely predisposed to it can be quite challenging. In The Lancet Psychiatry, Debra Foley and colleagues1 report findings of such a study. In their observational study they included 1155 adult patients from the Australian National Survey of Psychosis who were diagnosed with a psychotic disorder and who had received a fasting blood test for type 2 diabetes. Using logistic regression, they assessed the effect of age, family history of diabetes, and current (defined as within the past 4 weeks) antipsychotic drug use on the risk for type 2 diabetes. After adjustment for older age, treatment with antipsychotics was associated with diabetes in those without a family history of diabetes (clozapine p=0.01, quetiapine p=0.02, aripiprazole p=0.07, risperidone p=0.07, and olanzapine p=0.32), but not in those with a family history of diabetes (clozapine p=0.34, quetiapine p=0.82, aripiprazole p=0.18, risperidone p=0.79, and olanzapine p=0.39).

Type 2 diabetes and obesity are polygenic and multifactorial diseases. Of the 175 genomic loci identified for type 2 diabetes and obesity, only a few are shared between these disorders, suggesting a predominantly distinct genetic background.2 However, most of the genes identified so far have a modest effect on disease risk, suggesting that both diseases are unlikely to develop without the individual being exposed to an obesity-promoting or

---