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Title	**Modern slavery in the UK: How should the health sector be responding?**
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Commentary

Modern slavery in the UK: How should the health sector be responding?

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Abstract

Modern slavery is crime of extreme exploitation. It includes the use of coercion, force, deception and abuse of vulnerability for such purposes as trafficking, labour, sexual exploitation, forced criminal activity and domestic servitude. It is a topic of growing interest in the UK and beyond as it has emerged as an issue of considerable scale and consequence. To date, debates have been dominated by a law enforcement perspective. Less apparent has been an articulation of the implications of modern slavery for the health sector. This is despite growing evidence of the dire physical and mental health consequences for survivors. This paper addresses this gap by confronting a series of issues relevant to UK health systems. After describing what is modern slavery and the nature of the problem, we identify how the health sector has responded to date. We then articulate how health services and public health can more coherently and systematically meet the challenges of modern slavery through policy and practice. Finally, we present a call for the health sector to position itself as a central to the wellbeing of survivors and as a fundamental ally in modern slavery prevention.

Introduction

Modern slavery has received considerable attention in recent years and is high on the policy agenda in Britain, as elsewhere (1,2). The UK now has a Modern Slavery Act (2015) and an independent anti-slavery commissioner. An independent review of the Act and how it has been enforced has recently been announced by the government. There are stories of modern enslavement in the British press almost daily and recent high profile public awareness campaigns funded by the Home Office. Modern slavery – which is inclusive of and more commonly referred to as human trafficking – is increasingly framed as having global and local reach; recent stories from Libya, London and rural Lincolnshire reveal criminal exploitation across geographies, societies and communities.

Less common are commentaries on its implications for the health sector, including health services and public health. There are indications that this is changing, however. New guidance is available for UK healthcare practitioners (3) and training is emerging on how to identify and support victims (4). Public health is becoming involved in local partnerships with the police, local authorities, victim support organisations and other agencies aimed at sharing intelligence and producing consistent and coordinated responses.

The modern slavery agenda has been historically 'owned' and led by institutions outside of health, specifically law enforcement, and a coherent case for why and how the health sector should contribute is yet to be articulated. As activity in this complex and controversial sphere gathers pace, now is the time to better articulate the rationale, parameters and content of a health services and public health response to modern slavery.

What is modern slavery and how big is the problem? [embed NHSE video clip]

Modern slavery is an umbrella term that includes the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. It includes holding a person in a position of slavery, servitude, forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after (5). It can include human trafficking, sex trafficking, domestic servitude, forced labour, forced criminality and organ harvesting. It clearly violates basic rights to health. The ILO/Walkfree Foundation identified 40.3 million people living in modern slavery in 2016. All global regions are affected with particularly high prevalence in Africa. Europe and Central Asia account for nine per cent of the global estimate (6). These estimates of the number of victims are very difficult to establish. The National Crime Agency estimates 'tens of thousands' in the UK (7). The Global Slavery Index identifies a prevalence rate of 2.1 victims per 1,000 of the population (6). Slavery can be seen as a 'cyclical' process that produces cumulative harm and renders freedom difficult to achieve (8,9).

How is modern slavery currently understood?

Globally and nationally, modern slavery is primarily framed as an issue of law and order, with the historical focus of effort being on capturing and prosecuting perpetrators so as to eradicate it. Conceptual shifts have been encouraged by recent commentary (10-12), international guidance and activity (13). The UK Anti-Slavery Commissioner, for example, highlights multi-agency partnerships as an optimal operational framework to both find and convict offenders *and* respond to the multi-factorial needs of survivors (1).

Nevertheless, a recent mapping of anti-slavery networks in the UK identified that most local and regional partnerships are led by the police with other agencies rarely taking a leading role. While this approach may function in practice, it reflects the peripheral role that health and other agencies currently play in local action and highlights the challenge of moving debate and practice beyond law enforcement (14).

How is the UK health sector responding?

Most activity within the health sector has so far been aimed at improving awareness of modern slavery among the healthcare workforce. A recent study identified significant knowledge and confidence gaps among healthcare professionals (HCPs) about how to identify cases of human trafficking and what to do if victims are encountered (15). As a response, training packages across NHSE are in development (16). To date, however, responses in the UK have been locally initiated, small scale and variable. There is an opportunity to extend activity from the generic equipping of health service practitioners to a more focussed, specific and tailored approach to training and resourcing different health professions. There is also an opportunity to identify how public health, with its broader population-level focus, can contribute to this agenda. Without a considered framework on why and how this sector should respond; with the concomitant dangers of missed opportunities to address need or, on the other hand, ineffective, inefficient or even harmful practice is a risk.

Addressing the series of questions below may help us in arriving at such a framework for action in this area.

Q1: Is modern slavery an issue for the health sector?

Yes. Modern slavery is a concern for both public health and health services. Our recent rapid evidence assessment identified considerable personal and population health implications of modern slavery (17). Despite the difficulties of gaining accurate epidemiological data for victims of modern slavery, complex co-morbidities are characteristic of this population; several studies document poor physical health, high risk of physical injury, high risk of exposure to communicable diseases, high suicide risk, poor and/or restricted access to healthcare and a considerable burden of serious mental health problems including trauma and PTSD (15,18). Modern slavery is one of the most extreme examples of national and global health inequalities. Health care professionals encounter victims and require the support to know what to do and how to go about providing appropriate care (19).

Q2: What should be the scope and role of HCPs and services?

Healthcare workers can make an important difference to victims. They are potential allies in the identification of victims and crucial in providing appropriate and sensitive care. A recent cross-sectional survey of HCPs working in secondary care in the UK identified that 13 per cent had previous contact with a patient they knew or suspected of having been trafficked; among maternity services professionals this was 20 per cent (19). In addition, HCPs reported they lacked knowledge on how to identify victims (87%) and insufficient training to assist trafficked people (71%). It is also possible HCPs are disadvantaged in detecting modern slavery as victims seek to conceal their exploitation for fear of authorities, especially immigration enforcement.

These are opportunities missed that require practice changes. For example, recent guidance and training highlights the importance of ensuring patients are interviewed in the absence of others known to the patient, to eliminate the risk of exploiters 'talking for' and controlling the patient during treatment (3,13). Detailed international guidance is available on topics such as trauma-informed care, comprehensive health assessment and culturally appropriate, individualised care (8). These approaches require further tailoring to national, regional and local settings. In the US, local adaptations of survivor-centred care have been developed on a small scale (20), a toolkit is available to help HCPs detect and respond to the needs of trafficked people (13) and simulation methods have been successfully used in medical education (21). Such innovations can inform emerging practice in the UK. All these interventions require careful design, application and evaluation (22).

Health professionals are also in contact with survivors of modern slavery through the National Referral Mechanism (NRM); the means by which victims are assessed and supported out of exploitation. After a process of lengthy review in 2017, the NRM requires further development to better communicate health care rights to survivors and improved ways for first responders to safely identify health needs. Longer term healthcare support for those leaving safe houses after the 45 day support period of the NRM also requires development (15). At a governance level, NHS safeguarding policies require scrutiny to establish whether they sufficiently consider and address modern slavery.

Q3: How can the potential of HCPs be realised in addressing modern slavery?

Recognising victims of slavery and knowing how to respond requires staff training and support. It has been noted that modern slavery issues need integrating into safeguarding training for HCPs at different levels (16). Programmes at different levels are emerging but they are small scale and not comprehensive or tailored to different professions.

All HCPs require training and support (21), however practitioners in emergency departments, mental health and maternity require urgent support to up-skill as the specialisms most likely to encounter victims (15). Training and support can be coordinated through the Royal Colleges, medical schools, third sector organisations and professional training bodies such as Health Education England and on the basis of emerging best practice from overseas (23, 13). Primary care is in a key position to detect and deal with cases of victimisation (24) but the evidence base on how GPs and other primary care practitioners identify and develop approaches to addressing modern slavery is very underdeveloped (15). Learning from the US points to the need to standardise the content of training for HCPs; incentivise professionals to undertake training; and evaluate impact of knowledge and practice (22). Professionals may also need support dealing with secondary trauma. Examples of such support are rare and require further examination (25). In addition, professionals require confidence that an infrastructure exists to support survivors and that people in vulnerable circumstances are not being placed in more danger from either law enforcement or perpetrators if referrals are made.

Q4: How should the health sector influence the debate?

The health sector can also importantly shape the debate on modern slavery. Public health in particular, with its broader systems focus, is in a position to challenge oversimplified discussion about 'victims versus perpetrators' and 'slavery versus freedom' as it describes exploitation as a result of structural inequalities, expressed through poverty, gender inequality, stigma and shame (11). Such a perspective can add pressure nationally and globally to promote preventative policy making (26).

At a local and regional level, public health intelligence and influence has the potential to be an important voice in strategic alliances with the police, private enterprise and the third sector. Bringing a preventative focus, public health professionals in collaboration with law enforcement agencies can help draw attention to any local conditions under which exploitation may flourish and how local policy and development can be designed to be slavery-resistant (12). The recent national consensus statement between multiple public health, health services, law enforcement and third sector organisations provides a strong framework on which to build consistent collaborative practice (27). Accompanying this, Public Health England (PHE)'s recent case book of multi-agency working between the police, public health and other non-/statutory bodies provides illustrations of leadership and action to support people in the most vulnerable circumstances, including those who are victims of modern slavery (28)

In addition, public health bodies need to be central to influencing broad-base public health workforce awareness-raising. As intelligence gatherers, public health's statutory agencies and authorities can be a legitimate and powerful voice in the on-going development of locally led anti-slavery multi-agency partnerships. In England, the Association of Directors of Public Health and PHE are in a particularly strong position to advocate for, influence and direct a public health preventative framework within anti-slavery partnerships.

Public health leadership can also legitimately point to how the Modern Slavery Act sits at the intersections of other laws and governance processes that can coalesce to constrain access to health care, particularly among undocumented migrants who are at a particularly high risk of becoming or remaining in exploitative circumstances and may delay or be obstructed from seeking care (29,30).

Concluding remarks

The health sector has, to date, been at the periphery of action on modern slavery in the UK and elsewhere, despite often encountering the 'sharp end' of its health consequences. We call here for health sector colleagues to use the Act as an opportunity to assert our position as central to the wellbeing of survivors and as a fundamental ally in modern slavery prevention. As first steps we need: i) public health leaders to articulate their role in addressing modern slavery, preferably through active engagement in anti-slavery partnerships, ii) health service leaders in policy, strategy and delivery to fully integrate modern slavery work into existing safeguarding roles *and* provide consistent means of up-skilling the general healthcare workforce, and iii) healthcare professionals to undertake training to support behaviour change towards trauma-informed and patient centred care (30). Multiple additional actions for public health have been proposed elsewhere (17). We must also direct the broader agenda towards policy and practice underpinned by a sophisticated understanding of the root causes of slavery and an enforced regulatory framework that works in the favour of survivors.

Key messages:

- Modern slavery has significant health implications that demand a considered response from the health sector;
- To-date, most activity focuses on training health professionals to 'spot the signs' of modern slavery and support identified victims;
- There is an opportunity for the health sector to re-shape the debate to address the wider determinants of modern slavery;
- Public health can add an important preventative focus to the existing law enforcement approach to modern slavery.

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The ideas in this paper stemmed from a secondment of ES to PHE. ES wrote the first draft. SS and RJ contributed to revised drafts. All authors contributed to the intellectual content, editing and approved the final version for submission. ES is the guarantor.