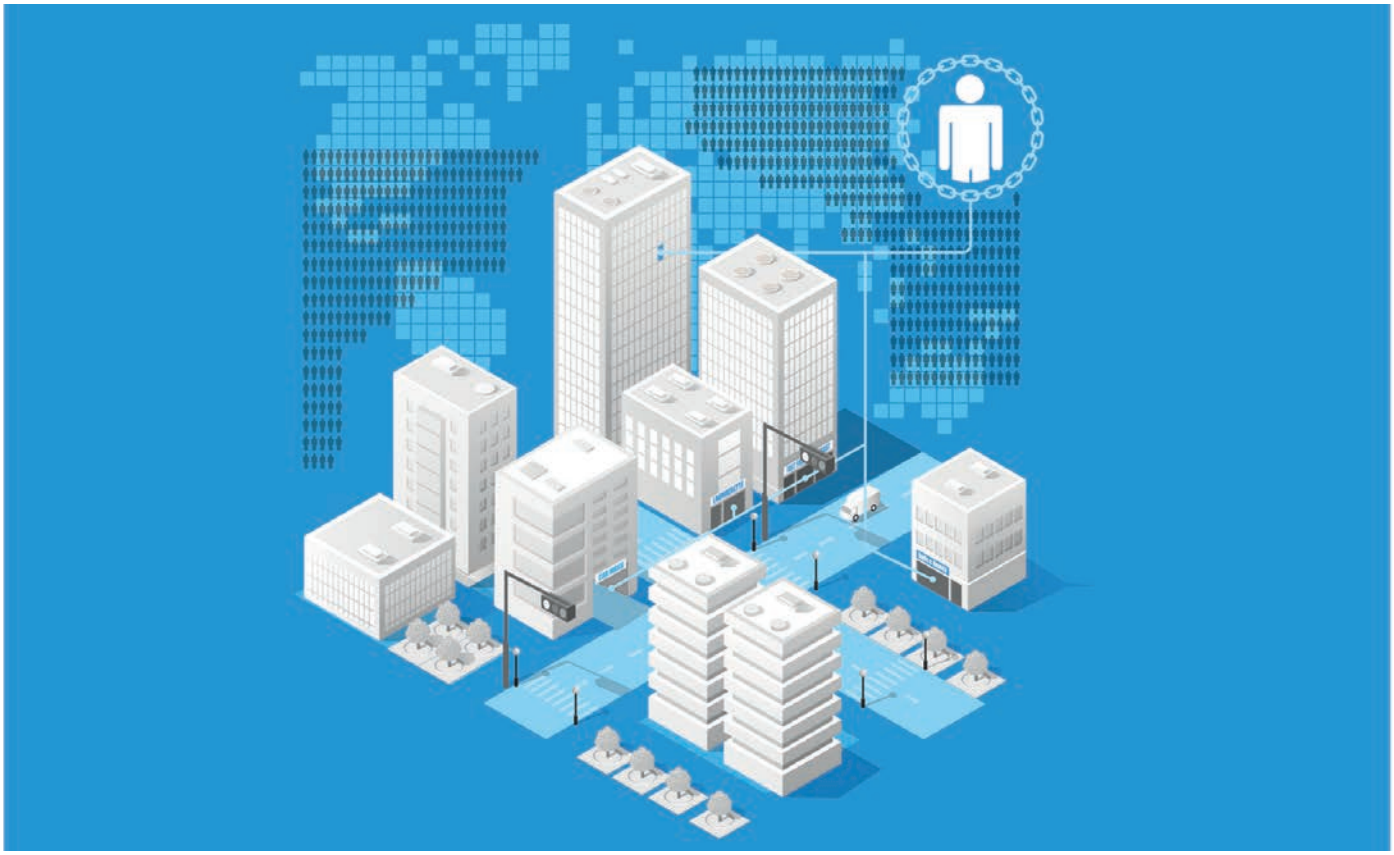
Hidden in plain sight: modern slavery human trafficking in the UK



Last year, there were an estimated 7,000 recorded victims of modern slavery reported in the UK. However, despite the urgency of the problem, the issues around modern slavery human trafficking are not always well understood. Journalist and author **Claire Laurent** speaks to those aiming to raise awareness and provide support in the healthcare setting.

Modern slavery human trafficking (MSHT) is the movement of people by force, fraud, coercion or deception in order to exploit them for financial gain. Exploitation may range from the prostitution of others, forced labour or services, domestic servitude or the removal of organs.

Modern slavery is a global business. According to 2017 figures from the International Labour Organization (ILO) and Walk Free Foundation more than 40 million people were trafficked in 2016 – 25 million into forced labour and 15 million into forced marriage, which often involves forced labour under the guise of marriage.

Most victims are 'recruited' in person, with the promise of good money and somewhere to live. Others in the sex industry may have been trapped through online job adverts and social media websites.

Very often, victims are threatened and can suffer extreme violence as the criminals exert control. Many have their identity documents confiscated and have most of their earnings withheld as 'payment' for living costs or for their journey to the UK. Threats often extend to the victim's family, who may be relying on money being sent home by the trafficked person.

Last year in the UK there were around 7,000 recorded victims of modern slavery making it third in the world after Albania and Vietnam. The Global Slavery Index estimates that 136,000 people are currently living as slaves in the UK – two people for every 1,000 of the population. Slavery affects adults and children, men and women, with forced labour the most common form of modern slavery.

Those working in the field say these figures are the tip of the iceberg. So much of slavery is hidden in plain sight – hand car washes, nail bars, takeaway restaurants, farms, crop picking, construction industry and other labouring – that it goes unnoticed and unreported.

Legislation and enforcement

In July, the government announced the launch of a modern slavery research centre, funded by £10 million of investment, following the implementation of the Modern Slavery Act 2015. However, a recent independent review of the Act has made some 80 recommendations to improve the

current approach to MSHT in the UK, which is seen as uncoordinated, inconsistent and complicated.

The Act allowed for the appointment of an independent anti-slavery commissioner to develop and implement a national anti-slavery strategy. Kevin Hylands resigned his post in May this year, citing that his independence had been treated at times as somewhat discretionary by the Home Office.

Dame Sara Thornton, who was chair of the National Police Chiefs' Council, has since been appointed to the role. She says: 'As independent anti-slavery commissioner, my role will be to encourage better identification and support for all victims of modern slavery.' In October 2019, Dame Sara published her *Strategic Plan for 2019–2021*, which outlines four priorities:

- Improving victim care and support
- Supporting law enforcement and prosecutions
- Focusing on prevention
- Getting value from research and innovation.

In conrast, the Home Office's *Modern Slavery Strategy*, published in 2014, based its approach on that used in serious and organised crime and counter-terrorism strategies. Largely focusing on the detection and prosecution of perpetrators and often tied to issues of migration status, many thought the mental and physical health of those who experience MSHT risked being seen as a secondary concern by the Home Office's model:

- Pursue: prosecuting and disrupting individuals and groups responsible for modern slavery.
- Prevent: preventing people from engaging in modern slavery.
- Protect: strengthening safeguards against modern slavery by protecting vulnerable people from exploitation and increasing awareness and resilience against this crime.
- Prepare: reducing the harm causes by modern slavery through improved victim identification and enhanced support and protection.

Trafficking can have huge repercussions for people's health, including psychological and physical trauma. Injuries may be acquired through violence, forced labour or sexual exploitation – including sexually transmitted infections and pregnancy. Post-trafficking, there are long term effects of poorly treated injuries as well as anxiety, depression and post-traumatic stress disorder (PTSD).

'Trafficking really shatters a person's sense of self and their trust in the world and people around them,' says Dr Sian Oram, lecturer in women's mental health at King's College London. She says that for trafficked people to be able to access healthcare, being listened to and treated with dignity are enormously important in their recovery.

Healthcare role

It can be daunting for clinicians to identify a victim of trafficking and act upon it, because of the risk of putting the person in greater danger. Dame Sara says: 'Victims of modern slavery may not be easy to spot. They may be distrustful of the authorities, unwilling or unable to communicate their fears due to coercion or language barriers, and they may not even recognise that they are a victim.

'Every day, doctors, nurses and other frontline practitioners may come across potential victims of modern slavery who present with a range of physical or psychological symptoms, partly as a result of their exploitation. I encourage all health practitioners to familiarise themselves with the indicators of modern slavery, and to refer them for appropriate support.

'NHS staff already play a crucial role in safeguarding vulnerable people. They operate at a key moment of intervention, where they can identify victims of modern slavery and refer them on for appropriate support.'

Adrian Boyle is a consultant emergency physician at Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust, and was part of a Department of Health policy research programme that resulted in the 2015 *PROTECT* report. The report synthesised the evidence on the number of identified trafficked adults and children using NHS services in England, their experience of services and how their health needs were met.

Of MSHT, Dr Boyle says: 'I see this very much as part of a domestic violence, child safeguarding continuum. A clinician's role should be restricted to identification, support and referral. We are not social workers [and] we are not police officers. We need to be have boundaries about what we can and can't do.

'Just knowing how to ask and refer would be helpful for the vast majority of staff. People with safeguarding responsibilities need a higher level of training.'

Hanni Stoklosa is executive director and co-founder of HEAL Trafficking – a US-based global organisation that takes a public health approach to tackling human trafficking. She is also an emergency physician at Boston's Brigham and Women's Hospital in the US. She says: 'We know that the majority of trafficked victims access healthcare at some point while they are being trafficked and exploited.' Very often, she says, they are either left for dead at the emergency department (ED) or they are brought in because treatment will make them useful to the trafficker again.

'They come in quite late or with things that are quite severe because most of the time traffickers won't allow victims access to healthcare' says Dr Stoklosa. She says that the overriding concern expressed by doctors is how to manage this situation while keeping the person safe. 'Health professionals need to have the tools and a reliable system in place that they can report into, otherwise they are not going to ask difficult questions.

'It's not just about awareness, it's not just about education, (it's about) changing attitudes. There needs to be a cultural shift. We need to change the way we interact not just with trafficked victims, but all patients. Education is not just around "here are the facts", but how we approach our patients in a trauma-informed way.' She says the evidence around managing domestic abuse has not yet permeated to MSHT but the approach is similar. 'If you try to force a disclosure, that will do more harm than good.'

When working in ED she says her tactic is to get the patient on their own. 'You use the excuse of getting a urine sample and you choose a bathroom two corridors down. You have not raised alarm bells and you have that discussion with them on the way to the bathroom. I start with something that is light like: "Where do you live?" I say: "I am your doctor and I care about your health and name whatever condition they come in with."

'I explain their health is related to their work, their relationships and where they live and that I ask the same questions of all my patients. I'm very careful to say nothing around immigration because that's the threat that traffickers use. I ask them if they have access to their documents and explain that I ask because some of my patients come here for a job and some are experiencing a lot of harms – so I want to be sure that's not happening to them or someone they know. I will name whatever I am most concerned about relating to that, so normalising it.' It is likely that someone who is trafficked will need an interpreter. This should not be the person accompanying them.

Like Dr Boyle, Dr Stoklosa emphasises that it is important to work within the healthcare system to provide care. It's not about rescuing anyone. 'Trafficked victims are afraid that someone is judging them. They feel afraid

if they tell their doctor, then they might be deported.' It's important, she says, to leave the door open for them to return.

Dr Rosie Riley is a junior clinical fellow in emergency medicine in the UK who has taken a dedicated interest in MSHT, establishing and running the Victim Identification and Trafficking Awareness (VITA) training programme. 'For the past five years, I have been delivering training for health professionals on how to identify and safeguard people who come into contact with healthcare services. Training focuses on trauma-informed communication skills: how to identify red flags, how people manifest, and the health impact of trafficking.'

Dr Riley is in discussion with Health Education England to make her training courses available across London, supported for the first time by trust budgets. The courses will help to fill a gap in training for health staff. Currently, there is little more than basic online courses around awareness on e-Learning for Health with some trusts providing additional training.

As a clinician, if you have the consent of the person to refer them for further support, that process will be through a trust's safeguarding procedures – very few will have specific guidelines in relation to MSHT.

NHSE/NHSI has established a modern slavery and human trafficking network with cross-government support and frontline membership to provide assurance that it is taking all reasonable steps to recognise, support, refer and safeguard vulnerable children and adults subject to MSHT. In place since December 2017, it remains unclear how this has translated into tangible support in the system. Some areas are developing their own procedures.

Rosie Luce is head of safeguarding / lead designated professional for adults and children in NHS Birmingham and Solihull Clinical Commissioning Group. She is part of a multi-agency programme across the West Midlands – Preventing Violence against Vulnerable People – which aims to prevent and raise awareness of hidden crimes such as MSHT; to safeguard, protect and support vulnerable victims and hold offenders to account.

The programme has a set of procedures, case studies and a strategy to support learning locally. Luce says: 'Procedures outline what first responders and professionals who are not responders should do. Children under 18 will normally be referred into local area multi-agency safeguarding procedures and cases are managed regionally too. For adults on the other hand, it will vary depending on local arrangements.'

West Midlands Police is part of the network.

Red flags for trafficking

- Withdrawn, submissive; seems afraid to speak to a person in authority
- Vague and inconsistent when explaining where they live, work or go to school
- Has old or serious injuries that are untreated
- Has delayed presentation
- Is vague and reluctant to explain how an injury occurred or give a medical history
- Not registered with a GP, school or nursery
- Has experienced being moved locally/regionally/nationally/internationally and/or moves location frequently
- Appearance suggests general physical neglect
- Struggles to speak English. ■

Recent convictions for human trafficking in the West Midlands were a welcome success after years of painstaking work. Detective superintendent Nick Walton says prosecuting trafficking offences is complex and slow and requires the cooperation of the victims, many of whom are frightened and simply not strong enough to stay the course. He says: 'Last year we saw about 600 victims referred into the NRM (national reporting mechanism) within the West Midlands.' Of those, West Midlands Police investigated around 350–400 cases but only saw about five offences charged. The NRM is a framework for identifying victims of MSHT. The National Crime Agency was responsible for collating data on the NRM until April 2019 when the Home Office assumed responsibility, something which campaigners say puts potential victims at risk of arrest in the 'hostile environment' created by the department.

Once victims have been identified, they are, with their consent, referred into the NRM by designated first responders. There are a number of agencies and charities who are first responders. The NHS is not one of them and so must report to a first responder to refer into the NRM. Views are divided as to whether the NHS should be a first responder. Dame Sara says she is open to listening to different perspectives and would need to see evidence that such a change would help victims.

Dr Oram, of King's College, says: 'I don't think the awareness is there yet.' She says that potentially a senior safeguarding person in the NHS could be a first responder but she warns that there are serious implications with referral because it brings people to the attention of the police and immigration and doesn't guarantee them support.

People accepted into the NRM are given 45 days for 'recovery and reflection'. Those not accepted into the are at risk of arrest and are not automatically given asylum. Doctors of the World policy and advocacy manager Anna Miller says: 'the definition of trafficking under the NRM is very narrow and doesn't provide proper protection'.

Anyone who was in any way complicit in their own trafficking, for instance, will not be accepted into the NRM. 'The common thing we see is people who come to the UK with some idea of what they are getting into but often the work opportunities are not quite what they thought. Their immigration status is not recognised. They can be in debt bondage. They don't feel free to leave because of repercussions.'

Miller says GP practices still routinely refuse to register people because of their lack of ID or address, although there is no legal restriction on access to primary healthcare. Those accepted into the NRM are entitled to free secondary health care too, but few organisations know this and while the person has a letter confirming they have reasonable grounds to remain, it does not state their right to free healthcare.

Devolved administrations

Scotland's Trafficking and Exploitation Strategy (2017) considers human trafficking to be a human rights issue and adopts a victim-centred approach. It recognises best practice relating to prevention measures. In line with Scottish legislation, progress is reported on the strategy annually. Northern Ireland's Human Trafficking and Modern Slavery Strategy for 2016/2017 aims to: reduce the risk of people being trafficked or exploited within Northern Ireland; increase public awareness and reporting; reduce demand for services of trafficked and exploited victims. ■

Resources

- Global Slavery Index: www.globalslaveryindex.org/2018/data/country-data/united-kingdom
- Independent Review of the Modern Slavery Act 2015 https://bit.ly/2EvFIJJ
- PEARR Tool: www.dignityhealth.org/hello-humankindness/human-trafficking/victim-centered-and-trauma-informed/using-the-pearr-tool
- Victim Identification and Trafficking Awareness https://vita-training.com