

Provider Responses Treatment and Care for Trafficked People



**Final Report for the Department of Health Policy Research
Programme**

Optimising identification, referral and care of trafficked people within the NHS (115/0006)

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Executive summary

Background

Human trafficking is the recruitment and movement of people – often by means such as coercion, deception, and abuse of vulnerability – for the purpose of exploitation. Trafficked people experience multiple health risks prior to, during, and following their trafficking experiences, and many suffer acute and longer term health problems. As such, National Health Service (NHS) professionals have an essential role in the identification, referral, and clinical care of trafficked people in England. Human trafficking now falls within the United Kingdom's (UK) 'Modern Slavery Act, 2015', which received Royal Assent on 26th March 2015. The Modern Slavery Act addresses both human trafficking and slavery, defining slavery as knowingly holding a person in slavery or servitude or knowingly requiring a person to perform forced or compulsory labour.

Yet, despite this renewed focus, there remains extremely limited evidence to inform health service responses to human trafficking. A systematic review conducted in 2012 found that previous research into the health needs of trafficked people focused predominantly on women in low and middle income countries who had been trafficked for sexual exploitation. Very little evidence existed on the needs of trafficked children, trafficked men, and of women trafficked for domestic servitude and labour exploitation, particularly in high income country settings. Evidence was also lacking on which healthcare services were most likely to be accessed by trafficked people and under what circumstances, and on the knowledge and training needs of NHS professionals. Our research programme therefore aimed to provide evidence to inform the NHS response to human trafficking, specifically the identification and safe referral of trafficked people and the provision of appropriate care to meet their health needs.

The research programme was designed based on three core objectives: (1) To synthesise evidence on the number of trafficked adults and children identified and using NHS services in England, the healthcare needs of trafficked people, and their experiences and use of healthcare; (2) to document NHS experience, knowledge and gaps about trafficked people's health care needs; and (3) to provide recommendations research-based papers and dissemination strategies to support NHS staff to identify, refer and care for trafficked people

and to become a strategic partner within the UK National Referral Mechanism (NRM)¹ and with other agencies.

Methods

Several studies were conducted using a range of research designs and data sources to meet these objectives:

- (1) Updated systematic review of evidence on the health needs (physical, mental, and sexual and reproductive) of trafficked people;
- (2) Systematic review of current knowledge and practice in the identification, referral, and provision of care to trafficked people;
- (3) Case series of the health needs of men and women trafficked for labour exploitation;
- (4) Cross-sectional survey of trafficked adults and adolescents in contact with support services in England;
- (5) Qualitative interviews with trafficked adults and adolescents in contact with support services in England;
- (6) Historical cohort study of trafficked adults and children in contact with secondary mental health services in South East London, using clinical informatics;
- (7) Cross-sectional survey of NHS staff knowledge, experience, and training needs in relation to human trafficking;
- (8) Qualitative research with NHS and non-NHS professionals to explore experiences of responding to human trafficking.

Preliminary findings from these research components were shared with key professionals at a stakeholder workshop in February 2015, which aimed to explore delegates' opinions regarding the content, format, and dissemination of future training materials.

Findings

Findings from this multi-methods study have identified the various health risks and healthcare needs of trafficked people in the UK and the NHS staff's opportunities, barriers readiness and willingness to provide appropriate care.

¹ The UK NRM is the framework by which people who may have been trafficked are identified, referred, assessed, and supported by the UK government. Since July 31st 2015, the NRM also covers modern slavery in England and Wales.

Health risks and healthcare needs of trafficked people in the UK

To understand the health and care needs of trafficked people, we drew primarily on the combined findings from:

- (1) **Updated systematic review** of evidence on the health needs (physical, mental, and sexual and reproductive) of trafficked people;
- (2) **Case series** of the health needs of men and women trafficked for labour exploitation in England;
- (3) **Cross-sectional survey** of trafficked adults and adolescents in contact with support services in England;
- (4) **Qualitative interviews** with trafficked adults and adolescents in contact with support services in England;
- (5) **Historical cohort** study of trafficked adults and children in contact with secondary mental health services in South East London, using clinical informatics;
- (6) **Qualitative interviews** with NHS and non-NHS professionals.

Collectively, these studies confirmed that physical and sexual violence is highly prevalent among trafficked women, men and children. For example, the cross-sectional survey - the largest single country study of health and trafficking conducted in a high-income setting - found that over 40% of men and over three quarters of women (77%) reported physical violence while trafficked, with two-thirds of women reporting they were forced to have sex. Findings of the systematic review also indicated that women and girls who had been trafficked for sexual exploitation experience a high prevalence of physical violence, ranging from 33% in a Cambodian case-file review to 90% in a multi-country European survey.

Results from all health and trafficking studies specifically emphasized the psychological harm and mental health care needs of trafficked people. Two-thirds of the individuals who participated in the cross-sectional survey reported symptoms levels indicative of serious psychological distress, including nearly half with symptoms indicative of PTSD and two-fifths reporting symptoms of suicidal ideation. The historical cohort study (which used clinical informatics data) further highlighted common diagnoses among adults as including PTSD and severe stress and adjustment disorders (39%) and depression and affective disorders (34%). Although evidence on the trajectory of mental health symptoms following a trafficking experience remains limited, the synthesis of these study findings indicates that mental health issues were enduring. Indeed, the UK survey is among very few studies that interviewed trafficked persons well after a trafficking experience had ended; participants had been out of the trafficking situation for a median of six months. The findings therefore suggest that

trafficked people experience symptoms of depression, anxiety and PTSD levels for long periods after leaving the trafficking situation. Yet, very little is known about what helps trafficked people to recover from the psychological impact of human trafficking.

Findings on the physical health problems experienced by trafficked people were also very similar across cross-sectional survey and systematic review. Common physical symptoms reported trafficked people included headaches; stomach pain; back pain; fatigue; memory problems; and dental problems. Self-reported symptoms among suggested a high prevalence of sexually transmitted infection.

Few adolescents were recruited to the cross-sectional survey, but findings from the systematic review suggested that trafficked children report similar mental and physical health problems as experienced by adults, including high symptom levels of depression and anxiety and various physical injuries, pain and discomfort. Among the twenty-nine young people (aged 16-21) who participated in the cross-sectional survey, there was a high prevalence of symptoms of psychological distress, including suicidal ideation, and two reports of attempted suicide.

Qualitative research with trafficked people found that a relatively small proportion of people come into contact with services while they are still in the trafficking situation. However, the majority of the trafficked people who took part in the research only visited a service provider once he or she was out of the trafficking situation, including because traffickers prohibited their movement. Trafficked people also explained that they did not seek the care they needed because of their irregular immigration status and lack of identity documents. Many of those who did attend a health service were accompanied by the trafficker or under surveillance by someone related to the trafficking situation.

Research with trafficked people and with health professionals and other stakeholders suggested that even where individuals might have rights to use health services, their access frequently appears to be constrained in part by their misunderstanding of their rights to services and the logistics of findings healthcare providers, individuals' reluctance or inability to negotiate access and/or the knowledge and attitudes of those they encounter at the services, especially gatekeepers, such as receptionists. Trafficked people's ability to register with GPs appeared to be a common barrier to receiving care, especially among those who were awaiting documentation from the Home Office. All findings point to the need for an intermediary or support advocate who can help trafficked people navigate the systems. Our studies also highlighted the problems associated with language and the availability of

interpreting services. This was an issue raised particularly by service providers. However, the majority of trafficked people who were able to access health services in England reported they were satisfied with the care they received.

NHS staff's opportunities, barriers, willingness and readiness to provide appropriate care.

To understand the healthcare providers' opportunities and barriers to providing care, as well as their willingness and preparedness to offer care to trafficked persons, we drew on the combined findings from:

- (1) **Systematic review** of current knowledge and practice in the identification, referral, and provision of care to trafficked people;
- (2) **Cross-sectional survey** of NHS staff knowledge, experience, and training needs in relation to human trafficking;
- (3) **Qualitative research** with NHS and non-NHS professionals to explore experiences of responding to human trafficking.;
- (4) **Historical cohort** study of trafficked adults and children in contact with secondary mental health services in South East London, using clinical informatics.
- (5) **Stakeholder workshop** that aimed to explore delegates' opinions regarding the content, format, and dissemination of future training materials.

Collectively, the findings indicate that healthcare provider knowledge about safe and appropriate approaches to identify and care for trafficked people is limited. Providers perceive numerous knowledge gaps and practical barriers to assisting trafficked people. Moreover, it appears that the guidance and training resources upon which providers can draw are relatively few, and those that are available are lacking evaluation. However, the results also confirm that providers are very interested in learning more about how to care for people who have been trafficked and, once informed, are willing to engage as a core component of a service referral network. Prior to our research, very little was known about what proportion of health professionals might be coming into contact with trafficked people. Findings from our survey of NHS staff indicate that one in eight (13%) have had contact with a patient they knew or suspected were trafficked—and among maternity services professionals, this proportion rose to one in five (20%). The clinical specialties most likely to come into contact with a trafficked person appear to be mental health, maternity, and emergency medicine.

However, while healthcare providers do appear to encounter cases of trafficking, the combined findings from the three studies indicate that health professionals generally feel unprepared to manage cases of human trafficking. For instance, 86.8% of NHS staff reported not knowing what questions they should ask to identify people who may have been trafficked and 78.3% believed that they had insufficient training to assist trafficked people. Findings from across the studies suggest that key challenges to providing care for trafficked people include immigration and language barriers, as well as lack of knowledge of the potential referral resources.

Specific training and guidance resources to support healthcare professionals to identify and respond to human trafficking are scarce. There was consensus across several studies, however, regarding the types of response that would be beneficial for trafficked people. Findings from the systematic review, as well from professionals participating in the qualitative research studies and in the stakeholder workshop, highlighted the need for multi-sectoral, sustained support and for trauma-informed and culturally appropriate care.

Importantly, our research indicates a great willingness on the part of NHS staff to learn about identifying and caring for trafficked people: over three quarters of those who took part in our survey wanted further training and information about human trafficking. Findings from the research studies and the stakeholder workshop raised pertinent questions about what might comprise satisfactory modes of information and training delivery. Participants recognized that e-learning was convenient, but believed that an online course would not be well-used or sufficient to meet their needs, and few reported having previously accessed the currently available online training. Staff did, however, want to be able to access key information online, including what to do when trafficking is suspected and urgent referral information. They also highlighted the importance of having a single, clearly designated number to call for referral and information.

Findings suggest the importance of developing a consolidated strategy for developing the health sector response to human trafficking, and we recommend that in doing so the Department of Health and other health agencies work closely with the main agencies involved in working to address human trafficking and modern slavery.

Recommendations for policy and practice

Findings from this study identify the need and clear opportunity for the strategic and operational involvement of the health sector in the response to human trafficking. Importantly, the results demonstrate the willingness of NHS professionals to engage with a clearly articulated and well-structured response to human trafficking. Integration into England's response to human trafficking will require the Department of Health, NHS England and other health agencies to collaborate across multiple sectors. A thematic summary of the below recommendations is provided in Appendix A.

Department of Health

1. Request departmental membership and participation of committees involved in the development of legislation, policy, and regulations pertaining to human trafficking, including the NRM, inviting representatives of the health sector as required (see chapter 5). Invite people with lived experience of trafficking with appropriate measures in place to support effective input;
2. Consider the impact of policy decisions on the health of trafficked people regarding equality, and health inequalities and equity impact assessments (see chapter 4.8);
3. Develop a departmental action plan regarding the health sector response to human trafficking, supplementing departmental and cross-departmental action plans on violence against women and cross-departmental action plans on human trafficking and modern slavery (see chapter 5). For maximum impact, to work closely with local authorities, the Local Government Association, Association of Directors of Social Services and Public Health England in developing these plans;
4. Include human trafficking/modern slavery within adult safeguarding policies, and produce and promote guidance on responding to human trafficking in healthcare settings, including that NHS staff who have concerns that a patient they are treating or assessing for charges may have been trafficked should seek advice from their safeguarding lead². If the patient appears to be in danger, the relevant NHS body should contact the police (see chapter 4.7 and 4.9);
5. Remove any barriers to GP registration that would prohibit trafficked people from registering (see chapters 4.4 and 4.8);
6. Ensure trafficked people are not unjustifiably denied medical care by informing relevant healthcare stakeholders of individuals' full range of rights and entitlements to

² NHS Safeguarding Leads are NHS staff who lead on issues relating to child protection and vulnerable adults

services, and by discouraging racism and bias to prevent refusal of services based on nationality, sex, language, race, or stigma or other protected characteristics as defined under the Equality Act 2010. Monitor regularly to ensure that individuals' rights to services are respected (see chapters 4.4 and 4.8);

7. Develop, with key partners, strategies to raise awareness and recognition of human trafficking by healthcare and other professionals, including further encouraging engagement by Overseas Visitor Managers with local and national organisations that support trafficked people(see chapter 4.7);
8. Update training resources (e.g. information leaflet and e-learning module launched in April 2013) for health professionals to identify, refer, and care for individuals they suspect have been trafficked, taking account of current evidence and working together with people with lived experience of trafficking and/or specialist voluntary organisations supporting trafficked people (see chapter 4.7 and 4.9);Lead the development and dissemination of user-friendly materials to inform trafficked people about NHS services, registration with GP services, and confidentiality and how it is defined (see chapter 4.8);
9. Hold providers of interpreting services accountable to quality assurance standards (see chapter 4.4 and 4.8).

Home Office

1. As the lead department on the development of policy on human trafficking and modern slavery, request the membership and participation of the Department of Health and Arm's Length Bodies (e.g. NHS England, Public Health England, and Health Education England, and Local Government) in committees involved in strategic planning and the development of legislation, policy and regulations pertaining to human trafficking and modern slavery, including the NRM (see chapter 5);
2. Provide guidance for relevant organisations (e.g. The Salvation Army and support providers) on making representations to extend the minimum 45-day reflection and recovery period for potentially trafficked people, including with regards to physical and mental health issues, pregnancy, and complex social needs. Review guidance for Competent Authorities on considering such representations (see chapter 4.8)³;

³ A revised NRM is currently being piloted, including testing decision-making by multi-agency panels. Guidance on considering representations to extend reflection and recovery periods should be provided to multi-agency panels, if rolled out.

3. Require that individuals suspected of having been trafficked are asked in safe ways about their health concerns at the first point of contact with First Responders and revise NRM referral form guidance to highlight that immediate medical need should be met prior to an NRM referral form being completed(see chapter 4.3)⁴;
4. Ensure that people referred into the NRM are provided with user-friendly information about NHS services, registration with GP services, and confidentiality and how it is defined (see chapter 4.8);
5. Amend NRM decision letters issued following positive reasonable grounds and positive conclusive grounds decisions to state specifically that as a potential/identified trafficked person the person is exempt from charges for primary and secondary NHS care as per the NHS (Charges to Overseas Visitors) Regulations 2015 (see chapter 4.8);
6. Ensure that those who make an immigration application for leave to remain as a trafficked person will have a 'Green: Paid or exempt from the health surcharge' banner on their NHS record, to reduce any difficulty accessing healthcare (see chapter 4.8).
7. Commission outreach support for individuals who have left safe-house accommodation after the NRM reflection and recovery period (see chapter 4.3 and 4.4);

Department for Education

1. Include human trafficking/modern slavery within child safeguarding policies (see chapter 4.7 and 4.9).

Police Chief Constables

1. Ensure police officers provide information about and offer referral to Sexual Assault Referral Centres for forensic examinations to support the prosecution of traffickers, where sexual abuse is suspected (see chapter 4.3);

⁴ A revised NRM is currently being piloted, including testing referrals by Slavery Safeguarding Leads. If rolled out, Slavery Safeguarding Leads should be required to ask about health concerns at their first point of contact with individuals suspected of having been trafficked.

Health Education England, the Royal Colleges, and professional organisations responsible for setting training standards for NHS staff:

1. Target training at NHS safeguarding leads and at professionals working in maternity services, mental health, paediatrics, dentistry, emergency medicine, and overseas visitors charging departments (see chapter 4.7 and 4.9)⁵;
2. Ensure that NHS professionals:
 - a. Are trained to be aware of indicators of possible trafficking and of how to respond appropriately to suspicions or disclosures of this form of abuse (see chapter 4.1, 4.2, 4.3, 4.4, 4.7 and 4.9);
 - b. Are trained to conduct identification and referral – including to NRM First Responders - in safe and linguistically appropriate ways that prioritise providers' and trafficked people's safety (see chapter 4.1, 4.2, 4.3, 4.4, 4.7 and 4.9);
 - c. Are trained to be aware of the needs of people with complex trauma and the impacts on their children (see chapter 4.3);
 - d. Explain to trafficked people the importance of confidentiality and how it is defined (see chapter 4.4);
 - e. Offer trafficked people attending health services a choice regarding the gender of health professionals and interpreters (see chapter 4.4);
 - f. Obtain a sexual history from trafficked people who access health services. National guidelines on sexual history taking, which have been developed for all health professionals irrespective of whether or not they are working in sexual health services, should be followed (see chapter 4.3);
 - g. Are aware that trafficked persons may continue to be vulnerable to exploitation and abuse after leaving the trafficking situation and ensure patients have safety plans and know how to access help if needed (see chapter 4.5);
 - h. Are aware of the likelihood of people who have been trafficked having high levels of mental health needs and high prevalence of abuse both prior to and during trafficking and can make referrals to appropriate agencies (see chapter 4.3).

⁵ Existing resources include the e-Learning for Healthcare online module “Identifying and Supporting Victims of Modern Slavery” and the Equalities and Vulnerable Groups e-learning module.

NHS England

1. Ensure trafficked people are not charged to access their medical and healthcare documents so they have information about the medical care they received while in the UK, especially if returning to their country of origin (see chapter 4.8).
2. Ensure GPs have access to training resources on identifying and responding to human trafficking in healthcare settings (see chapter 4.7 and 4.9);
3. Ensure that GP practices are made aware that identity documents and proof of address are not an essential requirement to register a patient (see chapter 4.8)
4. Ensure that health professionals have access to confidential and expert advice where they are concerned that a patient might be a trafficked person. This could be incorporated into the role of safeguarding leads (see chapter 4.8 and 4.9);

Clinical Commissioning Groups and Local Authority partners

1. Recognise trafficked people as a population with specific health needs in Joint Strategic Needs Assessments (see chapter 4.3);
2. Incorporate responding to concerns that a patient may have been trafficked into the role of NHS safeguarding leads (see chapters 4.8 and 4.9).

General Practitioners and surgeries

1. Remove barriers to GP registration that would prohibit trafficked people from registering (see chapter 4.4 and 4.8);
2. Ensure that registration for GP services is made as simple as possible and does not rely on ensuring proof of address (see chapter 4.4);
3. Ensure that trafficked people attending primary care are offered a choice regarding the gender of health professionals and interpreters (see chapter 4.4);
4. Ensure that interpretation is not provided by a person accompanying a patient who is suspected of being trafficked and that patients are seen privately (see chapter 4.4);
5. Obtain a sexual history from trafficked people who access health services. National guidelines on sexual history taking, which have been developed for all health professionals irrespective of whether or not they are working in sexual health services, should be followed (see chapter 4.3).

NHS Trusts

1. Incorporate responding to concerns that a patient may have been trafficked into the role of NHS safeguarding leads (see chapters 4.8 and 4.9)

2. Ensure staff have access to training resources on identifying and responding to human trafficking in healthcare settings, including specific training for safeguarding leads (see chapter 4.7 and 4.9);
3. Ensure that trafficked people attending NHS care are offered a choice regarding the gender of health professionals and interpreters (see chapter 4.4);
4. Ensure that interpretation is not provided by a person accompanying a patient who is suspected of being trafficked and that patients are seen privately (see chapter 4.4);
5. Ensure that staff obtain a sexual history from trafficked people who access health services. National guidelines on sexual history taking, which have been developed for all health professionals irrespective of whether or not they are working in sexual health services, should be followed (see chapter 4.3).

Commissioners of sexual health services

1. Ensure that sexual health services are available for trafficked people to access, regarding the type of exploitation suffered (see chapter 4.3);
2. Provide sexual healthcare that is appropriate to an individual's gender, age and culture. Sexual healthcare should be sensitive to an individual's culture and possible previous trauma and/or abuses and address both acute and longer term health needs, which may include counselling and treatment for STIs, HIV/AIDS, and sexual violence trauma, as well as for HIV post-exposure prophylaxis, hepatitis B vaccination, emergency contraception, contraceptive advice and supplies and abortion referral (see chapter 4.3);

Sexual health services

1. Provide sexual healthcare that is appropriate to an individual's gender, age and culture. Sexual healthcare should be sensitive to an individual's culture and possible previous trauma and/or abuses and address both acute and longer term health needs, which may include counselling and treatment for STIs, HIV/AIDS, and sexual violence trauma, as well as for HIV post-exposure prophylaxis, hepatitis B vaccination, emergency contraception, contraceptive advice and supplies and abortion referral (see chapter 4.3);
2. Establish local links with non-governmental organisations (NGOs) working with trafficked people (see chapter 4.2 and 4.4).

Mental Health Trusts and professionals

1. Incorporate responding to concerns that a patient may have been trafficked into the role of NHS safeguarding leads (see chapters 4.8 and 4.9);

2. Ensure staff have access to training resources on identifying and responding to human trafficking in healthcare settings, including specific training for safeguarding leads (see chapter 4.7 and 4.9);
3. Recognise that people with severe mental illness may be vulnerable to being trafficked (see chapter 4.5);
4. Recognise that people with mental health problems with a history of being trafficked may have experienced abuse prior to, during, and since trafficking and undertake routine enquiry (see chapter 4.5);
5. Recognise people with mental health problems with a history of being trafficked may be vulnerable to further abuse, including re-trafficking and domestic and sexual violence (see chapter 4.5);
6. Explain clearly to trafficked people and support services the arrangements for care coordination, and duration of care, care plans, and care programme approach (CPA). Recognise the possible additional communication requirements needed by trafficked people. All relevant members of the healthcare team should be aware of the patient's history, health and social needs and ongoing need for follow up (see chapter 4.5);
7. Be sensitive to the difficulties trafficked people could have if detention under the Mental Health Act is necessary (see chapter 4.5).

Maternity services and professionals

1. Recognise that indicators of trafficking include women who delay antenatal booking until their second or third trimester of pregnancy, or do not seek admission to a maternity unit until their labour is well established, especially those without English-language skills. In these cases midwives and other maternity professionals need to ask sensitively and in private about the woman's living and working situation, reproductive history, pregnancy history, and their general health and wellbeing (see chapter 4.3).
2. Consider safeguarding issues and involve appropriate agencies, ensuring women are at the centre of all decisions about their care and that of their infant and are aware of why their information may need to be shared with other carers (see chapter 4.3);
3. Recognise that in addition to core recommended care, trafficked women are likely to require additional care, such as that recommended by the National Institute for Health and Care Excellence (NICE) guideline on pregnancy and complex social factors, including information on how to access midwifery care outside of working hours (see chapter 4.3);

4. Ensure that all women who self-report or are suspected of being trafficked have access to one-to-one midwifery care during and after their pregnancy. This is particularly important for younger women who may have been trafficked for sexual exploitation to promote continuity of care, co-ordinate appropriate services and avoid the need for women to retell their trafficking and medical history (see chapter 4.3);
5. Be responsive to trafficked women's physical, psychological and social needs during and after pregnancy. Individual care plans should be developed and plans for timing and content of each contact discussed to ensure needs are addressed (see chapter 4.3);
6. Ensure that timing and duration of all contacts with trafficked women are flexible in terms of frequency and duration to allow more time to address complex needs if this is indicated, based on the individual needs of the woman (see chapter 4.3).
7. Discuss postnatal contacts with trafficked women, including duration of midwifery follow up, transfer to the primary health care team, and how care will be co-ordinated. All relevant members of the healthcare team should be aware of the woman's history, health and social needs and need for ongoing follow up (see chapter 4.3);
8. Ensure planned postnatal follow up, co-ordinated by one nominated lead across secondary and primary care sectors. If women move away from the local area, handover of care should be as detailed as possible, with documentation and details of how to re-register with relevant services discussed with the woman (see chapter 4.3).
9. Treat all trafficked women who come into contact with the maternity services with respect. Service providers need to ensure that all health professionals and support staff are aware of the importance of respectful, high quality care, as women who have experienced poor care, or have had contact with staff they perceived to be rude or critical of them may be reluctant to engage with services in the future (see chapter 4.4).

Acute Care Trusts and professionals

1. Incorporate responding to concerns that a patient may have been trafficked into the role of NHS safeguarding leads (see chapters 4.8 and 4.9);
2. Ensure staff have access to training resources on identifying and responding to human trafficking in healthcare settings, including specific training for safeguarding leads (including, as a minimum, the named doctor and nurse for child safeguarding, the lead midwife for safeguarding, the hospital Safeguarding of Vulnerable Adults (SoVA) lead, and the emergency department safeguarding lead (see chapter 4.7 and 4.9);

3. Be aware of the likelihood of trafficked people having high levels of mental health needs and make arrangements for their mental health to be assessed (see chapter 4.3).

Safeguarding Adults and Children's Boards

1. Monitor local trends in human trafficking and consider social care elements arising (see chapter 4.4).

Social Care

1. Social workers who are making care arrangements for trafficked adults, children, and young people need to be aware of the likelihood of them having high levels of mental health needs and should make arrangements for their mental health to be assessed with a view to providing relevant services both immediately and also at a later date when they may be more ready to discuss their experiences (see chapter 4.3).
2. Social workers must be alert to trafficked adults, children, and young people's need for sexual health services, which must be offered sensitively with consideration for the child or young person's confidentiality and dignity (see chapter 4.3).
3. Trafficked adults, children and young people require considerable support to navigate and access all types of healthcare services and social workers and carers need to be prepared to offer practical and emotional assistance with this, according to individuals' wishes (see chapter 4.4).
4. Social workers and carers should take account of the high levels of violence, sexual abuse and deprivation that trafficked adults, children, and young people may have experienced and the implications this may have for their ability to trust others and feel secure (see chapter 4.3).
5. Social workers should arrange interpreting services which trafficked adults, children, and young people experience as accessible and confidential in order to assist them in articulating their health needs and accessing health services (see chapter 4.4).

Voluntary sector support services

1. Prioritize individuals' medical and health needs during intake—especially urgent health needs - by:
 - a. specifically enquiring about health problems upon arrival into services;
 - b. addressing urgent problems as quickly as possible (see chapters 4.1, 4.2 and 4.3);

2. Develop links and supported referral pathways with health providers to ensure that a relevant range of professionals are prepared to identify, refer and treat individuals who have been trafficked (see chapter 4.1, 4.2, 4.3, and 4.4);
3. Inform and support trafficked people to use healthcare services, including by providing trafficking people with information about the NHS and their rights to access care, and by providing assistance to access and coordinate healthcare (see chapter 4.4). Assistance may be required with:
 - a. registering with services;
 - b. booking appointments;
 - c. ensuring provision of interpretation and translation services or advocacy;
 - d. paying for prescriptions and/or applying for exemptions from prescription charges;
 - e. accessing written medical information in an appropriate language and format;
 - f. providing healthcare professionals with basic information about human trafficking and appropriate referral pathways into and from support services.
4. Equip frontline voluntary sector support services staff with training to identify and respond to psychological distress (see chapter 4.3);

Research Community

Conduct research to:

1. Investigate the acceptability and effectiveness of psychological interventions to support the recovery of trafficked people (see chapter 4.6, 4.3, and 4.5);
2. Explore trafficked people's experiences of pregnancy and parenting (see chapter 4.3);
3. Explore the intergenerational impact of human trafficking on children (see chapter 4.3);
4. Investigate NHS primary care professionals' knowledge and experiences of human trafficking and associated information and support needs (see chapter 4.7);
5. Refine indicators of human trafficking and develop and test screening tools to identify trafficked people in healthcare settings (see chapter 4.6);
6. Investigate the effectiveness of training programmes in improving the identification and referral of potentially trafficked people (see chapter 4.6 and 4.7);
7. Investigate the generalizability of multi-agency models and guidelines for working with victims of violence and with vulnerable migrants with regards to trafficked people (see chapter 4.6 and 4.9).

1. Study aims and objectives

Aims

Our research programme aimed to provide evidence to inform the NHS response to human trafficking, specifically the identification and safe referral of trafficked people and the provision of appropriate care to meet their health needs.

Objectives

The objectives of the research were:

- 1) To synthesise evidence on the number of trafficked adults and children identified and using NHS services in England, the healthcare needs of trafficked people, and their experiences and use of healthcare services;
- 2) To document NHS experience, knowledge and gaps about trafficked people's health care needs;
- 3) To provide recommendations research-based papers and dissemination strategies to support NHS staff to identify, refer and care for trafficked people and to become a strategic partner within the UK National Referral Mechanism (NRM) and with other agencies.

2. Patient and Public Involvement

Early involvement

Our research group involved voluntary and statutory agencies involved in efforts to tackle human trafficking at a very early stage. These agencies helped the team to establish research priorities for the proposal (e.g. to investigate to which health services were used by trafficked people, whether and how people are able to access NHS care whilst in the trafficking situation, and NHS staff training needs), commented on the research proposal, and provided data and advice on methodological challenges.

Involvement during the research programme

A Research Advisory Group was established and met six times over the course of the research, providing advice and support by:

- Informing the research team on policy, service, and data issues of relevance to the research, including trends in human trafficking in the UK and rates of referrals to post-trafficking voluntary sector support services;
- Reviewing lists of documents and studies included in two systematic reviews and recommending other potentially relevant documents;
- Facilitating contact between the research team and support agencies who may be able to refer trafficked people to participate in the research;
- Assisting the research team to recruit trafficked people to participate in survey interviews;
- Providing details of NHS and non-NHS professionals who may be eligible to participate in qualitative interviews;
- Attending the stakeholder workshop event in February 2015;
- Reviewing research findings and advising on their interpretation and implications for policy and service provision.

In our original grant application we stated our intention to invite trafficked people to participate in our Research Advisory Group. It was not possible to identify trafficked people willing to take part in this group. The research team is aware that post-trafficking distress, safety concerns, requirements to relocate, and people's desire to "move-on" may mean that, for some trafficked people, participation is not in their best interest. Representatives of several organisations that provided direct services to trafficked people did, however, participate in the Research Advisory Group.

3. Background

Human trafficking

Human trafficking is “the recruitment, transportation, transfer, harbouring or receipt of persons by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation” (1). Women, men, and children are trafficked across and within national borders for forced sex work, domestic servitude, and into various labour sectors, including but not limited to agricultural, manufacturing and service industries, and frequently experience extreme physical, psychological and sexual violence and social marginalisation.

Since the original commissioning of this programme of work, the UK has instituted the ‘Modern Slavery Act, 2015’, which received Royal Assent on 26th March 2015. The Modern Slavery Act addresses both human trafficking and slavery, defining slavery as knowingly holding a person in slavery or servitude or knowingly requiring a person to perform forced or compulsory labour. An offence of human trafficking is committed if a person arranges or facilitates the travel of another person with a view to that person being exploited, where exploitation refers to slavery, servitude, forced or compulsory labour, sexual exploitation, removal of organs, or the securing of services by force, threats, deception or from children or vulnerable persons.

Measuring the scale of human trafficking is hampered by definitional complexities and the crime’s covert nature (2-6). The UK National Referral Mechanism (NRM) provides the pathway by which trafficked people may apply for temporary immigration protection, accommodation, and support (7, 8). In 2014, 1,669 adults and 671 children were referred into the NRM (9). 830 (35.4%) applications pertained to sex-trafficking, 305 (13.0%) to domestic servitude, and 788 (33.7%) to labour-trafficking. These data are unlikely, however, to give a full picture of human trafficking. Trafficked people are often unable, or unwilling, to engage with frontline agencies or the NRM. Fears of arrest, deportation or ill-treatment by police can hinder help-seeking and trust when help is offered (10-13). Trafficked children’s and adolescents’ distrust is exacerbated by the need to prove their status as children in order to access support from children’s services⁶.

Human trafficking and health

Under the new Modern Slavery Act, various health bodies have a duty to cooperate with the Independent Anti-Slavery Commissioner, including NHS Trust, NHS Foundation Trusts, and Local Health Boards. Within the act, however, there is limited guidance on meeting the health needs of people who have been trafficked.

Trafficked people experience a range of health risks prior to, during, and following their trafficking experiences (14), but research into the health needs of trafficked people is limited (15). A systematic review published in 2012 identified several important knowledge gaps including evidence on the:

- Health risks and outcomes experienced by women trafficked for domestic servitude and other forms of labour exploitation;
- Health risks and outcomes experienced by trafficked men and trafficked children;
- Health risks and outcomes experienced by trafficked women, men, and children in high income country settings;
- Medium- to long-term health outcomes among trafficked women, men, and children;
- Effective interventions to improve trafficked people's physical and mental health.

Studies conducted with women who have been trafficked for sexual exploitation and who are accessing post-trafficking voluntary sector support suggest in low and middle income countries suggested, however, that trafficked people experience high levels of physical and sexual violence and have significant physical, sexual, and mental health needs.

The review identified several studies conducted in low and middle income countries in which women and girls trafficked for forced sex work reported high levels of physical and sexual violence (15). A multi-country study conducted between 2004 and 2005, for example, surveyed 207 women trafficked for forced sex work and found that 95% of women reported having experienced either physical or sexual violence while trafficked (16). A qualitative analysis of case files of women and girls receiving support from an Indian NGO after being trafficked for forced sex work found that many women were raped upon initiation into sex work and were subjected to ongoing physical and sexual violence as a means of punishment and control (17). Other studies in South and South East Asia have compared the risk of violence among women trafficked into forced sex work and non-trafficked sex workers. Three studies, conducted in India and Thailand, suggest that the risk of violence shortly after entry into sex work is significantly higher among trafficked women (18-20). For many

trafficked people, experiences of violence and abuse predate their contact with their traffickers. A study of 120 Moldovan trafficked women, for example, of human trafficking found that 31% reported a history of child sexual abuse (21), while the above multi-country study reported a prevalence of 12%. Experiences of pre-trafficking violence may not only contribute to people's decision to migrate but may also influence how people experience and respond to later health risks (22).

The role of the NHS in responding to human trafficking

There are a number of scenarios in which healthcare professionals might encounter trafficked people and have an opportunity to provide clinical care and referral to appropriate support services (23). In England and Wales, NHS professionals are encouraged to notify the Home Office when they come into contact with patient they suspect has experienced human trafficking or modern slavery⁷. Yet, little is known about whether NHS professionals come into contact – either knowingly or unknowingly - with trafficked people, which clinical disciplines are most likely to see trafficked people, and under what circumstances. Similarly, little is known about healthcare professionals' knowledge and readiness to identify and respond to the needs of trafficked people.

In the USA, a cross-sectional survey of 180 emergency department staff found that although 79% knew what trafficking was, only 27% thought it was a problem that affected their patient population and just 6% believed that they had ever treated a trafficked person (24). 95% had received no formal training on responding to human trafficking, and the majority reported being hesitant or not confident in their ability to identify or correctly treat a trafficking person who presented to the emergency department. A pre-training survey of 178 healthcare professionals attending human trafficking training in the Middle East, Caribbean, and Central America reported generally high levels of knowledge regarding the health outcomes associated with human trafficking but found that many healthcare professionals lacked awareness of their role in responding to human trafficking (25). In the UK, a qualitative study of seven healthcare professionals working with women trafficked for sexual exploitation found that staff reported difficulties with building trusting relationships with trafficked patients and with coping with the emotional burden of women's needs and experiences (26). To our

⁷ From the 1st November 2015, specified public authorities have a duty to notify the Secretary of State of any individual identified in England and Wales as a suspected victim of human trafficking or modern slavery. This duty is intended to improve the identification of victims and build a more comprehensive picture of the nature and scale of modern slavery. NHS professionals are not bound by this duty but are encouraged to make a voluntary notification.

knowledge, no previous research has investigated whether UK health professionals come into contact with trafficked people, their knowledge and readiness to respond to human trafficking, or their training needs.

Trafficked people's entitlements to NHS care

Trafficked people's rights to healthcare are provided for by a number of international and regional instruments to which the UK is party. The Council of Europe Convention on Action against Trafficking in Human Beings (ECAT), for example, came into force in the UK on 1 April 2009 and requires the UK is to provide trafficked people with access to emergency medical care (27). More recently, the EU Directive 2011/36 on Preventing and Combating Trafficking in Human Beings and Protecting its Victims, replacing Council Framework Decision 2002/629/JHA (the "EU Directive") required the UK to provide trafficked people with access to "*necessary* medical treatment including psychological assistance, counselling and information, and translation and interpretation services where appropriate" (28).

Not everyone is entitled to access all NHS services in England without charge. The NHS (Charges to Overseas Visitors) Regulations 2015 legally oblige all NHS Trusts, NHS Foundation Trusts, and Local Authorities in the exercise of public health functions in England to establish whether patients are overseas visitors to whom charges apply or whether they are exempt from charge. When charges apply, these bodies must make and recover charges. Public health services are, however, exempt from charge for all people, including:

- Family planning services (excluding termination of pregnancy); diagnosis and treatment of specified infectious diseases; diagnosis and treatment of sexually transmitted infection.

Other services exempt from charge for all people include⁸:

- Accident and Emergency services (excluding services provided after admission as an inpatient or during follow-up outpatient appointments),
- Treatment received under the Mental Health Act 1983 or Mental Capacity Act 2005;

⁸ Charges only apply under the Charging Regulations for services provided in an NHS hospital or, when provided outside an NHS hospital, by staff employed by or under the direction of an NHS hospital.

- Treatment required for a physical or mental condition caused by torture, female genital mutilation, domestic violence, or sexual violence.

Charges are also not applied to:

- Non-EEA nationals subject to immigration control who have paid the newly introduced health surcharge;
- Refugees, asylum seekers, and certain categories of failed asylum seekers;
- Looked after children;
- Prisoners and immigration detainees;
- UK Government employees and war pensioners;
- Those covered by reciprocal healthcare agreements, other international obligations, and employees on UK-registered ships; and
- Victims and suspected victims of human trafficking as determined by the UK Human Trafficking Centre or the Home Office, plus their spouse/civil partner and any children under 18 provided they are lawfully present in the UK.

The specific exemption for victims and suspected victims of trafficking applies to anyone who the UK Human Trafficking Centre or Home Office have (i) conclusively identified as a trafficked person, or (ii) consider there are reasonable grounds to believe is a trafficked person and for whom a "reflection and recovery period" has not yet expired. That is, in order to make use of this exemption, a person who is thought to be a trafficked person must have been referred into the NRM.

Individuals may not self-refer into the NRM, but must instead be referred by a representative of a designated "First Responder" agency⁹. When making a referral First Responders complete a standardised referral form, comprising a list of indicators of human trafficking or modern slavery and a narrative summary of evidence to support the reasons for referral. Adults must consent to being referred into the National Referral Mechanism. Children are not required to consent to a referral being made on their behalf.

Once a referral has been made to the NRM, UK Human Trafficking Centre and Home Office caseworkers make a preliminary decision on whether there are "reasonable grounds" to

⁹ The current list of First Responders comprises: the Serious Organised Crime Agency, Police, UK Border Agency, Local Authorities, Gangmasters' Licensing Authority, Northern Ireland Health and Social Care Trusts, and selected non-governmental organisations (NGOs) with expertise in recognising and responding to human trafficking. The NGOs that currently have First Responder status are: the Salvation Army, the Poppy Project, Migrant Help, Medaille Trust, Kalayaan, Barnardos, Unseen, TARA, CTAC (NSPCC), BAWSO, and New Pathways.

consider the person to be a trafficked person or a victim of modern slavery¹⁰. If so, they will issue a positive “reasonable grounds” decision. A positive reasonable grounds decision grants the person a “reflection and recovery” period, which under ECAT should be of a sufficient duration to allow the person to “recover and escape the influence of the traffickers and/or take an informed decision on cooperating with the competent authorities”. The standard duration of the reflection and recovery period in the UK is 45 days, during which time individuals can access support – including accommodation - and no action can be taken to remove them from the UK. A more rigorous assessment of whether the person is “on the balance of probabilities” believed to be trafficked is also conducted during the 45-day period. A positive decision at this “conclusive grounds” stage enables the person to apply for discretionary leave to remain either because they have particularly compelling personal circumstances which justify remaining in the UK for a longer period or need to stay in the UK in order to pursue a claim of compensation against their traffickers or to assist with police enquiries¹¹. The period of leave awarded depends on the individual facts of the case, but is normally granted for a minimum of 12 and not more than 30 months. There is no statutory right of appeal against an NRM decision, although reconsiderations can be requested and decisions judicially reviewed.

Prior to being referred into the NRM, a person who is suspected of having been trafficked has no entitlement to free healthcare provided by in or under the direction of a NHS hospital on the basis that they may have been trafficked (although they may be eligible on other grounds, for example, because they have claimed asylum or are EU nationals with the right to reside in the UK). A positive reasonable grounds decision (Phase 2) grants the applicant a 45 day “reflection and recovery period”, during which time the trafficked person may access primary and secondary NHS healthcare without charge. The Overseas Charging regulations were revised in 2015 and the guidance updated to state that charges incurred prior to a person being referred into the NRM for identification must be refunded or, if not yet paid,

¹⁰ Following a review of the NRM commissioned by the Home Secretary, pilots have been established in two geographical areas (South West and West Yorkshire) to test the effectiveness of decision-making by multi-agency panels and referrals by Slavery Safeguarding Leads. Multi-disciplinary panels are comprised of representatives of relevant agencies and organisations with a relevant interest in modern slavery issues and protecting vulnerable individuals. The pilot schemes were launched in August 2015 for 12 months.

¹¹ The fact that a person is seeking compensation against their traffickers does not itself merit a grant of discretionary leave; leave is granted only where it would be unreasonable to pursue a claim from outside the UK. With regards to discretionary leave to remain to assist with police enquiries, an individual must have agreed to cooperate with the enquiry and the police must make a formal request for leave to be granted on this basis.

cancelled, if a positive reasonable grounds decision is made. If a conclusive grounds decision is received, the applicant can continue to access primary and secondary NHS healthcare without charge. If the UK Human Trafficking Centre or Home Office decide that there are not reasonable grounds to believe that the person is a trafficked person, the person is no longer exempt from charge other than for courses of treatment already under way, which remain free of charge until complete or until the person leaves the country. The spouse/ civil partner and dependent children of those exempt under this regulation are also exempt from charges in their own right, as long as they are here legally.

4. PROTECT: Methods and Findings

Section four details the methods and findings of each of the studies conducted as part of the PROTECT research programme. Sections 4.1 to 4.5 report on studies that focused on the health needs and care experiences of trafficked people. Sections 4.6 to 4.9 report on studies that focused on the NHS response to trafficked people's needs.

4.1 Systematic review of evidence on the health needs of trafficked people

Summary

The study updated a previous systematic review, published in 2012, summarising evidence on the health risks and outcomes experienced by trafficked people. The previous review identified nineteen studies, all of which reported on trafficked women and girls and focused predominantly on trafficking for sexual exploitation. This updated review identified papers reporting on twenty-nine studies, including trafficked men and children and people trafficked for labour exploitation. Studies were predominantly conducted in low and middle income country settings and focused on women who had been trafficked for sexual exploitation, typically either in contact with non-governmental support services or still engaged in forced sex work. Few studies have been conducted in high-income country settings or with clinical samples, and the generalisability of findings to the health needs of trafficked people in England is uncertain. Trafficked men, trafficked children, and women trafficked for labour exploitation and domestic servitude remain under-represented in research on health and human trafficking. However, preliminary evidence indicates a high burden of physical and mental health problems among these groups. Studies reported that trafficked women, men, and children experience high levels of violence and a high prevalence of physical symptoms such as headache, stomach and back pain, fatigue and memory problems, and of mental health problems such as depression, anxiety, and post-traumatic stress disorder (PTSD). Serological data on sexually transmitted infections are limited, but self-reported symptoms suggest a high prevalence of infection among trafficked women.

Implications

There are limited data on the health needs of trafficked people, especially in high income country settings and with regards trafficked men and trafficked children. However, findings from studies to date indicate that trafficking is associated with a range of physical, sexual, and mental health problems and suggest that trafficked people are likely to require a coordinated response by NHS and other support services.

Recommendations

1. Health Education England, the Royal Colleges, and professional organisations responsible for setting training standards for NHS staff should ensure that NHS professionals are trained to be aware of indicators of possible trafficking and how to respond appropriately to suspicions or disclosures of this form of abuse; and to conduct identification and referral – including to NRM First Responders – in safe and linguistically appropriate ways that prioritise providers' and trafficked people's safety;
2. Voluntary sector support services should prioritize individuals' medical and health needs during intake—especially urgent health needs – by specifically enquiring about health problems upon arrival into services and addressing urgent problems as quickly as possible;
3. Voluntary sector support providers should develop links and supported referral pathways with health providers to ensure that a relevant range of professionals are prepared to identify, refer and treat individuals who have been trafficked.

Aim

This review aimed to update and expand the search strategy of a previous systematic review, published in 2012, to summarise evidence on the health risks and outcomes reported in studies of trafficked people.

The objectives of the review were to estimate:

- 1) The prevalence and risk of violence experienced by trafficked people compared to non-trafficked people working in the same industry;
- 2) The prevalence and risk of physical, mental, and sexual health problems among trafficked people compared to non-trafficked people working in the same industry.

Methods

Inclusion criteria

- **Types of studies:** Cross-sectional surveys; case control studies; cohort studies; case series analyses; experimental studies with baseline measures for the outcomes of interest; or secondary analyses of organisational records.
- **Population:** Males or females (adult or child) that self-identify or are believed by the research team to have been trafficked. If studies include trafficked people as a subset of a broader sample, data on trafficked people must be reported separately.
- **Formats:** Peer-reviewed literature and academic dissertations and theses. No language restrictions were used.
- **Outcome measures:** Studies measuring the prevalence and/or the risk of physical, psychological or sexual violence whilst trafficked; and/or any reported measure of physical, mental, or sexual and reproductive health or disorder. No restrictions were placed on the method of measuring physical, mental, or sexual health outcomes.

Information sources: Electronic searches of 10 databases indexing peer-reviewed academic literature and five databases and websites indexing theses and dissertations, reference list screening, and citation tracking using Web of Knowledge and Google Scholar (see Appendix B). The terms used to search electronic databases were based on a previously published peer-reviewed systematic review and piloted prior to use (15). The lower and upper date limits for searches were 1st January 2011 and 17th April 2015, respectively.

Study screening, extraction, and appraisal: Titles and abstracts were independently assessed against the inclusion criteria by two members of the research team (Livia Ottisoiva and Stacey Hemmings); disagreements were resolved by consensus or with assistance from

a third member of the research team (Siân Oram). If a citation's relevance was uncertain following title and abstract screening it was retained for retrieval and full text screening. The full texts of potentially eligible studies were then independently assessed by the two reviewers (Livia Ottisova and Stacey Hemmings), with disagreement again resolved by consensus or with reference to a third member of the research team (Siân Oram). One reviewer (Livia Ottisova) extracted data on study design, sample characteristics, the definition and method of assessing human trafficking, outcome measures, and outcomes of interest. Data were extracted disaggregated by gender, age, and type of exploitation where possible.

Data analysis: Prevalence estimates and odds ratios for outcomes of interest were calculated. Where possible, estimates were calculated separately by gender and type of exploitation.

Findings

Included studies: Following screening of 1,124 titles and abstracts and 65 full text papers, 35 papers reporting on 29 studies were included in the review (Appendix C). 25 of the 29 studies were conducted with trafficked women or girls only. Eighteen of the 29 studies were conducted in from South or Southeast Asia, seven in Europe (single country studies in Israel, Italy, Moldova, and the UK) two in Central America, and one in North America. In reporting findings we draw particular attention to studies conducted in higher-income European settings and in North America, although the generalisability of these studies to the health needs of trafficked people in England is uncertain.

Violence: Across several studies, women and girls trafficked into sexual exploitation reported high levels of violence (Table 1). Among studies of trafficked people in contact with voluntary sector post-trafficking support services, the prevalence of physical violence ranged from 33% to 90%. Prevalence of sexual violence was also high. In Zimmerman et al's multi-country European study, for example, 94.8% of women reported having experienced either physical or sexual violence whilst trafficked. Increased risk of violence at entry initiation into sex work was reported across several studies; mixed findings were reported by studies measuring violence over other time periods. Kiss et al reported on a large multi-country study conducted in South East Asia and provided some of the only data on violence experienced by trafficked men and children. The prevalence of physical violence reported by trafficked women, men, and children was 38%, 49%, and 24%, respectively. Sexual violence was reported by 20%, 1%, and 21% of trafficked women, men, and children, respectively. As reported in more detail in chapter 4.2, Turner-Moss et al found that four of

seven women and seven of 23 men trafficked for labour exploitation in the UK reported physical violence while trafficked.

Table 1: Violence reported in studies of trafficked people

| Author and year | Type of Violence | Frequency of violence (Trafficked people) | Frequency of violence (Controls) | Odds ratio and 95% CI |
|-----------------------------|---|---|----------------------------------|-----------------------|
| Sex industry samples | | | | |
| Cwikel 2004 | Physical assault at work | 30/93 (32.3%) | 2/10 (20.0%) | 1.9 (0.35 - 19.4) |
| | Sexual assault at work | 20/93 (31.2%) | 1/10 (10.0%) | 2.5 (0.31–113.4) |
| Decker 2011 | Physical, sexual or psychological violence or mistreatment at work in the past week. | 44/85 (51.8%) | 254/730 (34.8%) | 2.0 (1.25 – 3.24) |
| | Sexual violence at initiation into sex work. | 10/85 (11.8%) | 26/730 (3.6%) | 3.6 (1.49 – 8.09) |
| Decker 2009 | Physical or sexual violence from a client in the past month. | | | |
| | a) Entry age <18 or forced or deceived into sex work | 31/62 (50.0%) | 10/28 (35.7%) | 1.8 (0.66 – 5.08) |
| | b) Entry <18 yrs | 20/38 (52.6%) | 10/28 (35.7%) | 2.0 (0.66 – 6.18) |
| | c) Forced or deceived into sex work | 17/37 (45.9%) | 10/28 (35.7%) | 1.53 (0.50 – 4.76) |
| George 2013 | Physical violence (past 6 months) | 280/574 (48.8%) | 322/563 (57.2%) | 0.90 (.067-1.22) |
| | Sexual violence (past 6 months) | 477/574 (83.1%) | 394/563 (70.0%) | 2.09 (1.42 – 3.06) |
| Gupta 2011 | Any violence in the past 6 months | | | |
| | a) Entry age <18 or forced or deceived into sex work | 84/157 (53.5%) | 256/655 (39.1%) | 1.79 (1.26-2.54) |
| | b) Entry <18 yrs, not forced or deceived into sex work | 50/96 (52.1%) | 256/655 (39.1%) | 1.69 (1.08 – 2.67) |
| | c) Entry age <18 yrs and forced or deceived into sex work | 16/26 (61.5%) | 256/655 (39.1%) | 2.49 (1.04 – 6.24) |
| | d) Entry >18 yrs and forced or deceived into sex work | 18/34 (52.9%) | 256/655 (39.1%) | 1.75 (0.83 – 3.74) |
| Sarkar 2008 | Physical, sexual or psychological violence in the first few months after entry into sex work. | 105/183 (57.3%) | 61/397 (15.3%) | 7.4 (4.8 – 11.3) |

| | | | | |
|---|--|-------------------|------------------|---------------|
| Silverman 2011 | Any violence in the first month after entry into sex work. | 66/88 (75.0%) | 66/123 (53.7%) | 2.6 (1.4-4.7) |
| | Physical or sexual abuse in past year. | 14/88 (15.9%) | 19/123 (15.5%) | 1.0 (0.5-2.2) |
| Wirth 2013 | Forced sexual intercourse in past year. | 23/107 (21.1%) | 218/1707 (12.8%) | 1.9 (1.1-3.0) |
| Post-trafficking support service samples | | | | |
| Di Tommaso 2009 | Any violence or material neglect while trafficked. | 1350/1644 (82.1%) | - | - |
| Kiss 2015 | <u>Women</u> | | - | - |
| | Physical violence while trafficked. | 388/1015(38.3%) | - | - |
| | Sexual violence while trafficked. | 204/1015(20.2%) | - | - |
| | <u>Men</u> | | - | - |
| | Physical violence while trafficked. | 188/383 (49.1%) | | |
| | Sexual violence while trafficked. | 5/383 (1.3%) | | |
| | <u>Children</u> | | | |
| | Physical violence while trafficked. | 82/344 (23.8%) | | |
| | Sexual violence while trafficked. | 74/344 (21.5%) | | |
| Le 2014 | Physical violence while trafficked. | 31/73 (43%) | - | - |
| | Sexual abuse while trafficked. | 44/73 (60%) | - | - |
| McCauley 2010 | Physical violence while trafficked. | 45/136 (33.1%) | - | - |
| | Sexually abused while trafficked. | 42/136 (30.9%) | - | - |
| Turner-Moss 2013 | <u>Women</u> | | | |
| | Physical violence while trafficked. | 4/7 (57.1%) | | |
| | <u>Men</u> | | | |
| | Physical violence while trafficked | 7/23 (30.4%) | | |
| Zimmerman 2008 | Physical violence while trafficked. | 145/192 (75.5%) | - | - |
| | Sexual violence while trafficked. | 172/192 (89.6%) | - | - |

* Estimates refer to trafficked women unless otherwise specified

Physical health: Six studies documented self-reported physical health symptoms reported by trafficked people in contact with voluntary sector post-trafficking support services (Table

2). The majority of studies were conducted in low and middle income country settings. Zimmerman et al's multi-country study included women trafficked for sexual exploitation and receiving support in Belgium, Bulgaria, Czech Republic, Italy, Moldova, Ukraine and the United Kingdom and reported that, when interviewed between 0 and 14 days after entering into voluntary sector post-trafficking support services, 63% of participants reported suffering from 10 or more concurrent symptoms. Among the most common physical health problems reported were headaches (82.3%), fatigue (81.3%), dizziness (70.3%), back pain (68.8%) and memory loss (62.0%). Gender-disaggregated data were reported by Kiss et al, who found a high prevalence of physical health symptoms among trafficked men, women, and children in their multi-country South East Asian study. Commonly reported symptoms included headache (22% of men, 22% of women, and 20% of children), fatigue (24% of men, 17% of women, and 13% of children), dizziness (23% of men, 18% of women, and 19% of children), and back pain (19% of men, 19% of women, and 17% of children).

Table 2: Physical health symptoms reported in studies of trafficked people

| Author-year | Sample Size | Headache | Back pain | Stomach pain | Dental pain | Fatigue | Memory problems |
|------------------|-------------|----------|-----------|--------------|-------------|---------|-----------------|
| Crawford 2008 | 20 | 35% | | 25% | | 10% | |
| Cwikel 2004 | 84 | 60% | 40% | 53% | 57% | | |
| Kiss 2015 | 1,015 | 21% | 19% | | 10% | 18% | 16% |
| Oram 2012 | 120 | 62% | 51% | 61% | 58% | | 44% |
| Turner-Moss 2013 | 35 | 43% | 36% | 10% | 23% | 30% | 13% |
| Zimmerman 2008 | 192 | 83% | 69% | 61% | 58% | 81% | 62% |

Sexual health: Thirteen studies reported on the overall prevalence of self-reported symptoms of sexually transmitted infection (STI), which ranged from 5.7% in a study of sexually exploited women in brothel and detention settings in Israel to 65.9% in a cross-sectional survey of trafficked female sex workers in Thailand (Table 3). Two studies reported on prevalence of STI reported by trafficked women accessing support services in Europe; Da Conte, reporting results from serological tests and Zimmerman et al, reporting self-reported symptoms of STI. Each reported a prevalence of 58%. No data were available reporting on the sexual health of trafficked men.

Table 3: Prevalence of sexually transmitted infection reported in studies of trafficked people

| Author-Year | Sample Size | STI prevalence |
|-----------------|-------------|--------------------------------|
| Crawford 2008 | 20 | 35% |
| Cwikel 2004 | 84 | 6% |
| Dal Conte 2011 | 1,400 | 58% |
| Decker 2011 | 85 | 66% |
| George 2013 | 574 | 49% |
| Goldenberg 2013 | 31 | 23% |
| McCauley 2010 | 73 | 66% |
| Servin 2015 | 20 | 30% |
| Silverman 2008 | 246 | Syphilis 20% Hepatitis B 4% |
| Silverman 2014 | 211 | 39% |
| Urada 2014 | 56 | 32% |
| Varma 2015 | 27 | 53% |
| Zimmerman 2008 | 192 | 58% |

Mental health: Six studies reported on the prevalence of depression, anxiety, or post-traumatic stress disorder (PTSD) among trafficked people in contact with support services, and a further two studies reported on symptoms of psychological distress (Table 4). Abas et al used diagnostic instruments to assess mental disorder among Moldovan trafficked women; screening instruments were used by the remaining seven studies to assess probable disorder.

Abas et al reported that 55% of the sample met diagnostic criteria for mental disorder at an average of 6 months after returning to Moldova: 6% anxiety disorder, 13% depression, and 36% PTSD. Higher risk of mental disorder was associated with experiences of childhood sexual abuse (Adjusted Odds Ratio [AOR] 4.68, 95% CI 1.04-20.92), longer duration of exploitation (AOR 1.12, 95% CI 0.98-1.29), and unmet social needs (AOR 1.80; 95% CI 1.28-2.52). Higher levels of post-trafficking social support were associated with reduced risk of mental disorder (AOR 0.64; 95% CI 0.52-0.79). Higher prevalence of probable disorder was reported by Hossain et al, measuring symptoms among women at 0-14 days after entry into support services: 55% of women screened positive for reported symptoms indicative of depression, 48% of anxiety, and 77% of PTSD when interviewed 0-14 days after entry into

voluntary sector post-trafficking support services. After adjusting for violence prior to and during exploitation, women who had been exploited for six months or more reported significantly higher symptom levels of depression (AOR 2.23, 95% CI 1.11-4.53) and anxiety (AOR 2.22, 95% CI 1.11-4.46). After the same adjustments, women who had been out of the trafficking situation for three or more months reported significantly lower levels of symptoms of depression (AOR 0.4, 95% CI 0.2-0.8) and anxiety (AOR 0.39, 95% CI 0.2-0.8).

Data on mental health problems among trafficked men and trafficked children were particularly lacking. Kiss et al, reporting on a multi-country study conducted in South East Asia, however, reported that 48% of men screened positive for anxiety, 61% for depression, and 46% for PTSD. For children, the equivalent figures were 32%, 57%, and 27%.

Table 4: Psychological distress reported in studies of trafficked people

| Author and year | Instrument and threshold used to assess mental distress | Prevalence of mental distress |
|---------------------------------------|---|--|
| Anxiety | | |
| Abas 2013 | Diagnostic assessment using Structured Clinical Interview for DSM-IV disorders | <u>Women:</u> 7/120 (6%) |
| Hossain 2010 | Brief Symptom Inventory mean score ≥ 1.87 | <u>Women:</u> 98/204(48%) |
| Kiss 2015 | Hopkins Symptoms Checklist 25 score ≥ 1.75 | <u>Women:</u> 138/287 (48%) <u>Men:</u> 185/383 (48%) <u>Children:</u> 111/344 (32%) |
| Tsutsumi 2008 | Hopkins Symptoms Checklist 25 score ≥ 1.75 | <u>Women:</u> 148/164 (90%) Sexual exploitation: 43/44 (98%) Labour exploitation:105/120 (88%) |
| Turner-Moss 2013 | Brief Symptom Inventory mean score ≥ 1.87 | <u>Women:</u> 1/10 (10%) <u>Men:</u> 5/23 (22%) |
| Depression | | |
| Abas 2013 | Diagnostic assessment using Structured Clinical Interview for DSM-IV disorders | <u>Women:</u> 15/120 (13%) |
| Cwikel 2004 | Centre for Epidemiologic Studies Depression Scale mean score | <u>Women:</u> 48/84 (57%) |
| Hossain 2010 | Brief Symptom Inventory mean score ≥ 1.87 | <u>Women:</u> 112/204(55%) |
| Kiss 2015 | Hopkins Symptoms Checklist 25 score ≥ 1.75 | <u>Women:</u> 191/288 (67%) <u>Men:</u> 232/383 (61%) <u>Children:</u> 197/344 (57%) |
| Tsutsumi 2008 | Hopkins Symptoms Checklist 25 score ≥ 1.75 | <u>Women:</u> 141/164 (86%) |
| Turner-Moss 2013 | Brief Symptom Inventory mean score ≥ 1.87 | <u>Women:</u> 2/10 (20%) <u>Men:</u> 5/24 (21%) |
| Post-traumatic stress disorder | | |
| Abas 2013 | Diagnostic assessment using Structured Clinical Interview for DSM-IV disorders | <u>Women:</u> 43/120 (36%) |
| Cwikel 2004 | PTSD Checklist Civilian Version score ≥ 50 | <u>Women:</u> 17/87 (20%) |
| Hossain 2010 | Harvard Trauma Questionnaire, mean score ≥ 2.00 | <u>Women:</u> 157/204 (77%) |
| Kiss 2015 | Harvard Trauma Questionnaire, mean score ≥ 2.00 | <u>Women:</u> 126/288 (44%) <u>Men:</u> 177/383 (46%) <u>Children:</u> 91/344 (27%) |
| Tsutsumi 2008 | PTSD Checklist Civilian Version score ≥ 50 | <u>Women:</u> 22/164 (13%) |
| Turner-Moss 2013 | Harvard Trauma Questionnaire, mean score ≥ 2.00 | <u>Women:</u> 1/6 (17%) <u>Men:</u> 3/19 (16%) |
| Other psychological distress | | |
| Gray 2012 | Hopkins Symptoms Checklist 25 score (≥ 1.75 indicative of anxiety or depressive disorder) | <u>Women:</u> Anxiety and depression mean score for total sample 1.97 |
| Le 2014 | Self-Reporting Questionnaire-20, mean score >7 | <u>Women:</u> 47/73 (64%) |

4.2 Case series of the health needs and experiences of men and women trafficked for labour exploitation

Summary

This study analysed data from a case series of anonymised case records of a consecutive sample of 35 men and women who had been trafficked for labour exploitation in the UK and who were receiving support from the non-governmental organisation Migrant Helpline between June 2009 and July 2010. Over three-quarters of the sample was male (77 %) and two-thirds aged between 18 and 35 years (mean 32.9 years, SD 10.2). Participants had been trafficked for domestic work, food packaging and processing, construction, and other forms of labour exploitation. Forty percent of participants reported violence while trafficked and a high proportion endured unsanitary and unsafe living and working conditions that are likely to have posed risks to physical and mental health. Forty-three percent reported having been denied medical care while trafficked. Post-trafficking, physical health symptoms were reported by 81% percent. Commonly reported symptoms included headache, back pain, fatigue, and vision and dental problems. Findings are also reported in Turner-Moss *et al* 2014 (29).

Implications

People who are trafficked into various low-skill labour sectors are highly likely to emerge with significant health needs that require assessment and appropriate health care. Health problems may relate to experiences of violence, poor living and working conditions, or inadequate nutrition and medical care while trafficked. Although trafficked people may have very limited access to medical care, our findings suggest that some may reach health facilities. Interpretation of the results is limited, however, by the small size of the study sample.

Recommendations

1. Health Education England, the Royal Colleges, and professional organisations responsible for setting training standards for NHS staff must ensure that NHS professionals are trained to be aware of indicators of possible trafficking and how to respond appropriately to suspicions or disclosures of abuse; and to conduct identification and referral – including to NRM First Responders – in safe and linguistically appropriate ways that prioritise providers' and trafficked people's safety;
2. Sexual health services should establish local links with non-governmental organisations (NGOs) working with trafficked people;

3. Voluntary sector support services should prioritize individuals' medical and health needs during intake—especially urgent health needs – by specifically enquiring about health problems upon arrival into services and addressing urgent problems as quickly as possible;
4. Voluntary sector support services should develop links and supported referral pathways with health providers to ensure that a relevant range of professionals are prepared to identify, refer and treat individuals who have been trafficked.

Aim

This study aimed to describe the health risks and needs of people trafficked to the UK for labour exploitation.

The objectives of the study were to:

1. Describe the living and working conditions experienced by men and women trafficked to the UK for labour exploitation;
2. Describe the prevalence of abuse and of health symptoms experienced by men and women trafficked to the UK for labour exploitation.

Methods

Study design and setting: Case series using anonymised case records of a consecutive sample of men and women receiving post-trafficking support from Migrant Helpline between June 2009 and July 2010.

Participants: Migrant Helpline service users who (1) consented to share their anonymised data; (2) were aged 18 years or older; (3) had been referred to Migrant Helpline as people who were suspected of having been trafficked for labour exploitation. We defined human trafficking in line with the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Girls (1). Service users who had not been referred to the Migrant Helpline as people who were suspected of having been trafficked, who had been referred following suspicions of trafficking for sexual exploitation, or who lacked capacity to consent were excluded.

Measures: Data were collected routinely by Migrant Helpline caseworkers at the point of entry into the service, using standardised intake assessment forms, on:

1. Socio-demographic characteristics: gender, age, country of origin, languages spoken, immigration status;
2. Trafficking characteristics: type of exploitation, time since leaving exploitation, living and working conditions, and experiences of physical violence and threats;
3. Physical health: presence and severity of self-reported physical health symptoms were measured using a modified version of the Miller Abuse Physical Symptom and Injury Survey (MAPSAIS).(30) Service users were asked whether they had experienced 21 physical health symptoms in the previous two weeks and severity was measured on a four point Likert scale.

4. Mental health: Symptoms of anxiety and depression in the past two weeks were measured using the relevant subscales of the Brief Symptom Inventory (BSI), a shortened version of the SCL-90-R.(31) Standard scoring was used for subscales (i.e., a mean symptom score calculated and response items scored 0–4, with 0 meaning “not at all” and 4 meaning “extremely”). Mean scores are calculated by summing the values (i.e. 0-4) for the items in each subscale and dividing the sum of each subscale by the number of endorsed items in that subscale.(32) In order to compare scores with reference groups, mean scores are converted to standardized T scores.
5. Alcohol use: Service users were asked how often they drank alcohol during the time they were trafficked (not at all, occasionally/sometimes, most days, or every day) and whether they used any type of legal or illegal drug while trafficked.

As data were collected at the point of entry into services, information is not available regarding the outcome of NRM or immigration procedures.

Data analysis: Descriptive statistics were calculated to report the prevalence of violence and abuse, poor living and working conditions, and self-reported physical health symptoms; prevalence of probable post-traumatic stress disorder (PTSD); and mean scores for anxiety, depression and hostility. Mean scores for anxiety, depression and hostility were calculated and compared to US population norms for adults. To our knowledge, BSI general population norms are not available for UK or other populations. Analyses were conducted in STATA 11.

Ethics: Ethical approval for this study was granted by the ethics committee of the London School of Hygiene & Tropical Medicine (Reference A191 5354).

Findings

Socio-demographic and trafficking characteristics: During the study period, 108 men and women who had been trafficked for labour exploitation and were aged 18 years and over were supported by Migrant Helpline. The duration of support ranged from 1 to 635 days. 35 men and women (32.4%) consented for their data to be shared with the research team. We are unable to assess whether there are differences between the third of trafficked Migrant Helpline service users who consented to share their data and the two thirds who did not.

The majority of the sample was male (n=27, 77%) and aged between 18-35 years (mean 32.9 years, SD 10.2, range 19-56 years). Over half of the sample (n=19, 54%) originated

from South or Southeast Asia. However, nearly one third of the sample was UK or EU nationals and could live and work legally in the UK. Forty one percent reported not being able to speak English. Three quarters of the sample (n=26, 74%) had been out of the trafficking situation for less than a month at the time of interview. The main labour sectors into which service users were trafficked were domestic work (37%), food packaging and processing (29%) and construction (20%) (Table 5). People were also trafficked for exploitation in a range of other settings, however, including shop, nail bar and restaurant work, stealing petrol, and car cleaning. 31% of service users were trafficked for more than one form of exploitation.

A high proportion of service users reported having endured violence and poor living and working conditions while trafficked. Forty percent of participants reported experiencing physical violence while they were trafficked (Table 5), and thirty percent of participants said their working conditions were unsafe and likely to result in illness or injury. Unhygienic and unsafe living conditions were reported by 37% and 41%, respectively. Thirty percent reported having been deprived of food and water and 43% reported being deprived of medical care while trafficked.

Table 5: Trafficking experiences of men and women trafficked for labour exploitation

| | n (%) |
|---|--------------|
| Type of exploitation ^{† (n=35)} | |
| Domestic work | 13 (37.1) |
| Food Packaging/Processing | 10 (28.5) |
| Construction | 7 (20.0) |
| Other | 14 (40.0) |
| Time since trafficking ⁽ⁿ⁼³⁵⁾ | |
| <1 month | 26 (74) |
| 1-2months | 6 (17) |
| >2 months | 3 (9) |
| Violence ⁽ⁿ⁼³⁰⁾ | |
| Physical violence | 12 (40.0) |
| Witnessed violence | 7 (23.3) |
| Threats to family or to worker | 12 (40.0) |
| Working conditions ⁽ⁿ⁼³⁰⁾ | |
| Unhygienic working conditions | 6 (21.4) |
| Unsafe working conditions | 8 (29.6) |
| No information on how to work safely | 16 (57.1) |
| No protective equipment provided | 13 (46.4) |
| Long periods of harsh conditions | 12 (42.9) |
| Living conditions ⁽ⁿ⁼³⁰⁾ | |
| Deprived of food or water | 9 (30.0) |
| Deprived of medical care when needed | 13 (43.3) |

| | |
|------------------------------|-----------|
| Unhygienic living conditions | 11 (36.7) |
| Unsafe living conditions | 11 (40.7) |

¹ As several participants were trafficked for more than one form of exploitation, rows are not mutually exclusive.

Physical and mental health : Eighty-one percent (25/31) of participants reported one or more symptoms of poor physical health; and 30% reported five or more concurrent symptoms (mean 3.1, SD 3.5, range 0-14). The most commonly reported symptoms included headache (43%), back pain (35%), fatigue (30%), vision problems (23%), and dental pain (23%) (see Table 6). Chronic health problems, including cardiovascular disease, diabetes, and epilepsy, were reported by 37% of participants. The prevalence of self-reported substance use during trafficking was very low: two service users reported drug use (both cannabis) and three reported heavy alcohol use (drinking most days or every day).

Table 6: Physical health symptoms reported by men and women trafficked for labour exploitation (n=30)

| | n (%) |
|---|-----------|
| Constitutional symptoms | |
| Significant weight loss | 4 (13.3) |
| Fatigue | 9 (30.0) |
| Loss of appetite | 7 (22.6) |
| Neurological symptoms | |
| Headaches | 13 (43.3) |
| Fainting or losing consciousness | 2 (6.7) |
| Dizzy spells | 3 (10.0) |
| Difficulty remembering things | 4 (13.3) |
| Gastrointestinal symptoms | |
| Pain in stomach/abdomen | 3 (10.0) |
| Upset stomach, vomiting or other digestive problems | 5 (16.1) |
| Cardiovascular symptoms | |
| Breathlessness | 3 (10.0) |
| Chest pain or palpitations | 4 (13.3) |
| Musculoskeletal symptoms | |
| Back pain | 11 (35.5) |
| Fractures or sprains | 0 (0.0) |
| Joint or muscle pain | 3 (10.0) |
| Facial injuries | 2 (6.7) |
| Eye, ear and upper respiratory symptoms | |
| Eye pain, injury or difficulty seeing | 7 (22.6) |
| Ear pain, injury or difficulty hearing | 3 (10.0) |
| Colds, sinus infections or flu | 5 (16.1) |
| Dermatological symptoms | |
| Rashes, red areas, unusual bumps, sores or itching | 3 (10.0) |
| Burns | 2 (6.7) |
| Dental symptoms | |
| Toothache or mouth/gum problems | 7 (22.6) |

Among male service users, the mean scores for symptoms associated with anxiety and depression were 0.75 and 0.86; these symptom levels are in the 92nd percentile compared to men in a general US population. Among females, the equivalent scores for anxiety and depression were 0.75 and 1.03, respectively; in the 82nd percentile compared to women in a general US population.

4.3 Cross-sectional survey of health needs, access and care experiences reported by trafficked people

Summary

This study surveyed trafficked adults and adolescents in contact with support services in England. The study included 150 adults, but recruitment of adolescents proved extremely challenging: seven adolescents were recruited from a target of 30. Nonetheless, this is the largest single country study of health and trafficking conducted in a high-income setting. The study showed that many trafficked adults who are in contact with support services in England experience medium- to long-term physical, sexual, and mental health problems. Women trafficked for sexual exploitation and for domestic servitude experienced high levels of sexual violence while trafficked and both men and women reported a high prevalence of diagnosed STIs. Twenty-nine percent of women reported one or more pregnancies while trafficked. Levels of missing data were high with respect to men's experiences of sexual violence prior to and during trafficking, which may mean that estimates under-represent the extent of sexual abuse of trafficked men. Psychological symptom levels were higher among people who experienced sexual violence prior to trafficking, incurred injuries whilst trafficked, and had ongoing fear of their traffickers even once out of the trafficking situation. Higher number of unmet social needs (e.g. financial difficulties and social isolation) also increased the risk of high levels of psychological symptoms. Analysis of data from the 24 young women and 5 young men (aged 16-21) in the sample also showed a high prevalence of mental health problems and of sexual violence, and found that five of the 24 young women had become pregnant while trafficked. Findings are also reported in Oram *et al* 2016 (33).

Implications

Findings indicate that people trafficked for sexual exploitation, domestic servitude, and for a range of forms of labour exploitation are likely to experience a range of immediate and longer-term health problems. We are unable to report on whether the health needs experienced by the trafficked people in our sample present prior to trafficking; investigating the aetiology of the health problems experienced by trafficked people was beyond the scope of this research. However, the obligation to provide necessary medical treatment to trafficked people under European Union Directive 2011/36 does not depend on whether health problems developed as a consequence of their experiences in the UK.

NRM First Responders may be well placed to enquire about individuals' health concerns and to ensure immediate medical needs are addressed, but guidance on completing NRM referral forms does not include reference to possible medical needs (34, 35). Modern

slavery guidance for frontline staff includes guidance on arranging emergency medical treatment and meeting urgent health needs and could also be usefully updated to direct frontline staff to enquire about immediate health needs (36). For other trafficked people, longer term health problems may require the extension of the NRM reflection and recovery period beyond the minimum provision of 45 days and/or the provision of outreach support. When considering healthcare needs of women trafficked for domestic servitude, it is noteworthy that many reported that they were sexually abused. Moreover, findings on the prevalence of STIs among both men and women indicate that sexual health services will need to be part of a fundamental package of post-trafficking medical care. Continuity of care and coordination of appropriate services will be important to avoid trafficked people having to retell their experiences of trafficking and their medical history. Finally, the results highlight that trafficked people's mental health appears to be deeply affected by their daily living circumstances, including financial security and interpersonal relationships. The study was conducted with trafficked people in contact with post-trafficking support services, and findings may not be generalizable to trafficked people who choose or are not able to access support services or to those in current situations of exploitation.

Recommendations

1. Health Education England, the Royal Colleges, and professional organisations responsible for setting training standards for NHS staff must ensure that NHS professionals are trained to be aware of indicators of possible trafficking and how to respond appropriately to suspicions or disclosures of abuse; to conduct identification and referral – including to NRM First Responders – in safe and linguistically appropriate ways that prioritise providers' and trafficked people's safety; to be aware of the likelihood of people who have been trafficked having high levels of mental health needs and high prevalence of abuse both prior to and during trafficking and can make referrals to appropriate agencies; to be aware of the needs of people with complex trauma and the impacts on their children; and to obtain a sexual history from trafficked people who access health services. National guidelines on sexual history taking, which have been developed for all health professionals irrespective of whether or not they are working in sexual health services, should be followed.
2. NHS Trusts and GPs and surgeries should ensure that staff obtain a sexual history from trafficked people who access health services. National guidelines on sexual history taking, which have been developed for all health professionals irrespective of whether or not they are working in sexual health services, should be followed;;

3. Clinical Commissioning Groups and Local Authority Partners should recognise trafficked people as a population with specific health needs in Joint Strategic Needs Assessments;
4. Commissioners of sexual health services should ensure that sexual health services are available for all trafficked people to access, regarding the type of exploitation suffered. Sexual health services and commissioners of sexual health services should provide sexual healthcare that is appropriate to an individual's gender, age, and culture. Sexual healthcare should be sensitive to an individual's culture and possible previous trauma and/or abuses and address both acute and longer term health needs, which may include counselling and treatment for STIs, HIV/AIDS, and sexual violence trauma, as well as for HIV post-exposure prophylaxis, hepatitis B vaccination, emergency contraception, contraceptive advice and supplies, and abortion referral;
5. Police Chief Constables should ensure that police officers provide information about and offer referral to Sexual Assault Referral Centres for forensic examinations to support the prosecution of traffickers, where sexual abuse is suspected;
6. Social workers must be alert to trafficked adults', children's and young people's need for sexual health services, which must be offered sensitively with consideration for the person's confidentiality and dignity;
7. Social workers and carers should take account of the high levels of violence, sexual abuse and deprivation that trafficked adults, children, and young people may have experienced and the implications this may have for their ability to trust others and feel secure;
8. Maternity services and professionals should: recognise that indicators of human trafficking include women who delay antenatal booking until their second or third trimester of pregnancy, or do not seek admission to a maternity unit until their labour is well established, especially those without English-language skills; consider safeguarding issues and involve appropriate agencies; recognise that in addition to core recommended care, trafficked women are likely to require additional care such as that recommended by the NICE guidance on pregnancy and complex social factors; ensure that all women who self-report or are suspected of being trafficked have access to one-to-one midwifery care during and after their pregnancy; are responsive to trafficked women's physical, psychological, and social needs during and after pregnancy and develop individual care plans; ensure that timing and duration of all contacts with trafficked women are flexible in terms of frequency and duration; discuss postnatal contacts with trafficked women, including duration of midwifery follow up, transfer to the primary health care team, and how care will be

- coordinated; and ensure planned postnatal follow up, coordinated by one nominated lead across secondary and primary care sectors;
9. Acute Care Trusts and professionals and social workers should be aware of the likelihood of trafficked people having high levels of mental health needs and make arrangements for their mental health to be assessed;
 10. Home Office should require that individuals suspected of being trafficked are asked in safe ways about their health concerns at the first point of contact with First Responders and revise NRM referral form guidance to highlight that immediate medical need should be met prior to an NRM referral form being completed¹²;
 11. Home Office should commission outreach support for individuals who have left safe-house accommodation after the NRM reflection and recovery period;
 12. Voluntary sector support services should prioritize individuals' medical and health needs during intake—especially urgent health needs – by specifically enquiring about health problems upon arrival into services and addressing urgent problems as quickly as possible. Frontline post-trafficking support services staff should be trained to identify and respond to psychological distress;
 13. Voluntary sector support services must develop links and supported referral pathways with relevant health providers to ensure that health professionals are prepared to identify, refer, and treat individuals who have been trafficked;
 14. Research community should conduct research to (i) explore trafficked people's experiences of pregnancy and parenting; (ii) explore the intergenerational impact of human trafficking on children; (iii) investigate the acceptability and effectiveness of psychological interventions to support the recovery of trafficked people.

¹² A revised NRM is currently being piloted, including testing referrals by Slavery Safeguarding Leads. If rolled out, Slavery Safeguarding Leads should be required to ask about health concerns at their first point of contact with individuals suspected of having been trafficked.

Aim

The study aimed to examine the health risks, needs, and care experiences of trafficked adults and young people in contact with health and support services in England.

Objectives:

- 1) to investigate the socio-demographics, experiences of violence, and physical and mental health of trafficked men and women;
- 2) to investigate the socio-demographics, experiences of violence, and physical and mental health of trafficked young people;
- 3) to identify predictors of medium- to long-term poor mental health among trafficked men and women.

Methods

Study design and setting: We conducted a cross-sectional survey over a period of 18 months (June 2013 – December 2014), in England.

Participants: Individuals were eligible to participate in the study if they were (a) were aged 14 years or older; (b) had experienced human trafficking; (c) had been identified as a trafficked person by statutory or voluntary agencies; and (d) had previously received or were currently receiving assistance from one or more statutory or voluntary agencies. No restrictions were placed on exploitation type, time since exploitation, country of origin (i.e. UK nationals who had experienced trafficking were eligible to participate), or language. We defined human trafficking in line with the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Girls (1). People were not eligible to participate if they were: (a) currently in the exploitation setting; (b) too unwell or distressed to participate; or (c) unable to give informed consent.

The research team requested assistance from 19 voluntary sector organisations that either provided government-funded post-trafficking support or were authorised to refer potentially trafficked people for such support, and from 10 healthcare provider organizations and 15 social services departments located in areas in which high numbers of trafficked people had been previously identified. Nine voluntary organizations did not respond, and one voluntary organization and five social services departments declined to assist (see Appendix D for participating organisations). Participating organisations were based in London, the South East, East Anglia, the West Midlands, and the North West. Organisations approached a convenience sample of potential participants, provided basic study information, and liaised with the study team to schedule research interviews. Face to face interviews were conducted

by trained researchers, with assistance from qualified and independent interpreters as required.

All participants were given a £20 high street shopping voucher to thank them for their participation. Travel and childcare expenses were reimbursed in cash. Careful consideration was given to the decision to give £20 vouchers to trafficked people who participated in the research. We anticipated that potential participants would have limited financial resources, and were concerned that vouchers should not act as an undue inducement to participate. Yet, providing research participants with cash and/or vouchers to thank them for their time and participation is a widespread practice and we were reluctant to exclude trafficked people from this on the basis of their financial and other vulnerabilities. It was made clear to all participants that receiving the voucher was not dependent on completing the survey interview: vouchers were given at the start of the interview and it was explained that the participant would keep the vouchers even if they decided to withdraw from the study.

Measures

Survey instruments that had been previously validated for use with people who had experienced trauma and abuse and in multiple languages were used where possible. The following measures were used:

1. **Socio-demographic factors**, including gender, age, country of origin, education, marital status, and number and location of children.
2. **Pre-trafficking and trafficking experiences**, including exploitation type, duration of exploitation, time since escape living and working conditions, and violence (37) Extreme restriction of movement was defined as never being allowed to travel unaccompanied and/or being locked into a room.
3. **Medical history and physical health**. Medical history (including psychiatric disorder) was assessed using questions from the 2007 English Adult Psychiatric Morbidity Survey.(38) Participants were categorised as having a chronic medical condition if they had been diagnosed with one or more of arthritis, asthma, bronchitis, diabetes, epilepsy, hepatitis, heart disease, high or low blood pressure, HIV, kidney problems, or tuberculosis. Physical symptoms were assessed using the Miller Abuse Physical Symptoms and Injury Survey.(39) Severe symptoms were defined as symptoms which bothered the participant “quite a lot” or “extremely” (versus “not at all” or “a little”).

4. **Psychological health.** A variety of instruments were used to assess participants' post-trafficking psychological health. For adult participants, probable depressive disorder was assessed as a score of 10 or more on the Patient Health Questionnaire-9 (PHQ-9) (40), and probable anxiety disorder as a score of 10 or more on the Generalized Anxiety Disorder 7 (GAD-7) (41). Probable depression and anxiety was assessed with reference to the two weeks prior to interview. For adolescents, psychological distress in the six months prior to interview was assessed as scores above 5, 4, and 6 on the emotional difficulties, conduct difficulties, and hyperactivity subscales of the Strengths and Difficulties Questionnaire, respectively. Probable PTSD was assessed as a score of 3 or more on the 4 item version of the PTSD Checklist-Civilian (PCL-C), with reference to the four weeks prior to interview (42). Participants were categorised as having high levels of psychological symptoms if they screened positive for probable depressive disorder, anxiety disorder or PTSD. Suicidality was measured using the Revised Clinical Interview Schedule (CIS-R), with reference to the week prior to interview (43): participants who endorsed two or more items were categorised as suicidal.
5. **Wellbeing.** Wellbeing was measured using the EuroQual Visual Analogue Scale (EQ-VAS). Participants were asked to record their self-rated health on the day of interview on a scale of 0 ("Worst imaginable health state") to 100 ("Best imaginable health state").
6. **Substance use.** High-risk alcohol use was assessed as a score of 5 or more on the Alcohol Use Disorders Identification Test Consumption (AUDIT-C).(44, 45) Drug use was assessed using questions from the British Crime Survey, which ask whether the participant had used any of a list of drugs ever or in the past four weeks (cannabis, amphetamines, amyl nitrate, cocaine, crack cocaine, ecstasy, heroin or methadone, LSD, magic mushrooms, glues, solvents, gas, or aerosols, or other (46).
7. **Sexual and reproductive health,** including diagnosed sexually transmitted infection (STI), was assessed using questions adapted from the third UK National Survey of Sexual Attitudes and Lifestyles.(47)
8. **Unmet social care needs** were assessed using a modified 15-item version of the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS).(48, 49) Interviewers rated items as presenting "no problem", a "met need", or an "unmet need", based on participants' reports of their current situation. Higher scores reflect a greater level of unmet need.

Data analysis: Analyses were conducted in STATA 11. Descriptive statistics (proportions for categorical variables, and either means and standard deviations or medians and inter-

quartile ranges (IQR) for continuous variables) were used to describe socio-demographic and trafficking characteristics and other variables of interest.

Analysis of factors predicting high levels of psychological symptoms was conducted using multivariable logistic regression following multiple imputation of missing data, which allowed us to deal with the potential biases that could have arisen from missing data. The proportion of missing data per variable ranged from 0% to 15.3% (mean 4.6%); 60.7% of participants had missing data for one or more variable of interest. Patterns of missing data were investigated and logistic regression was used to identify predictors of missing data: missing data on covariates were assumed to be missing at random (MAR). Missing data were imputed using the STATA “ice” command for multiple imputation via chained equations (50); the multiple imputation model included all variables that predicted missingness and those that are used in the presented analysis. Sixty-five imputed datasets were created. The STATA “mim” command was used to perform a combined analysis of imputed datasets (51). Variables associated with high levels of psychological symptoms in bivariate analysis ($p < 0.2$) and a priori confounders were entered into a multivariable logistic regression model. The model was refined by sequentially removing covariates that were non-significant ($p > 0.2$) and not confounders (evaluated as a change in any remaining parameter estimate greater than 20% compared to the full model) (52).

Ethics: Ethical approval was provided by the National Research Ethics Service (NRES) Committee South East Coast – Kent (reference 13/LO/0099). Study procedures followed the World Health Organization Ethical and Safety Recommendations for Interviewing Trafficked Women and General Medical Council guidance on obtaining consent for research purposes (53, 54). Potential participants were offered verbal and written information about the study, regarding the purpose, subject, and nature of the study, and given a minimum of 24 hours to consider their participation before consent was sought. The voluntary nature of participation was emphasised, with care taken to explain that neither participation nor non-participation would have any impact on support provision by referring or other organizations or on any ongoing or future criminal, immigration, or other proceedings. All participants were advised prior to consent being obtained that they may find parts of the interview upsetting, and asked if there was anyone they would like to be contacted if they became very distressed. Participants were advised during the informed consent process that the information they provided would be confidential and anonymous, except for situations in which a failure to disclose information may expose the participant or others to risk of death or serious harm. Interviewers contacted the Principal Investigator (LMH, a consultant psychiatrist) to discuss situations in which confidentiality may have needed to be broken. All participants were

assigned a unique ID number, which was used at all times when managing the research data to protect participants' identify. Data that included identifiable details about study participants were stored separately from the research data. Transcripts of the qualitative interview component were anonymised during transcription.

Further research: Consent was sought from all participants to be approached for future research studies (see Appendix E); very few participants declined this request.

Findings

We aimed to recruit 120 trafficked adults (aged 18 years and older) and 30 trafficked adolescents (aged 14 to 17 years) to the study. We were able to over-recruit trafficked adults, but the recruitment of trafficked adolescents proved to be extremely challenging, including because:

- local authorities lacked systems to search their records for looked after children who had experienced trafficking,
- some of the voluntary sector organisations contacted were reluctant to refer their young service users to the study,
- voluntary sector organisations working with young people who had experienced or were at risk of experiencing trafficking had few trafficked clients aged under 18 years;
- young people were reluctant to participate in the study and to talk about their experiences.

Seven adolescent participants were recruited to the study, aged 16 to 17. Data are therefore presented firstly on trafficked adults (aged 18 years and older) and then on trafficked young people (aged 16 to 21). Our definition of “young people” is not used within the NHS or the UK NRM, but allows analysis of the full dataset while preserving participant anonymity.

Socio-demographic, trafficking, and health characteristics of trafficked adults

169 adults were invited to participate, of whom 150 (88.8%) consented, including 98 women and 52 men. Of the nineteen individuals who did not participate, six were too psychologically unwell to participate, one was too physically unwell, two were pregnant and too close to their due date, five left the support service before an interview could be scheduled and could not be contacted, two were in ongoing situations of exploitation, two reported that ongoing police and immigration interviews meant that they had too much going on to participate in the research, and one did not give a reason.

For women the median time since escaping trafficking was 16 months (IQR 3, 38) while for men the time since escape was 3 months (IQR 1.2, 6). Participants originated from more than 30 countries, including Nigeria (n=25, 16.7%), Poland (n=23, 15.3%), and Albania (n=15, 10%). Women were most often trafficked for sexual exploitation (n=42, 42.9%) or domestic servitude (n=39, 39.8%). Over four-fifths (n=45, 82.7%) of men were trafficked for labour exploitation, working in settings including agriculture (n=14, 26.9%), construction (n=8, 15.7%), and car washing (n=7, 13.7%). Four-fifths of participants (n=118, 78.7%) were receiving support from Government-funded support services that required them to have been referred into the UK NRM. All participants were asked whether they had been referred into the UK NRM: 43.3% (n=65) of all participants reported that they did not know whether such a referral had been made.

Table 7: Survey of trafficked adults: sample characteristics (n=150)

| | Total n=150 (%) | Men n=52 (%) | Women n=98 (%) | p |
|--|--------------------|-----------------|-------------------|--------|
| Pre-trafficking | | | | |
| Mean age left education in years (SD) | 16.9 (5.4) | 18.1 (3.4) | 16.2 (6.2) | 0.02 |
| Physical violence prior to trafficking | 72 (48.0) | 15 (28.9) | 57 (58.2) | 0.002 |
| Sexual violence prior to trafficking | 32 (21.3) | 2 (3.9) | 30 (30.6) | 0.001 |
| Trafficking | | | | |
| Type of exploitation | | | | |
| Domestic servitude | 44 (29.3) | 5 (9.6) | 39 (39.8) | <0.001 |
| Sexual exploitation | 43 (28.7) | 1 (1.9) | 42 (42.9) | |
| Labour exploitation | 59 (39.3) | 45 (86.5) | 14 (14.3) | |
| Median months in trafficking situation (IQR) | 7 (3, 36) | 3 (1,5) | 12 (5, 60) | 0.01 |
| Threats to self while trafficked | 118 (78.2) | 36 (69.2) | 82 (83.7) | <0.001 |
| Threats to family while trafficked | 63 (41.7) | 16 (30.8) | 47 (48.0) | <0.001 |
| Physical violence while trafficked | 97 (64.7) | 22 (42.3) | 75 (76.5) | <0.001 |
| Sexual violence while trafficked | 67 (66.3) | 2 (3.9) | 65 (66.3) | <0.001 |
| Injury while trafficked | 83 (55.3) | 17 (32.7) | 66 (67.4) | <0.001 |
| No access to passport/identity documents | 90 (60.0) | 22 (42.3) | 68 (69.4) | 0.003 |
| Extreme restriction of movement | 108 (74.0) | 30 (60.0) | 78 (81.3) | 0.005 |
| Post-trafficking | | | | |
| Mean age in years (SD) | 32.4 (10.8) | 36.8 (11.9) | 30.0 (9.4) | 0.001 |
| Currently married/living with a partner | 21 (14.2) | 13 (25.0) | 8 (8.3) | 0.006 |
| Has 1 or more children | 81 (54.4) | 29 (55.8) | 52 (53.6) | 0.80 |
| Median months since left trafficking situation (IQR) | 6 (2, 30) | 3 (1.2, 6) | 16 (3, 38) | <0.001 |
| Median months contact with support service (IQR) | 3.0 (1.2, 7.5) | 1.6 (0.9, 4.3) | 4.4 (1.4, 12.5) | <0.001 |
| Still afraid of the traffickers | 107 (71.3) | 29 (55.6) | 78 (78.6) | 0.002 |
| Median number of unmet needs (IQR) | 2 (1, 4) | 2 (1, 3) | 3 (1, 4) | 0.57 |
| Lacks a confidante | 49 (32.7) | 18 (34.6) | 31 (31.6) | 0.11 |

Information regarding the pre-trafficking, trafficking and post-trafficking characteristics of the sample is provided in Table 7. Over 40% of men (n=22, 42.3%) and over three quarters of women (n=75, 76.5%) reported physical violence while trafficked. Two-thirds of women reported being forced to have sex while trafficked, including 95% (n=40) of women trafficked for sexual exploitation, 54% (n=21) of women trafficked for domestic servitude, and 21% (n=3) of women trafficked for other forms of labour exploitation. Twenty-nine percent (n=28) of women reported that they had one or more pregnancies while trafficked; ten women

reported having seen a midwife while trafficked and twelve women reported having had an abortion while trafficked.

The prevalence of pre-trafficking violence was also high. Pre-trafficking physical violence was reported by 28.9% (n=15) of men and 58.2% (n=57) of women. Thirty percent of women (n=30) also reported pre-trafficking sexual violence, perpetrated predominantly by partners (n=9, 9.2%) and family members (n=5, 5.1%). Two men reported having been forced to have sex before trafficking and two having been forced to have sex while trafficked. However, the high levels of missing data for these measures (44.3% and 19.2%, respectively) may mean that sexual abuse experienced by trafficked men is under-reported.

Participants had a median of 2 (IQR 1, 4) unmet social needs, with more than a quarter having unmet needs relating to budgeting and not having enough money for essential items (n=38, 26.0%), accessing benefits (n=41, 28.3%), social lives (n=55, 37.7%), or having enough to do (n=55, 37.2%). One third (n=49, 32.7%) reported that they did not have family or friends in whom they could confide. Over half the sample were parents, suggesting that their experiences of trafficking could have consequences for their parenting and for the wellbeing of their children.

Findings regarding the physical and mental health of the adult sample are provided in Table 8. The most commonly reported severe physical symptoms were headaches (n=68, 45.0%), being easily tired (n=64, 42.4%), back pain (n=39, 25.8%), dizzy spells (n=38, 25.2%), and memory problems (n=43, 28.5%); the prevalence of each of these symptoms was significantly higher among women than among men. The prevalence of probable depressive disorder, anxiety disorder or PTSD (i.e. of high levels of psychological symptoms) was 69.8% (n=97), and 38.0% (n=57) of participants reported suicidal ideation. Women were more likely to report high levels of psychological symptoms than men (OR 4.0, 95% CI 1.8, 8.6) and to report suicidal ideation (OR 6.7, 95% CI 2.8, 16.3). Women also reported significantly lower subjective wellbeing (median score of 50, interquartile range 40,80) than men (median score of 80, interquartile range 50,90).

Table 8: Survey of trafficked adults - physical and mental health (n=150)

| | Total N=150 (%) | Men N=52 (%) | Women N=98 (%) | p |
|---|--------------------|-----------------|-------------------|--------|
| Constitutional symptoms | | | | |
| Easily tired | 64 (42.4) | 9 (17.3) | 55 (56.1) | <0.001 |
| Weight loss | 10 (6.6) | 3 (5.8) | 7 (7.1) | 0.73 |
| Loss of appetite | 35 (23.2) | 2 (3.9) | 33 (33.7) | <0.001 |
| Neurological symptoms | | | | |
| Headaches | 68 (45.0) | 11 (21.2) | 57 (58.2) | <0.001 |
| Dizzy spells | 38 (25.2) | 7 (13.5) | 31 (31.6) | 0.02 |
| Memory problems | 43 (28.5) | 5 (9.6) | 38 (38.8) | <0.001 |
| Fainting | 6 (4.0) | 1 (1.9) | 5 (5.1) | 0.33 |
| Gastrointestinal symptoms | | | | |
| Stomach pain | 29 (19.2) | 4 (7.7) | 25 (25.5) | 0.009 |
| Vomiting, upset stomach, constipation or diarrhoea | 21 (13.9) | 1 (1.9) | 20 (20.4) | 0.002 |
| Cardiovascular symptoms | | | | |
| Chest/heart pain | 25 (16.6) | 5 (9.6) | 20 (20.4) | 0.10 |
| Breathing difficulty | 20 (13.3) | 3 (5.8) | 17 (17.4) | 0.05 |
| Musculoskeletal symptoms | | | | |
| Back pain | 39 (25.8) | 5 (9.6) | 34 (34.7) | 0.001 |
| Dental pain | 33 (21.9) | 4 (7.8) | 29 (29.6) | 0.002 |
| Eye, ear and upper respiratory symptoms | | | | |
| Eye pain | 15 (9.9) | 5 (9.6) | 10 (10.2) | 0.86 |
| Ear pain | 9 (6.0) | 4 (7.7) | 5 (5.1) | 0.55 |
| Dermatological symptoms | | | | |
| Rashes, itching, sores | 28 (18.5) | 4 (7.7) | 24 (24.5) | 0.01 |
| Psychological symptoms | | | | |
| Depression, anxiety, or PTSD | 97 (64.7) | 21 (40.3) | 79 (77.6) | <0.001 |
| Depression | 62 (41.3) | 12 (23.1) | 50 (51.0) | 0.001 |
| Anxiety | 58 (38.7) | 10 (19.2) | 48 (49.0) | 0.001 |
| PTSD | 71 (47.3) | 13 (25.0) | 58 (59.2) | <0.001 |
| Suicidal ideation | 57 (38.0) | 7 (13.5) | 50 (51.0) | <0.001 |
| High-risk drinking | 21 (14.0) | 17 (33.3) | 4 (4.1) | <0.001 |
| Drug use (in past month) | 7 (4.7) | 3 (5.8) | 4 (4.1) | 0.57 |
| Sexually transmitted infection | 26 (17.3) | 4 (7.7) | 22 (22.5) | 0.04 |

As shown in Table 9, high levels of psychological symptoms were associated with female gender, pre-trafficking sexual violence, pre-trafficking physical violence, injury while trafficked, and extreme restriction of movement while trafficked.

Table 9: Survey of trafficked adults -Multivariable logistic regression model of factors associated with high levels of psychological symptoms among trafficked men and women (n=150)

| Variable | Overall | |
|--|----------------------|---------|
| | Adjusted OR (95% CI) | P value |
| Gender (female vs. male) | 2.0 (0.7-5.8) | 0.21 |
| Pre-trafficking | | |
| Pre-trafficking sexual violence | 3.2 (0.7-15.0) | 0.13 |
| Pre-trafficking physical violence | 1.8 (0.7-4.5) | 0.23 |
| Trafficking | | |
| Injury during trafficking | 2.1 (0.8-6.0) | 0.14 |
| Extreme restriction during trafficking | 2.1 (0.7-6.1) | 0.16 |
| Post-trafficking | | |
| Ongoing fear of the traffickers | 2.3 (0.9-6.3) | 0.10 |
| Unmet social needs | 2.0 (1.1-3.5) | 0.02 |
| Lack of a confidante | 3.0 (1.0-8.8) | 0.05 |

Socio-demographic, trafficking, and health characteristics of trafficked young people

Socio-demographic and pre-trafficking characteristics: Twenty-nine young people aged 16-21 years participated in the study, twenty-five were recruited through voluntary sector post-trafficking support services, and four through local authorities' looked after children's services. The sample included 24 females and 5 males. All but one of the young men were aged 20-21, while the young women were more evenly spread across the 16-21 age range. The majority of the sample originated from African countries, with Nigeria the country of origin for two-fifths of the young women (n=10, 41.7%). However, nearly a third (7) of the young women were Eastern European.

Eight participants (7 female, 1 male) had been married or promised in marriage, including two young women who had been trafficked for marriage. At the time of interview, only one described herself as currently married or promised in marriage. Three young women had children who were living with them in the UK at the time of the interview.

Eleven of the young women and all but one of the young men reported having being hit, kicked or physically hurt prior to being trafficked. Eight of the young women said that they had been forced to have sex before they had been trafficked.

Trafficking experiences: As with the adults who completed the survey, all the young people were removed from the trafficking situation at the point of interview. The length of time that had elapsed since they left that situation ranged from three weeks to six and a half years.

The median length of time since leaving the trafficking situation was 12 months (IQR 3-24 months). In contrast to the adults, the length of time since leaving the trafficking situation did not differ significantly between males and females (p=0.601).

Young females were most often trafficked for sexual exploitation, including forced marriage, (n=17), but were also trafficked for domestic servitude and for labour exploitation in the agricultural sector. Young males were trafficked to be exploited in car washing and factory work, and for sexual exploitation.

Trafficking for sexual exploitation, including forced marriage, was by far the largest category of work that this group of young people were trafficked into (n=18) with trafficking for domestic servitude the second largest category (n=7) (Table 10). This reflects the gender balance in this group of respondents but it also highlights that, for the majority of this group of vulnerable young people, sexual exploitation and its consequences were central experiences. Sex work and domestic servitude are frequently characterised by informal and illegal working arrangements and are particularly resistant to inspection or regulation. Only two of the young people reported working eight hours or less a day. Thirteen said that they had no fixed hours. Only four had had one or more rest day a week when working. The length of time the young people had remained within the trafficking situation ranged from two weeks to eight years. The median duration of exploitation was 12 months (IQR 4, 42) .

Table 10: Survey of trafficked young people - type of exploitation experienced

| Type of exploitation | Total n=29 | Males n=5 | Females n=24 |
|----------------------|---------------|--------------|-----------------|
| Sex work | 15 | 1 | 14 |
| Forced marriage | 3 | 0 | 3 |
| Domestic servitude | 7 | 1 | 6 |
| Agricultural labour | 1 | 0 | 1 |
| Car washing | 1 | 1 | 0 |
| Factory labour | 1 | 1 | 0 |

Violence: Table 11 shows that this group had experienced a high prevalence of harm while trafficked. Twenty-six of the 29 young people (22 female; 4 male) described being threatened with physical hurt while trafficked and eleven had been threatened with harm to their family. Two-thirds (17 female; 3 male) said they had been scared of their traffickers. Twenty-four (21 female; 3 male) reported being physically hurt while trafficked and 16 young

women had received an injury. Eighteen young people had been forced to have sex, including 2 of the 5 young men and 16 of the 24 young women.

Table 11: Survey of trafficked young people - experiences of violence while trafficked

| Violence during trafficking | Total n=29 | Males n=5 | Females n=24 |
|------------------------------------|-----------------------|----------------------|-------------------------|
| Threats to self while trafficked | 26 | 4 | 22 |
| Threats to family while trafficked | 11 | 1 | 10 |
| Physical violence while trafficked | 24 | 3 | 21 |
| Sexual violence while trafficked | 18 | 2 | 16 |
| Injury while trafficked | 16 | 0 | 16 |

Deprivation: The young people in the sample had also suffered considerable deprivation while trafficked, as shown in Table 12. Fifteen young women and three young men had been confined in a locked room while seventeen had been denied access to their passport or identity documents. Thirteen young people (11 female; 2 male) had had nowhere to sleep or had slept on the floor and 12 (10 female; 2 male) described sleeping in overcrowded conditions. Nearly half the group (14) said that they had had no clean clothing and six described lacking basic hygiene facilities. Eleven had lacked sufficient food while four reported lacking sufficient water. A small number described being forced to drink alcohol (8) or take drugs (4) and three were forced to take medication while trafficked.

Table 12: Survey of trafficked young people - experiences of deprivation while trafficked

| Experiences during trafficking | Total n=29 | Males n=5 | Females n=24 |
|---|-----------------------|----------------------|-------------------------|
| Confined in a locked room | 18 | 3 | 15 |
| Denied access to their passport or identity documents | 17 | 1 | 16 |
| Nowhere to sleep or had slept on the floor | 13 | 2 | 11 |
| Sleeping in overcrowded conditions | 12 | 2 | 10 |
| No clean clothing | 14 | 2 | 12 |
| Lacking basic hygiene facilities | 6 | 1 | 5 |
| Lacked sufficient food | 11 | 2 | 9 |
| Lacking sufficient water. | 4 | 1 | 3 |

Pregnancy and Sexual Health: Five young women had become pregnant while trafficked: three of these young women had been trafficked for sexual exploitation, one for domestic servitude, and one for labour exploitation. Two of these young women reported having had an abortion during the time they were trafficked, two were currently pregnant, and one had

given birth and had their child with them. None of these women had seen a midwife during the time they were trafficked. A further two young women had children that had been conceived after leaving the trafficking situation.

Four young women reported having ever been diagnosed with an STI and two as having been diagnosed with HIV, including young women trafficked for sexual exploitation, domestic servitude, and labour exploitation.

Physical Health: Over half the young people (15 female, 1 male) described being bothered by headaches in the last four weeks and nine (8 female, 1 male) had had problems with their memory. Seven (6 female, 1 male) had been worried by stomach pains and seven young women had had back pain in the same period, including one of the three young women who were pregnant at the time of interview. Six young women had experienced dental pain.

Mental Health: A high prevalence of mental health problems was found among group of young people. Two-thirds (16 female, 3 male) had reported symptoms at levels indicative of psychological distress. Over half (15 female, 1 male) had symptoms indicative of PTSD and twelve (11 female, 1 male screened) reported suicidal ideation. Two young people described having ever attempted suicide, one whilst in detention. Both described difficulties in coping with the overwhelming feelings they were experiencing.

4.4 Trafficked people's experiences of accessing and using health services

Summary

Trafficked people's access to healthcare, while in the trafficking situation, is compromised by controls and restrictions imposed by their traffickers, including being accompanied to medical appointments. For many, immigration status and lack of identity documents serve as further barriers to care. Once they exit the trafficking situation, trafficked people's access to healthcare services is dependent upon having the correct documentation and ability to navigate registration systems. Support workers are crucial to enabling and supporting access to healthcare services. Once able to access healthcare services, trafficked people's experiences of healthcare services are generally very good, with participants reporting feeling listened to, respected, and supported. The importance of access to interpreters and being able to choose the gender of healthcare professionals was highlighted. However, trafficked people who had experienced detention described detention as a period of limited access to and poor quality of healthcare. Trafficked people were generally not asked about their trafficking experiences after leaving the trafficking situation by health professionals and reported mixed opinions about whether they would want to discuss their experiences of trafficking with a medical professional.

Implications

Findings suggest that although many trafficked people may be unable to access healthcare services during the time they are trafficked, a proportion do come into contact with healthcare professionals. Barriers to accessing healthcare services are not limited to controls imposed by traffickers, but also include insecure immigration status, difficulties providing required documentation, and lack of access to appropriate interpreters. Trafficked people are likely to require ongoing support (e.g. outreach) from post-trafficking support agencies after the NRM reflection and recovery period in order to access care for medium to long term health needs.

Recommendations

1. Department of Health should ensure trafficked individuals are not unjustifiably denied medical care by informing relevant healthcare stakeholders of individuals' full range of rights and entitlements to services, and by discouraging racism and bias to prevent refusal of services based on nationality, sex, language, race, or stigma or other protected characteristics as defined under the Equality Act 2010 . Monitor regularly to ensure that individuals' rights to services are respected;

2. Department of Health and GPs and surgeries should remove any barriers to GP registration that would prohibit trafficked people from registering. GPs and surgeries should ensure that registration for GP services is made as simple as possible and does not rely on ensuring proof of address;
3. NHS Trusts and GPs and surgeries should ensure that trafficked people are offered a choice regarding the gender of health professionals and interpreters, that interpretation is not provided by a person accompanying a patient who is suspected of being trafficked, and that patients are seen privately.
4. The Department of Health should hold providers of interpreting services accountable to quality assurance standards;
5. Health Education England, the Royal Colleges, and professional organisations responsible for setting training standards for NHS staff must ensure that NHS professionals are trained to be aware of indicators of possible trafficking and how to respond appropriately to suspicions or disclosures of abuse; to conduct identification and referral – including to NRM First Responders – in safe and linguistically appropriate ways that prioritise providers' and trafficked people's safety; to explain to trafficked people the importance of confidentiality and how it is defined; and to offer trafficked people attending health services a choice regarding the gender of health professionals and interpreters;
6. Sexual health services should establish local links with non-governmental organisations (NGOs) working with trafficked people;
7. NHS services and professionals should treat all trafficked people who come into contact with services with respect. Service providers need to ensure that all health professionals and support staff are aware of the importance of respectful, high quality care, as trafficked people who have experienced poor care, or have had contact with staff they perceived to be rude or critical of them, may be reluctant to engage with services in the future;
8. Safeguarding Adults and Children's Boards should monitor local trends in human trafficking and consider social care elements arising;
9. Social workers and carers should be aware that trafficked adults, children and young people require considerable support to navigate and access all types of healthcare service and be prepared to offer practical and emotional assistance with this, according to individuals' wishes;
10. Social workers should arrange interpreting services which trafficked adults, children, and young people experience as accessible and confidential in order to assist them in articulating their health needs and accessing health services;

11. Voluntary sector support services should inform and support trafficked people to use healthcare services, including by providing trafficking people with information about the NHS and their rights to access care, and by providing assistance to access and coordinate healthcare. Assistance may be required with registering for services, booking appointments, ensuring provision of interpretation and translation services or advocacy; paying for prescriptions and/or applying for exemptions from prescriptions charges; accessing written medical information in an appropriate language and format; and providing healthcare professionals with basic information about human trafficking and appropriate referral pathways into and from support services;
12. Voluntary sector support services should develop links and supported referral pathways with relevant health providers to ensure that health professionals are prepared to identify, refer, and treat individuals who have been trafficked;
13. Home Office should commission outreach support for individuals who have left safe-house accommodation after the NRM reflection and recovery period.

Aim

To understand what types of health services trafficked people had used, how they had accessed them and their experiences of using these services.

Objectives

- (1) To investigate whether trafficked people had accessed health services while trafficked, which services, and under what circumstances;
- (2) To investigate how trafficked people had accessed health services in the post-trafficking period;
- (3) To understand trafficked people's experiences of using healthcare services;
- (4) To understand trafficked people experiences of being asked about human trafficking.

Methods

Study design and setting: Qualitative interviews conducted as part of a cross-sectional survey of trafficked people (June 2013- December 2014) in England. Details of inclusion criteria and recruitment procedures are provided in section 3.3.

Data collection: Open-ended questions regarding participants' access to and use of healthcare services during and since escaping the trafficking situation were asked at the end of survey interviews. A copy of the interview questions is provided in Appendix F. With the consent of the participant interviews were digitally recorded and audio files were transcribed verbatim.

Data analysis: Transcripts were analysed in NVIVO using framework analysis (Smith and Firth 2011). The initial coding frame was based on the qualitative interview schedule and on themes which emerged during the data collection period. Themes were discussed between the project team refined and revised. Extracts used in this report are attributed to the participants by gender, type of trafficking they experienced and their age range.

Ethics: Ethical approval was provided by the National Research Ethics Service (NRES) Committee South East Coast – Kent (reference 13/LO/0099).

Findings

One hundred and sixty trafficked people participated in a cross-sectional health survey conducted as part of the PROTECT research programme. One hundred and forty of these participants (87.5%) participated in a qualitative interview at the end of their survey interview;

136 (97.1%) consented for their qualitative interview to be digitally recorded. Seventy (50.0%) interviews were conducted with the aid of an interpreter.

Access to health services during the trafficking episode

Many trafficked people reported that their traffickers denied them access to health care services. However, others were registered with GP's in local surgeries, saw A&E staff and health professionals based in walk-in centres, and some accessed maternity services. Access, when allowed, was often closely monitored by their traffickers. Even in cases where healthcare access was less controlled, trafficked people reported that they did not always feel confident or able to access healthcare and were concerned about the possible repercussions of accessing healthcare services. Trafficked people did not always have access to their identity documents which are required for registration and some were only able to use forged documents to register with a GP.

Traffickers' control of use of healthcare services: It was unusual for trafficked persons to have open and full access to GP and health services when they were in the trafficking situation. Many trafficked people described their anxiety and distress at having been denied access to health care during their trafficking situation by the traffickers. In the worst situations, trafficked persons were unable to access any care as they were imprisoned and locked up:

"I didn't see anyone. The man I was living with kept me locked up and I couldn't get out or meet people. That's why I ran away in the end, as he was a nasty man and I didn't want to be imprisoned like that". (Female, trafficked for sexual exploitation, 31-40);

"They didn't let me to go out" (Male trafficked for domestic servitude 22-25).

Less overtly, trafficked people were prevented from accessing healthcare services by not being provided with information about where healthcare services were located and how to register and being prevented from having access to identification documents:

"No, because I didn't have insurance I didn't know where is GP doctors, nothing" (Male: trafficked for work in Agriculture 31-40).

Trafficked persons were not able to rest or recover when unwell or injured; they were still required to work. Not accessing health services because of concerns about possible implications was cited as a reason for not seeking health intervention even when injured:

"I had broken ribs, also. But I'm not sure why I didn't want to go to doctor. Maybe because I didn't want to lose job" (Male, trafficked for factory work, age 51-60).

There were several examples of trafficked persons treating their own health conditions with non-prescription medicines, or medication they had brought from their countries of origin, or with medicines provided by the traffickers. These self-treatments were for symptoms of cold and flu, headaches, aches and pains, as well as dental pain and infection. Several trafficked persons reported having problems with their dental health, and having no access to a dentist meant that they managed the pain with non-prescription medicines and painkillers.

Registering with and accessing healthcare services whilst trafficked: A minority of trafficked people interviewed who were in the trafficking situation were registered with GPs in local surgeries, attended walk-in centres and emergency departments, and accessed maternity services. Use of private healthcare services was also reported, generally for dental treatment but also in one case for termination of pregnancy. More frequently, trafficked people reported that they lacked the official documents needed to register and had difficulties negotiating language barriers, problems which, especially when combined with restrictions imposed by their traffickers, prevented access:

"First I didn't know how to speak any English. When I went to the GP, they asked for this form, that letter and they asked me so many other questions. Then they told me to come tomorrow – the next day. When I go again, the next day they told me they couldn't register me until my visas and my passport – my immigration status was okay....And after that I never went back to them because the people I was with, they don't even allow me to go" (Female trafficked for cleaning work 22-25).

"The second time that I had contact with health services was when I was 4-5 months pregnant. This was during the time that I snuck out of the house and went to the local GP surgery. When I arrived they told me that I needed 'a passport and a proof of address. I explained that I didn't have this documentation and they turned me away. They said they couldn't see me." (Female trafficked for domestic servitude 22-25).

Traffickers exerted a great deal of control over access to healthcare services even when people did manage to register for care:

"I did provide my passport and my details, my name and my international insurance number and I was supposed to go for an appointment after 4 days. But [my traffickers] sent me to get a job and he told me that I don't need to go for this appointment anymore and he said that he called and cancelled it (Male trafficked for car washing 51-60).

Trafficked people also reported having registered with healthcare services multiple times using false identities, and of re-registering when they left the situation and entered the asylum system:

"I was told to present myself as a normal person. When I went to seek asylum, obviously I was registered again and I put false names" (Female trafficked for domestic servitude 31-40).

Registration requirements differed between GP surgeries, even at a local level. One woman described, for example, how she was initially denied access at one GP surgery as she had no photographic identification, at another practice having proof of address was sufficient. Access in this case, as in others examples, was enabled by a friend:

"They give me a form to fill it in and I give it back to the receptionist, I think they put everything down on the computer, and he gave me next day appointment to see a doctor yeah" (Female trafficked for domestic servitude 31-40).

Traffickers, other trafficked people, neighbours, and friends were named as people who helped the trafficked person register with GPs and to access health services. It was rare for trafficked people to be able to access healthcare services without being accompanied by the people who were exploiting them:

"I was taken to the GP to register ...by my trafficker... he was there with me... I wasn't really comfortable to tell him (GP) stuff" (Female, trafficked for domestic servitude, 22-25).

For other trafficked people, their first contact with health services was during a medical emergency:

"I was found unconscious in the street when I was heavily pregnant and I was taken to the hospital by ambulance. I just remember waking up in hospital." (Female, trafficked for sexual exploitation, 31-40).

Traffickers, who accompanied trafficked persons to GP and other healthcare appointments, would sometimes act as unofficial translators. For some trafficked people, this meant that they did not understand what was discussed during their consultation or the diagnosis that was given:

"It was sort of with the trafficker, the GP was asking, talking to me, and the woman was saying it in my language, I shouldn't answer anything, I shouldn't say anything, she was the one that was talking." (Female trafficked for domestic servitude 22-25).

For another trafficked person, who was injured by the trafficker whilst he was working, having the trafficker accompany and speak for him meant that the GP was not told the truth about his injury:

"Because [my trafficker] went there with me, he told staff that I can't speak any English ... he will speak for me – interpret for me and he told them some story... Yes, the doctor asked me directly as well but I was worried, I didn't want to say it was this person because he was there with me." (Male, trafficked for car washing 51-60).

When participants were taken to GP and health services by the people who were exploiting them, having a private consultation was impossible. Fear about potential reprisals from traffickers prevented them from going to their GP independently:

"I was afraid of what they would do if they found out that I contacted a GP on my own initiative" (Female, trafficked for domestic servitude, age 31-40).

Talking to a GP or other health professional about their experiences was not something many of the participants in this study had considered. In essence, for many,, having access to health services while trafficked meant that they were not able to talk about their experiences or seek help or support for their health issues or the situation they were in.

Access to health services in the post trafficking period

Participants described having accessed GP services, dentists, maternity services, secondary mental health services, sexual health services, and specialist services for specific clinical conditions. However, the majority of trafficked people reported that they needed ongoing support from post-trafficking services to negotiate access to and maintain contact with services and to continue treatment. Access to interpreters was also key to understanding the care they were receiving. Health professionals did not always know about their patients' trafficking experiences. Although not all trafficked people wanted to be asked about their experiences of trafficking, others felt it was important that health professions knew what had happened to them. Women generally spoke very highly of the maternity care they had received, although in a small number of cases services were not responsive to women's needs during and after pregnancy. Trafficked people's need for support from mental health services sometimes only became apparent to them in the longer term, after they had been out of the trafficking situation for some time.

Registration with GP, initial tests and results: Once they had escaped their trafficking situation, participants' access to healthcare services depended upon their having relevant and correct documentation to register with a GP. Registration with GP seemed to be more problematic for trafficked people from non-EU countries; participants described having had to wait for documents provided by the Home Office to enable registration and access. Many of the participants who accessed GP services were routinely given blood and urine tests. Although trafficked persons consented to these, as they wanted to know that they that they were healthy and had not contracted infections, many reported that they had not been advised of the outcomes of these tests, did not know how to access their results, or experienced delays in finding out the results.

Role of support workers in ensuring access to healthcare services: Participants identified their support workers as crucial to enabling and supporting ongoing access to health services in the post-trafficking period, Support workers undertook all of the following tasks: they explained how health services worked in England; acted as advocates during registration; negotiated with gatekeepers; ensured that their clients had the necessary documentation; followed up on referrals; supported people to attend appointments; helped them to explain their health issues to health professionals; collected and explained prescriptions; made future appointments; explained the processes involved in GP health assessments and acted as interpreters.

Support workers also helped the trafficked person by explaining to health professionals about their clients' experiences and the context for their health concerns. This was important when GPs were perceived as being dismissive or insensitive:

"I was really worried about how affected I am from abortion and how fertile I am...and then Support Worker told her that I was human trafficking victim and she somehow changed attitude" (Female trafficked for sex work 22-25).

Interpretation and translation: For many trafficked people in this study, having access to an interpreter was crucial. For some, difficulties speaking English and a lack of access to interpretation meant that they did not understand the medical tests and interventions that were performed or the prescriptions they were provided with, raising concerns about informed consent. Others described having had access to telephone interpretation services. Although participants generally expressed a preference for face-to-face interpretation, telephone interpretation services did make an important difference to participants' abilities to communicate their health concerns and understand the advice provided to them. A small number of participants described having been supported by unofficial translators. These unofficial translators were either other employees in the health setting or support workers who accompanied the trafficked persons to their health appointments. Trafficked people described their dissatisfaction with this situation, particularly where they did not want their support workers to know about their health concerns and wanted to speak with the GP only.

Maternity and midwifery services: Maternal health provision was generally experienced as very positive, when women were able to access it. Midwives were reported to be sensitive, kind, helpful and readily available:

"They were really nice and friendly and they got me clothes, food and toiletries; one of the nurses even did my hair for me. They told me that I had to eat for my baby and they asked me what kind of food I liked so they could make sure I had the food I liked" (Female, trafficked for forced marriage, age 31-40)

"How am I going to cope?" And the midwife I met there, the doctor I met there just tried to reassure me that I am gonna get support" (Female, trafficked for domestic servitude, age 31-40).

There were only a couple of exceptions whereby women reported being treated poorly, disrespectfully or unkindly by midwives. One woman, who had arrived during the night at the hospital described, for example, that:

"They was treating me exactly like a prostitute. They was just saying to me: "Go away, when the time is gonna come, we gonna accept you" and they was "was trying not touch me," (Female, trafficked for sex work, age 26-30).

During interviews women only described antenatal care they had accessed after having exited the trafficking situation; it is not clear what support they had during the trafficking episode if any.

Secondary mental health services and support for mental health problems: Many trafficked people reported experiencing mental health problems, reporting that it was difficult to forget about and move on from their experiences.

"You think that you can hide this or you just forget but sometimes it comes back and then you need to talk with somebody" (Female, trafficked for factory work, age 41-50).

Trafficked people subject to immigration control reported feelings of anxiety and dread, and described these proceedings exacerbating their distress and, in some instances, as causing them to experience flashbacks:

"I think the anxiety and the fear really got to me...all of a sudden I start to hear somebody talking especially at night...making a curse... don't know if it's a dream or trance or something..." (Female, trafficked for domestic servitude, age 41-50).

Access to counselling and to secondary psychiatric care was, however, often problematic. In this extract the mental health problems experienced by a woman who had been trafficked for sexual exploitation had not been addressed despite numerous consultations with her GP:

"I've been trying to address a situation with mental health for a prolonged period of time...my doctor was aware of the fact that I was being made to take drugs, aware of the situation.... referred me to online CBT course. ...I finally got the help that I needed when I moved out of the refuge...I'd been attempting to, to reach the help that I needed for, I would say over 6 years". (Female, trafficked for sex work, age 22-25).

Several trafficked people reported that they had been prescribed antidepressants by their GP, although this was not always seen to be helpful:

"They said maybe I was depressed, and I would need counselling...medications to help with my depression. I said ok. I will go and think about it. But I didn't really take the medications." (Female, trafficked for domestic servitude, age 22-25)

"They phoned my GP as well but they don't seem to do anything at the moment. So he just prescribed a sleeping tablet" (Female, trafficked for domestic servitude, age 41-50).

However, other participants described positive experiences where GP's recognised the need for additional support:

"[The GP told me that]I needed more in depth help and one to one counselling". (Female, trafficked for sex work, age 22-25)

"[The doctor said] maybe you need somebody to sit down. When you come here, it's ten minutes. Maybe you need an hour" (Female, trafficked for sex work, age 31-40).

Being asked about trafficking

Participants' feelings about being asked about their experiences of trafficking varied. Some participants could see no reason why a GP or other healthcare professional would ask them about their experiences of trafficking, abuse, and exploitation and suggested that it was not the role of the healthcare professional to do so, seeing their personal lives and health problems as two separate issues. Others did not want to be asked about trafficking: they did not want to talk about it, the experiences were painful to revisit, and they had no wish to discuss it. Yet others felt that – although talking about their experiences was difficult - it was important for healthcare professionals to understand what had happened to them, as their experiences had impacted on their physical, mental, and sexual health:

"I don't want to talk about it. It upsets me. I don't like talking about it, or speaking about it. It brings back a lot of memories, but it hurts me to speak about it, but obviously now I'm okay, but before I didn't like speaking about at all and now for me to get any help, I need to speak about it." (Female, trafficked for domestic servitude, age 41-50)

Trafficked people's feelings about being asked about their experiences of trafficking depended on a number of factors: recognising themselves as a person who had been trafficked; trusting that healthcare professionals would keep their information private and not tell other people; understandings about the causes of their health problems; and beliefs about what types of help healthcare professional could offer them.

Satisfaction with healthcare services

Most participants talked about their interactions with healthcare professionals in very positive terms. Once trafficked people had been able to negotiate access to services, many were given a choice about the gender of their healthcare professional: this was particularly important for many of the women in the study. Participants described how they felt that they had been treated with respect, listened to, and supported:

"This second doctor, he was like, human, that he actually care about me. That if I said something he did (it)" (Male, trafficked for agricultural labour exploitation, age 31-40).

"My GP is nice.... Once a month she sees me. She will sit for at least half an hour talking to me. She keeps encourage (me)" (Female, trafficked for domestic servitude, age 31-40).

"I feel safe...Before, I couldn't do anything about it and I was really worried about things... Now, I can go for whatever concerns I have and get it checked out. I feel much more relaxed" (Female, trafficked for domestic servitude, age 22-25).

However, participants also gave examples of care that had not been satisfactory. Poor care included cases in which women had not been able to choose the gender of their health professional. Trafficked people also described the healthcare that they had received while in immigration detention as having been very poor. One woman, for example, reported being unable to see a health professional while in immigration detention:

"[I] wanted to see doctor but they won't give me appointment, when I'm going there they say the nurse or the doctor that will do the check for me is, she's, he's not around" (Female, trafficked for domestic servitude, age 22-25).

Another woman, who asked for support after having been diagnosed with HIV reported the following response from the nurse providing her care:

"I know you have this problem but it's not the end of the world, now there's medication you can take you can live a normal life. And that's all I got from detention." (Female, trafficked for sex work, age 22-25).

Young people's experiences of accessing and using health services

The young trafficked people (i.e. aged 16-21 years) in our sample identified a range of barriers to accessing health services. In common with the adults participating in the study, these included having their access to healthcare and freedom to make decisions about healthcare restricted by traffickers. One young woman, for example, described how she had an abortion arranged by her traffickers. While she was in hospital, a nurse encouraged her to approach the authorities and explain her situation but was too frightened of her traffickers to do so:

"I said if I don't go ahead with it I'll be dead" (Young woman trafficked for domestic servitude, age 18-21).

Other young people encountered complex gatekeeping systems that impeded or delayed their use of healthcare services, including after escaping from their trafficking situation:

"It wasn't easy, because my friend tried many times before to register me with GP because it was kind of an emergency. I needed to see a doctor because I was pregnant, but the GP wouldn't register me without any papers from the Home Office, so we had to wait until that paper arrived and then I was registered." (Young woman trafficked for sex work, age 18-21)

Some of the challenges of dealing with complex and unfamiliar systems and organisations were compounded by language barriers and a lack of interpreters or reliance on telephone interpreting systems could make for difficulties in communicating directly with health professionals. A young man who had had experience of a telephone interpreting service remarked, for example, that:

'Maybe it would be better if the interpreter came in person' (Young man trafficked for factory work, age 18-21).

Since many of these young people lacked the usual support networks that enable adolescents to navigate health services, they relied instead on support workers, foster carers and other individuals, including friends. Once they had left the trafficking situation, such people played a key role in assisting young people to access health advice and treatment and register with appropriate services as well as attending appointments.

Young people emphasised the importance of being given time to explain problems and being listened to and were critical of encounters in which they felt healthcare professionals had not taken their opinions seriously:

"The most important thing is to ask, and to give you time to explain how you are feeling instead of just assuming what is wrong, giving you the chance to explain, and listening to your opinion about why you feel like that" (Young woman trafficked for sex work, age 16-17)

It was clear that considerable thought and sensitivity were required from health professionals. Young people described being frightened, embarrassed and anxious about confidentiality in their contacts with health services. One young woman who had been trafficked for domestic servitude had had multiple contacts with health professionals whilst with her traffickers but had not been asked about her situation. She felt that she could have told someone that she had been trafficked had they asked and if she had been assured confidentiality. While some young people needed and wanted to talk about their experiences, for others, talking was too distressing. Opportunities need to be available for such young people to access counselling or secondary mental health services in the future when they might be ready to receive such support.

4.5 Trafficking and severe mental illness

Summary

This study used an innovative data resource to identify trafficked people in contact with secondary mental health services in South East London and provides the first evidence on the socio-demographic and clinical characteristics of trafficked people with severe mental illness. Findings show that mental health services are caring for trafficked people with a range of diagnoses, including psychoses. In addition to experiencing multiple severe traumas while trafficked, many patients had also experienced violence, abuse, and threat of harm both prior to and since escaping trafficking. Many trafficked patients had complex social and legal needs, particularly insecure immigration status and accommodation, which impacted on psychological symptoms and the provision of mental healthcare. Findings are also reported in Oram *et al* 2015 and Domoney *et al* 2015 (55, 56).

Implications

Findings from this analysis indicate that the mental health needs of trafficked people in contact with secondary mental health services are likely to be diverse and for many, their diagnose may be for more severe forms of illness (e.g. psychosis) beyond common disorders associated with traumatic events. Not surprisingly, the results suggest that trafficked people will have a history of multiple forms of violence, not only during the trafficking experience, but also before and many may have lingering fears of abuse or retaliation by traffickers or others.

Recommendations

1. Health Education England, the Royal Colleges, and professional organisations responsible for setting training standards for NHS staff must ensure that NHS professionals are trained to be aware the trafficked persons may continue to be vulnerable to exploitation and abuse after leaving the trafficking situation and ensure patients have safety plans and know how to access help if needed;
2. Mental Health Trusts and professionals should also recognise that people with severe mental illness may be vulnerable to being trafficked;
3. Mental Health Trusts and professionals should recognise that people with mental health problems with a history of being trafficked may have experienced abuse prior to, during, and since trafficking and undertake routine enquiry, and recognise that these patients may be vulnerable to further abuse, including re-trafficking and domestic and sexual violence;

4. Mental Health Trusts and professionals should explain clearly to trafficked people and support services the arrangements for care coordination, and duration of care, care plans, and care programme approach (CPA). Recognise the possible additional communication requirements needed by trafficked people. All relevant members of the healthcare team should be aware of the patient's history, health and social needs, and ongoing need for follow up.
5. Mental Health Trusts and professionals should be sensitive to the difficulties trafficked people could have if detention under the Mental Health Act is necessary;
6. Research community should conduct research to investigate the acceptability and effectiveness of psychological interventions to support the recovery of trafficked people.

Aim

This study aimed to investigate the socio-demographic and clinical characteristics of trafficked people with severe mental illness. To our knowledge, there had been no previous research conducted with a clinical sample of trafficked people. Accordingly, very little is known about the socio-demographic and clinical characteristics of trafficked people who have severe mental illness.

Methods

Study design and setting: Historical cohort study of trafficked patients in contact with secondary psychiatric services provided by the NHS in South East London. Data were provided by the South London and Maudsley NHS Foundation Trust (SLaM) Biomedical Research Centre (BRC) Case Register. SLaM has a monopoly on the provision of secondary mental health services in the London boroughs of Croydon, Lambeth, Lewisham, and Southwark, serving a population of approximately 1.2 million. The SLaM Case Register Interactive Search (CRIS) allows for the searching and retrieval of anonymised full patient records from the electronic clinical records of over 200,000 patients since 2006 (57).

Participants: Cases were SLaM patients whose care team had recorded concerns that they may have been trafficked (defined in accordance with the UN Optional Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, and including both international and internal trafficking). Search terms were used to search the free-text clinical case notes and correspondence of all patients in contact with SLaM services between January 2006 and July 2012 (see Appendix G). The records of potentially eligible patients were retrieved. One research assessed eligibility by reviewing clinical notes and correspondence between the mental health and other professionals involved in the patients' care (e.g. general practitioners, social services, solicitors, voluntary sector services). A second researcher independently assessed the first 10 returned records and an additional random 10% of records. In order to permit comparison of clinical characteristics between trafficked and non-trafficked adult patients, we generated a sample of non-exposed patients (i.e. SLaM patients whose notes did not indicate that they had experienced human trafficking) matched for gender, age (+/- 2 years), primary diagnosis, type of initial care (inpatient/non-inpatient), and year of most recent service contact.

Measures: Quantitative data were extracted on the following measures as follows. Unless otherwise specified, measures were recorded at entry into care.

1. **Human trafficking:** Patients were categorised as having been trafficked if their free text clinical notes (including but not limited to clinical notes made at entry into care) indicated that their care team believed that the patient had or may have been trafficked.
2. **Socio-demographic characteristics:** Gender is routinely recorded. Age at first contact was calculated by subtracting date of birth from the date of first contact with SLaM services (both routinely recorded). Information on marital and living alone status with was extracted from structured fields and free text notes.
3. **Abuse history:** Patients were categorised as having experienced childhood abuse if free text notes indicated physical or sexual abuse aged 17 years or younger, and as having experienced adulthood abuse if notes indicated physical or sexual abuse aged 18 years or older.
4. **Psychiatric history:** Data on prior contact with secondary mental health services and psychiatric inpatient admission were extracted from free text clinical notes. Secondary mental health services provide specialist care for people with severe mental health problems, based either in hospitals or in the community.
5. **Diagnosis and functioning:** Primary ICD-10 diagnosis is routinely recorded in PJS(58). Where primary diagnosis changed over time, primary diagnosis at most recent contact was extracted. If no diagnosis was recorded (n=30), clinical records were independently reviewed by two consultant psychiatrists (LMH and MA) and a diagnosis assigned: initial inter-rater agreement was high (0.97) and in all cases consensus was reached on the diagnosis. Patients were categorised as having substance misuse problems if one or more of the following were recorded at entry into services: (i) primary or secondary diagnosis of substance misuse disorder; (ii) Health of the Nation Outcome Scales (HoNOS, a clinical outcome measure routinely used and recorded by English mental health services) substance misuse subscale scored at 2 or higher(59); (iii) substance misuse was indicated on standard risk assessment; (iv) current or historical drug use or alcohol misuse was indicated in the clinical free text notes. Patients were categorised as having deliberately self harmed if their clinical free text notes indicated a deliberate self-harm (DSH) event.
6. **Characteristics of clinical care:** Adverse pathway into care was defined as referral to SLaM via either the emergency department or the police service. Referral source is routinely recorded. Inpatient admission and discharge dates are routinely recorded and were used to identify inpatient admissions and total duration of inpatient admission. Dates of compulsory inpatient admission (i.e. detained under section 2 or section 3 of the Mental Health Act 1983) are also routinely recorded. Total duration of SLaM Care was calculated by subtracting the date of first referral from the date of

final discharge, excluding any periods between referrals (upper date limit of 24th January 2013).

Data regarding patients' referral into and outcome of NRM and immigration procedures are not routinely recorded in structured or free text fields, and were not extracted for analysis. Free text clinical notes and items of correspondence were downloaded for each trafficked patient for qualitative analysis. As some individuals' case notes comprised many entries over several years, search terms based on a priori themes and preliminary were used for a subset of records to bring back only those notes which referred to these topics. Downloaded notes were transferred into an Excel spreadsheet for analysis.

Analysis: Descriptive statistics (proportions for categorical; means and standard deviations for quantitative variables) were calculated to describe the socio-demographic and clinical characteristics of the sample. To preserve anonymity results are not reported where cell counts are less than five.

Random intercept logistic regression models were with trafficking status as the outcome variable were fitted to compare characteristics of trafficked and matched non-trafficked patients. The proportion of missing data ranged from 0% to 37.4% (mean of 6.6%), and 58% of our sample had missing data in one or more variables. Predictors of missingness were identified using logistic regression and missing data on covariates were assumed to be missing at random (MAR). We used multiple imputation via chained equations (50) to create 58 imputed datasets (i.e. as the percentage of missing cases (51)). We used the "xtlogit" command for fitting random intercept logistic regression models to the multiply imputed data. Estimates and standard errors of the parameter estimates from the imputed datasets were combined according to Rubin's rule and implemented using the Stata command "mim"(60).

Random intercept for the matching ID representing clusters of matched subjects was included in the logistic models to take account of possible correlation (non-independence) of matched subjects. Potential confounders (history of contact with secondary mental health services, history of psychiatric inpatient admission, substance abuse problems, childhood abuse, adulthood abuse, and total duration of SLaM services) were entered simultaneously in the logistic regression models.

Thematic analysis was used to conduct qualitative analyses of free text clinical notes and correspondence. In the initial stage of analysis, a selection of case notes were read and potential codes noted. The full sample of case note extracts was then read and an initial

coding framework was developed. Finally, codes were collated into themes, which were iteratively checked and refined against the coded extracts and the overall data set. Codes and themes were reviewed against the data by a second researcher. Pilot work indicated that data on how patients were identified as potentially trafficked people were not sufficiently rich for thematic analysis and content analysis was therefore used to address this objective.

Ethics: Ethics approval for the research use of CRIS-derived anonymised databases was granted by an independent Research Ethics Committee (Oxfordshire C, reference 08/H0606/71). An Oversight Committee reviews all applications to use CRIS, and gave approval for this study (11/025).

Findings

Searches of the CRIS database identified 133 patients, including 37 patients aged less than 18 years at first contact, whose records indicated were trafficked people (Table 13). Over four-fifths (81.3%) of the trafficked adult sample and two thirds (67.6%) of the trafficked children sample was female. Among adults, the mean age was 26.7 (SD 6.8, range 18-49) and among children the mean age was 14.9 (SD 2.5, range 8-17). The most common countries of origin of adult patients were Nigeria (17.7%), China (9.3%), and Uganda (7.3%); among children the most commonly recorded countries of origin were Nigeria (18.9%) and Afghanistan (13.5%).

The majority of the trafficked adults had been trafficked for sexual exploitation (58.3%), with 10% trafficked for domestic servitude, and 8% trafficked for other forms of exploitation. No details were available regarding type of exploitation for one fifth (21.9%) of the trafficked adult sample. Children's notes indicated that one-third had been trafficked for sexual exploitation and one-third for domestic servitude or other forms of exploitation, with no information regarding type of exploitation recorded for the remaining one-third of children. Records which lacked detailed accounts of patients' experiences of trafficking typically included other relevant information that indicated that the patient was a trafficked person e.g. that the patient was involved in criminal proceedings against their trafficker, was claiming asylum in relation to their experiences while trafficked, or was receiving social services or voluntary sector support as a trafficked person.

Records indicated that for two fifths (43%) of adult cases, mental health professionals were informed that their patient was a potential trafficked person by another professional involved in their care, including by voluntary sector post-trafficking support services, general practitioners and other health services, police, and social services. In approximately half of

the cases (51%), adults were identified as potentially trafficked people by SLAM mental health professionals. With respect to the child cases, mental health professionals were made aware that their patient may have been a trafficked person by other professionals involved in their care in 63% of cases – most frequently by social services but also by other health professionals. Children were identified as potentially having been trafficked by mental health professionals in 31% of cases.

Table 13: Socio-demographic and clinical characteristics of trafficked adults and children in contact with secondary mental health services in South East London 2006-2012 (n=133)*

| | Adults | | Children | |
|---------------------------------------|--------|------|----------|------|
| | N=96 | % | N=37 | % |
| Gender | | | | |
| Female | 78 | 81.3 | 25 | 67.6 |
| Male | 18 | 18.7 | 12 | 32.4 |
| Region of origin | | | | |
| Europe | 24 | 25.0 | - | - |
| Africa | 46 | 47.8 | 20 | 54.1 |
| Asia | 16 | 16.7 | 11 | 29.7 |
| Other | 8 | 8.3 | 5 | 13.5 |
| Living arrangements | | | | |
| Alone | 24 | 25.0 | 7 | 18.9 |
| With foster carers | - | - | 13 | 35.1 |
| With partner only | 6 | 6.3 | - | - |
| With children only | 8 | 8.3 | - | - |
| With others | 38 | 39.6 | 11 | 29.7 |
| Unknown | 20 | 20.8 | ns | - |
| Type of exploitation | | | | |
| Sexual | 56 | 58.3 | 12 | 32.4 |
| Domestic servitude or labour | 18 | 18.7 | 12 | 32.4 |
| Unknown | 21 | 21.9 | 13 | 35.1 |
| Experiences of child abuse | | | | |
| Physical or sexual | 41 | 42.7 | 28 | 75.7 |
| Physical | 29 | 30.2 | 22 | 59.5 |
| Sexual | 23 | 27.1 | 19 | 51.4 |
| Experiences of adulthood abuse | | | | |
| Physical or sexual | 58 | 60.4 | - | - |
| Physical | 40 | 41.7 | - | - |
| Sexual | 43 | 44.8 | - | - |

* Due to data not shown to preserve anonymity columns may total less than 100%.

Among adults, the most common diagnoses were PTSD and severe stress and adjustment disorders (38.5%) and depression and affective disorders (34.4%), followed by schizophrenia (Table 14). A fifth (21.8%) of the adult sample had previous contact with secondary mental health services. Eight adults had contact with secondary mental health

services that preceded the trafficking situation, of whom seven had been admitted as psychiatric inpatients prior to being trafficked. While under the care of SLaM services, one-third of the adult sample (35.4%) were admitted as psychiatric inpatients, and a fifth (20.8%) had one or more compulsory admissions. A third (32.3%) of trafficked adults had adverse pathways into care (i.e. referral via police or emergency departments), with a further third (33.3%) referred by primary care. Maternity services accounted for 10.3% of referrals of trafficked women, the third most frequent source of referrals for trafficked women after primary care and emergency departments.

Among children, the most common diagnoses were PTSD, severe stress and adjustment disorders (27%) and depression (27%). Just under a fifth (18.9%) had adverse pathways into care, and a fifth (21.6%) were admitted as psychiatric inpatients while under the care of SLaM services.

Table 14: Clinical characteristics and illness severity of trafficked adults in contact with secondary mental health services in South East London 2006-2012 (n=133)*

| | Adults | | Children | |
|---|--------|------|----------|------|
| | N=96 | % | N=37 | % |
| ICD-10 Primary diagnosis | | | | |
| Schizophrenia and related | 14 | 14.6 | - | - |
| Affective disorders | 33 | 34.4 | 10 | 27.0 |
| PTSD, severe stress, or adjustment disorder | 27 | 28.1 | 10 | 27.0 |
| Other ¹ | 10 | 10.4 | 11 | 29.7 |
| No disorder | 9 | 9.4 | 6 | 16.2 |
| Unknown | ns | - | - | - |
| Substance misuse problems ever | | | | |
| Yes | 33 | 34.4 | ns | - |
| No | 31 | 32.3 | ns | - |
| Unknown | 32 | 33.3 | ns | - |
| History of contact with secondary mental health services | | | | |
| Yes | 21 | 21.8 | 8 | 21.6 |
| No | 61 | 63.5 | 24 | 64.9 |
| Unknown | 14 | 14.6 | 5 | 13.5 |
| History of inpatient admission | | | | |
| Yes | 13 | 13.5 | ns | - |
| No | 70 | 72.9 | ns | - |
| Unknown | 13 | 13.5 | ns | - |
| Adverse pathway into SLaM care | | | | |
| Yes | 31 | 32.3 | 7 | 18.9 |
| No | 63 | 64.6 | 30 | 81.1 |
| Unknown | ns | - | - | - |
| SLaM inpatient admission at first contact | | | | |
| Yes | 15 | 15.6 | ns | - |
| No | 81 | 84.4 | ns | - |
| SLaM inpatient admission | | | | |
| Yes | 34 | 35.4 | 8 | 21.6 |
| No | 62 | 64.6 | 29 | 78.4 |
| Compulsory admission while SLaM patient | | | | |
| Yes | 20 | 20.8 | ns | - |
| No | 76 | 79.2 | ns | - |
| Deliberate self harm while SLAM patient | | | | |
| Yes | 21 | 21.9 | 10 | 27.0 |
| No | 75 | 78.1 | 27 | 73.0 |

* Due to data not shown to preserve anonymity columns may total less than 100%.

Patients who were aged 18 or older at first contact with SLaM services and had a recorded ICD-10 psychiatric disorder were compared to a randomly selected matched sample of 287

non-trafficked SLaM service users (1:3.4). Trafficked patients were significantly more likely to be compulsorily admitted as a psychiatric inpatient than non-trafficked patients (AOR 7.86, 95%CI 2.18-26.6, p=0.022) and to have a significantly longer duration of inpatient stay (AOR 1.48, 95%CI 1.01-2.15, p=0.045). No association was found between trafficking status and either adverse pathway into care (AOR 0.91, 95% CI 0.4-2.05, p=0.824) or history of substance abuse problems (AOR 0.55, 95% CI 0.27-1.17, p=0.122).

Qualitative analysis indicated that mental health professionals experienced a range of challenges in responding to the mental health needs of the trafficked people in this sample. Trafficked people's social and legal insecurity – particularly with regards to immigration status and, subsequently for adult patients, entitlement to accommodation and other services– emerged as a dominant theme and caused a range of problems for the provision of mental health care. Professionals documented their concerns that patients' precarious social and legal situations impacted negatively on their mental health and in some cases were the cause of their psychological symptoms:

“[I] advised we would support her as much as we could but realistically we are unable to take the stress i.e. immigration issues away....Her main preoccupation is that of her immigration issues not yet being resolved which clearly impact negatively on her mental well-being.”

Mental health professionals also recorded how patients' social and legal insecurity disrupted, and in some cases delayed, the provision of therapeutic support:

“It will be difficult for [her] to engage in any long term psychotherapeutic support before she has the result of her asylum application.”

Patients being moved to new accommodation outside of the SLaM catchment area experienced interrupted continuity of care and disrupted therapeutic relationships. Even when patients were moved within the SLaM catchment area, frequent changes of address could lead to difficulties staying in touch with patients, again interrupting continuity of care. For other patients, not being entitled to housing impacted on inpatient admission and discharge decisions:

“[She] is agreeing to informal admission for a period of observation and investigation of her mental health needs. Home Treatment [Team] input may be difficult as she currently has nowhere to live.”

Although in some cases, queries were raised as to whether patients' motivations for accessing care were related to their need for accommodation, professionals documented spending considerable time helping patients with social, legal and financial issues. This support included writing letters and reports for solicitors and helping to organise access to benefits and other support services, although professionals recorded that patients claiming asylum or who had no recourse to public funds were frequently ineligible for further support. Access to support was also limited by a lack of available provision: professionals recorded, for example, that there were long waiting lists for psychological therapy and the closure of voluntary sector services due to funding cuts:

"[She] was keen to receive help, and as such we have placed her on our psychology waiting list [for cognitive behavioural therapy]. Unfortunately we have a waiting list for treatment."

"She is an asylum seeker with no recourse to public funds and her legal advice centre has been closed."

Qualitative analyses also highlighted challenges to the provision of mental health care that arose from patients' recent or ongoing experiences of trauma. In some cases this was due to patients' unwillingness to discuss their experiences, but in other cases clinicians recorded having limited their questions due to ongoing police investigations. Other barriers to patient engagement included issues relating to the gender of staff and cultural differences in understanding mental health problems.

4.6 Systematic review of guidance on responding to the needs of trafficked people in healthcare settings.

Summary

This systematic review aimed to synthesise current knowledge and practice in responding to the needs of trafficked people in healthcare settings, specifically exploring identification, referral, and provision of care. Searches of electronic databases, reference list screening, citation tracking, and expert recommendations identified 44 documents for inclusion in the review. The review highlights several indicators that might suggest to healthcare professionals that their patient may be a trafficked person, including signs of abuse and neglect, unfamiliarity with the local language, being accompanied by a seemingly controlling companion and a lack of official documentation. The review also summarises good practice in supporting trafficked people disclose their experiences, such as finding a private space consultations, taking time to gain trust and avoiding the use of companions or those accompanying the patient as interpreters. The review identified a broad consensus regarding the need for comprehensive and holistic support for trafficked people from the point of identification through to long term recovery, an emphasis on the provision of trauma-informed, culturally appropriate care, and the importance of multi-agency working. However, the review found that there is limited empirical evidence to inform the identification, referral, and care of trafficked people by healthcare providers. In particular, no studies were identified which tested the effectiveness of psychological interventions for trafficked people. The acceptability of evidence-based treatments for PTSD and depression – such as cognitive behavioural therapy, narrative exposure therapy, and eye movement desensitization and reprocessing – among trafficked people is uncertain, as is the generalizability of therapies effective for other traumatised groups such as victims of domestic violence and asylum seekers and refugees

Implications

Due to the multiplicity of physical, psychological, and sexual and reproductive health problems experienced by trafficked people, healthcare professionals play a key role in identifying, referring, and caring for trafficked people. Responding to these needs requires that healthcare professionals adopt trauma-informed and culturally-sensitive approaches to working with trafficked people, conduct comprehensive health assessments, and collaborate with a range of agencies, including law enforcement and voluntary support services. Training for healthcare professionals should include information about in-country referral and support options for trafficked people and national reporting requirements, if applicable. At the local level, healthcare professionals should establish clear referral pathways and

information-sharing protocols with relevant agencies. However, the review also highlights that evidence to inform healthcare responses is lacking and identifies several priorities for future research.

Recommendations

The research community should conduct research to:

- Refine indicators of human trafficking and develop and test the sensitivity and specificity of screening tools to identify trafficked people in healthcare settings.
- Investigate the effectiveness of training programmes in improving the identification and referral of potentially trafficked people.
- Investigate the generalizability of guidelines for working with victims of violence and with vulnerable migrants to trafficked people.
- Investigate the acceptability and effectiveness of psychological interventions to support the recovery of trafficked people.

Aim

This systematic review aimed to synthesise current knowledge and practice in responding to the health needs of trafficked people, specifically exploring identification, referral, and provision of care.

Methods

Inclusion criteria

- **Types of studies:** Randomised controlled trials, other experimental designs, cohort studies, case control studies, cross-sectional surveys, secondary analyses of organisational records, case series analyses, case studies, qualitative studies, or literature reviews.
- **Population:** Males or females (adults or children) who were currently or had previously been trafficked. Human trafficking was defined in accordance with the United Nations Optional Protocol on the Prevention, Punishment and Suppression of Trafficking in Persons, Especially Women and Children
- **Formats:** Peer-reviewed or grey literature (e.g. theses, dissertations, published or unpublished reports), excluding editorials, opinion pieces, and textbooks. No language restrictions were used.
- **Setting:** Primary, secondary, tertiary or emergency health settings, specialist post-trafficking support services (statutory or voluntary) in World Bank high income countries.
- **Outcomes:** Knowledge, practice, guidance, or interventions regarding the identification, referral, or clinical care of trafficked people in healthcare settings.

Information sources: Sixteen biomedical and social science databases (including MEDLINE, Embase and PsycINFO) and 21 grey literature websites and databases (including Department of Health; Open Grey; La Strata International and Innocenti project) were searched from 1st January 1990 to February 2015 (see Appendix H). We considered that the Home Office Modern Slavery Unit, UK Visas and Immigration, and UK Human Trafficking Centre were unlikely to have unpublished information relevant to this review and did not conduct searches of their websites. Electronic searches were supplemented using reference list screening, forwards citation tracking using Web of Science and Google Scholar, and expert recommendations (including from members of our Research Advisory Group).

Study screening, extraction, and appraisal: Two reviewers independently screened title and abstract against the inclusion criteria; disagreements were resolved by consensus or with assistance from a third independent reviewer. If a citation's relevance was uncertain following title and abstract screening it was retained for retrieval and full text screening. Two reviewers independently assessed the full text of potentially eligible studies against the inclusion criteria, with disagreement again resolved by consensus or with reference to a third independent reviewer. Two reviewers extracted data from each study into a standardised extraction form. Data were extracted on a) study populations and sample characteristics, b) study design and methods, and c) data relating to (i) trafficked people's understandings, expectations and experiences of their health needs/health sector, (ii) knowledge, practice, guidance, or interventions regarding the identification, referral, or clinical care of trafficked people in healthcare settings care approaches; (iii) interventions used to assist health providers in identifying, referring, or providing care for trafficked people. Quality appraisal was independently conducted by two reviewers using adapted Joanna Briggs Institute checklists.

Data analysis: The review protocol stated that meta-ethnography would be used to synthesise the review findings. However, due the lack of primary studies included in the review, this technique could not be used. Extracted data were therefore analysed using framework analysis (61). This approach is a matrix-based method involving the identification of thematic groupings into which data can be categorised. The advantages of using framework analysis in systematic reviews has been documented in previous systematic reviews (62, 63) and include its rigour and its flexibility in allowing multiple members of the research team to be involved in analysis (64). Analysis was conducted by two reviewers and began with immersion and familiarisation through repeated reading of the extracted data. The original texts were frequently referred to in order to check consistency and accuracy of the text as well as the emerging concepts and themes (65). Concepts were charted onto a MS Excel spreadsheet in order visualise overarching themes and to draft a working conceptual framework (65). The conceptual framework was iteratively revised as new categories emerged and older categories were merged.

Findings

Included studies: Following screening, 44 papers were included in the review (see Appendix I): 18 peer-reviewed journal articles, three conference poster presentations, 20 published reports, two unpublished dissertations, and one unpublished report. Of the 44 included papers, 19 reported the findings of primary studies. The key themes that emerged from the literature concerned the identification of trafficked people in clinical settings,

promoting disclosure, providing care, ensuring safety, supporting recovery, and partnership working.

Identification of trafficked people in clinical settings: Commonly reported indicators included signs of physical and sexual abuse such as broken bones, burns, chronic pelvic pain and sexually transmitted infections as well as the inability to speak the local language, lack of official documents, fear of deportation, poor engagement with the healthcare provider and attending with a controlling companion (66-75). Additional indicators for children included maturity, self-confidence, access to money and goods that are inconsistent with the child's age (67, 69, 75) being of no fixed abode or going missing (67, 69, 73, 75) and not attending school (67, 69, 75). However, the review did not identify either empirical evidence to underpin these indicators or evaluations of screening tools to identify trafficked people in healthcare settings.

Promoting disclosure: Several studies described instances in which trafficked people had come into contact with healthcare services but were seen in the presence of their traffickers, preventing disclosure of abuse (23, 66, 68, 70, 72, 76-81). They highlighted the importance of seeing potentially trafficked patients privately, and the applicability of domestic violence protocols in this regard (80). The importance of never allowing an individual accompanying a potentially trafficked patient to interpret for them was also highlighted by several papers (23, 66, 68, 70, 72, 77, 78, 80, 82-85) and, conversely, the importance of providing access to professional interpreters. Bilingual co-workers may also be able to assist. Several papers described how many trafficked people experience intense feelings of betrayal, guilt, and shame (72, 83, 86) and emphasised the importance of building trust with trafficked patients through sensitive, informal, and non-judgmental language and by acknowledging trafficked peoples' fears about the consequences of disclosure (23, 70, 72, 74, 78, 82-89).

Providing care: In providing guidance regarding the provision of care, several authors emphasised the importance of trauma-informed care (80, 84-86, 89-91), i.e. care that recognises the impact multiple experiences of trauma have on trafficked people's health and their interactions with healthcare services. Using this approach, services would seek to empower trafficked people by putting them at the centre of decision making, emphasising the nature and importance of informed consent, and ensure that patients are not pushed to discuss the detail of their events before they are ready to do so (85, 92). The provision of culturally appropriate care was another common theme. (70, 72, 73, 80, 81, 84-86, 88, 89, 93-95). In particular authors drew attention to cultural differences in attitudes towards health, particularly mental health, and argued that typically Western approaches such as counselling

may not be appropriate for all trafficked people (84, 94). Authors also highlighted that trafficked patients may need both longer appointment times and a longer overall duration of contact with healthcare services (74, 85).

Ensuring safety: Guidance suggested that health services should put in place procedures to safeguard patients and staff from potential risk of harm from traffickers (23, 96) and implement robust information sharing protocols (23, 76, 77, 80, 84, 95, 96).

Supporting recovery: No primary research was identified which reported on the efficacy of therapeutic interventions with trafficked people. Authors suggested using interventions that have been used successfully with people with experiences of domestic violence and sexual assault and with refugees (including cognitive behavioural therapy (CBT), trauma-focused CBT (TF-CBT), peer-support and psycho-education (66, 70, 80, 83, 85, 95, 97)) and highlighted the potential value of adjunctive therapies, such as mindfulness, art therapy, writing, music and outdoor activities, was also highlighted (85, 91, 94).

Partnership working: Papers emphasised the importance of working closely with other agencies such as law enforcement and social services (23, 67, 70, 71, 78, 80, 89, 96, 98-101) and highlighted poor information sharing and communication as barriers to coordinated care (71, 96, 99). Papers also highlighted a need for health services to establish clear referral pathways to ensure appropriate support and care for people experiencing trafficking (83, 96).

Service development: A number of papers called for the development of specific services for trafficked people and advocated a range of service models, including one-stop-shops, mobile outreach and trauma-specific services (80, 86, 89, 91, 102). However, no evaluations of service model options were identified by the review.

4.7 NHS professionals' knowledge and experience of human trafficking: cross-sectional survey

Summary

This study surveyed 782 NHS professionals attending mandatory child protection and/or vulnerable adults training sessions at 10 secondary healthcare provider organisations in England and meetings of the UK College of Emergency Medicine. Participants completed self-administered questionnaire which asked about prior training and contact with potentially trafficked people, perceived and actual human trafficking knowledge, confidence in responding to human trafficking, and interest in future human trafficking training. Previous contact with a potentially trafficked person was reported by 13.0% of participants; among maternity services professionals this rose to 20.4%. However, 86.8% reported lacking knowledge of what questions to ask to identify potentially trafficked people and 78.3% reported that they had insufficient training to assist trafficked people. Findings are also reported in Ross *et al* 2015 (103).

Implications

The findings indicate that NHS professionals are interested in receiving information and training on human trafficking. While this research was not able to gather a representative sample of need by clinical discipline, our findings suggest that training is likely to be particularly relevant to professionals working in maternity services, mental health, paediatrics and emergency medicine. Although the research has identified key clinical disciplines for targeted training, training resources should be made accessible to all NHS professionals, including those working in non-clinical roles. Findings indicate that training needs to cover not only what NHS professionals need to know about human trafficking but also what they need to do in response to suspected cases of human trafficking.

Recommendations

1. Department of Health should include human trafficking and modern slavery within adult safeguarding policies, and produce and promote guidance on responding to human trafficking in healthcare settings, including that NHS staff who may have concerns that a patient they are treating or assessing for charges may have been trafficked should seek advice from their safeguarding lead. If the patient appears to be in danger, the relevant NHS body should contact the police.
2. Department for Education should include human trafficking and modern slavery within child safeguarding policies;

3. Department of Health should (i) develop, with key partners, strategies to raise awareness and recognition of human trafficking by healthcare and other professionals, including further encouraging engagement by Overseas Visitors Managers with local and national organisations that support trafficking people; (ii) update training resources (e.g. information leaflet and e-learning module launched in April 2013) for health professionals to identify, refer, and care for individuals they suspect have been trafficked, taking account of current evidence and working together with people with lived experience of trafficking and/or specialist voluntary organisations supporting trafficked people;
4. Health Education England, the Royal Colleges, and professional organisations responsible for setting training standards for NHS staff should target training at NHS safeguarding leads, at professionals working in maternity services, mental health, paediatrics, dentistry, emergency medicine, and overseas visitors charging departments¹³. NHS professionals should be trained to be aware of indicators of possible trafficking and how to respond appropriately to suspicions or disclosures of abuse; to conduct identification and referral – including to NRM First Responders – in safe and linguistically appropriate ways that prioritise providers’ and trafficked people’s safety;
5. NHS Trusts should ensure that staff have access to training resources on identifying and responding to human trafficking in healthcare settings, including specific training for safeguarding leads. Hospital staff receiving human trafficking training should include, as a minimum, the named doctor and nurse for child safeguarding, the lead midwife for safeguarding, the hospital SOVA lead, and the emergency department safeguarding lead;
6. NHS England should ensure that GPs have access to training resources on identifying and responding to human trafficking in healthcare settings;
7. Research community should conduct research to investigate NHS primary care professionals’ knowledge and experiences of human trafficking and associated information and support needs;
8. Research community should investigate the effectiveness of training programmes in improving the identification and referral of potentially trafficked people.

¹³ Existing resources include the e-Learning for Healthcare online module “Identifying and Supporting Victims of Modern Slavery” and the Equalities and Vulnerable Groups e-learning module.

Aim

This study aimed to measure NHS professionals' contact with and readiness to respond trafficked people.

Objectives

The objectives of the study were (1) to estimate the proportion of NHS professionals who have come into contact with trafficked people; (2) to measure NHS professionals' knowledge and confidence to respond to human trafficking (including identification, referral, and clinical care).

Methods

Study design and setting: Cross-sectional survey conducted at ten secondary healthcare provider organisations in England and meetings of the UK College of Emergency Medicine. Secondary healthcare provider organisations were selected in areas in which five or more trafficked people had been identified by police prior to 31st December 2012 (Birmingham Women's Hospital NHS Foundation Trust, Cambridge University Hospital NHS Foundation Trust, Croydon Health Services NHS Trust, East Kent Hospitals University NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, Hillingdon Hospitals NHS Foundation Trust, Homerton University Hospital NHS Foundation Trust, King's College Hospital NHS Foundation Trust, and South London and Maudsley NHS Foundation Trust).

Participants: Healthcare professionals attending face-to-face mandatory child protection and/or vulnerable adults training sessions at the above organisations or meetings of the UK College of Emergency Medicine. No incentives for participation were offered.

Measures: Self-administered questionnaire, designed to be relevant across a range of clinical disciplines and settings (see Appendix J). The PROTECT questionnaire was developed by an expert panel of researchers at King's College London and the London School of Hygiene and Tropical Medicine to assess healthcare professionals' levels of knowledge and attitudes towards human trafficking. The questionnaire was piloted with healthcare professionals (n=7) and with King's College London health visitor students (n=40). Following revisions, the questionnaire comprised 51 items over six sections: (i) background information (6 items); (ii) experience of training and responding to human trafficking (9 items); (iii) clinical awareness of human trafficking (9 items); (iv) knowledge about human trafficking (19 items); (v) responding to human trafficking (13 items); (vi) interest in attending human trafficking training (2 items).

Analysis: Data were analysed using STATA 12. Descriptive statistics (frequencies, percentages, means and standard deviations, and medians and inter-quartile ranges) were calculated. The psychometric properties of the PROTECT questionnaire were evaluated using exploratory factor analysis. Maximum Likelihood Analysis with oblique rotation was used for factor analysis, after the Kaiser-Mayer Olkin measure (KMO) indicated that the sample was adequate for factor analysis (KMO=0.85). Cronbach's alpha was used to assess internal construct reliability within the identified scales. Correlation analysis and multiple regressions were used to assess internal consistency of the PROTECT questionnaire and the discriminative characteristics of the scales with respect to participants who had and had not previously received training on human trafficking.

Ethics: Ethical approval for this study was provided by the National Research Ethics Service Committee South East Coast-Kent (13/LO/0113). Local approval was also provided by each of the participating Trusts.

Findings

Sample: 782 of 892 healthcare professionals invited to take part in the study consented to participate (84.4% response rate). The majority of the sample were female (80.6%) and white (70.7%) The sample included professionals from a range of clinical disciplines including mental health (22.3%), maternity (17.5%), emergency medicine (11.3%) and paediatrics (6.6%), working across a range of professional roles, including nurses (33.4%), doctors and dentists (15.8%), and midwives (8.3%). Further detail is provided in Table 15.

Table 15: Survey of NHS professionals- socio-demographic and employment characteristics (n=782)

| | n=782 (%) |
|----------------------------------|------------------|
| Gender | |
| Male | 152 (19.4) |
| Female | 630 (80.6) |
| Age (years) | |
| 19 – 24 | 95 (12.1) |
| 25 – 30 | 176 (22.5) |
| 31 – 40 | 158 (20.2) |
| 41 – 70 | 171 (21.9) |
| Ethnicity | |
| White | 553 (70.7) |
| Mixed | 26 (3.3) |
| Asian/British Asian | 72 (9.2) |
| Black/African/Caribbean | 72 (9.2) |
| Other | 9 (1.1) |
| Clinical discipline | |
| Clinical therapies ¹ | 62 (7.9) |
| Emergency medicine | 89 (11.3) |
| Maternity | 137 (17.5) |
| Mental health | 174 (22.3) |
| Paediatrics | 52 (6.6) |
| Other clinical | 182 (23.3) |
| Non clinical | 24 (3.1) |
| Current NHS role | |
| Doctor/Dentist | 124 (15.8) |
| HCA/Porter | 35 (4.5) |
| Midwife | 65 (8.3) |
| Nurse | 265 (33.4) |
| Psychologist/counsellor | 34 (4.3) |
| Student | 48 (6.1) |
| Technical support/administration | 33 (4.2) |
| Other ² | 126 (16.1) |

Due to missing data, columns may not total to 782.

¹ Physiotherapy, audiology, speech and language therapy

² Physiotherapist, occupational therapist, speech and language therapist, audiologist dietician, social worker, operating department practitioner, radiographer, phlebotomy, pharmacist, safeguarding lead, prison link worker, chaplain.

Psychometric analysis: Cronbach's alpha scores suggested that the internal consistency of the following questionnaire subscales was good or higher: clinical awareness of human trafficking ($\alpha=0.93$, 95% CI 0.92-0.94), knowledge of human trafficking ($\alpha=0.63$, 95% CI 0.59-0.66), and responding to human trafficking ($\alpha=0.64$, 95% CI 0.60-0.68). Maximum likelihood factor (MLF) analysis of the clinical awareness of human trafficking subscale revealed a dominant one factor solution, with all items loading onto the one factor weighted higher than 0.71 and with uniqueness below 0.30. MLF analysis of the responding to human trafficking subscale similarly showed a one factor solution. After dropping two items from the

knowledge of human trafficking subscale (1. diabetes is not likely to be associated with situations of human trafficking; and 2. coronary heart disease is not likely to be associated with situations of human trafficking), a two factor solution was indicated, with one factor loading onto symptom-based questions and the other factor loading onto questions about general knowledge of human trafficking. Further analyses found that clinical awareness was significantly correlated with knowledge ($R=0.1305$, $p=0.001$) and with responding to trafficking ($R= 0.3497$, $p=0.001$), and that experience of human trafficking training was correlated with clinical awareness ($R=0.385$, $p<0.001$) and responding to human trafficking ($R=0.136$, $p<0.001$).

Contact with potentially trafficked people: Previous contact with a potentially trafficked person was reported by 13% of participants. Among professionals working in maternity services, the proportion reporting prior contact with a potentially trafficked person rose to 20.4% ($n=28$) (Table 16). Contact with a potentially trafficked person ranged from 6.7% to 20.8% across the study sites, and was reported by 14.3% of participants from London-based NHS Trusts and 10.1% of participants from NHS Trusts outside of London. Of the 102 professionals reporting previous contact with trafficked people, 24.5% had been informed that their patient was a trafficked person by another professional involved in their care, 32.4% reported that their patient had disclosed experiences of trafficking, and 10.8% reported knowledge or suspicions arising from other reasons, including police involvement and the child being in foster care. A third (32.3%) of participants reporting previous contact with a patient they knew or suspected of having been trafficked did not report why their suspicions had arisen.

Table 16: Survey of NHS professionals - prior contact with potentially trafficked people (n=782)

| | No prior contact, n(%) N=680 | Prior contact, n(%) N=102 |
|--|---|--------------------------------------|
| Clinical discipline | | |
| Clinical therapies ¹ (n=62) | 60 (96.8) | 2 (3.2) |
| Emergency medicine | 75 (84.3) | 14 (15.7) |
| Maternity | 109 (79.6) | 28 (20.4) |
| Mental health | 149 (86.1) | 24 (13.9) |
| Paediatrics | 43 (82.7) | 9 (17.3) |
| Other clinical | 164 (90.6) | 17 (9.4) |
| Non clinical | 21 (87.5) | 3 (12.5) |
| Clinical role | | |
| Doctor/Dentist | 100 (83.3) | 20 (16.7) |
| HCA/Porter | 34 (97.1) | 1 (2.9) |
| Midwife | 40 (61.5) | 25 (38.5) |
| Nurse | 244 (92.1) | 21 (7.9) |
| Psychologist/counsellor | 28 (82.4) | 6 (17.6) |
| Student | 41 (85.4) | 7 (14.6) |
| Technical support/ administration | 29 (87.9) | 4 (12.1) |
| Other ² | 111 (88.1) | 15 (11.9) |

Due to missing data, columns may not total to 782.

¹ Child was in foster care, child was not parent's, inconsistent information, unusual situation, poor communication, reduced self-esteem, police involvement, noted in records, poor living conditions

² Physiotherapist, occupational therapist, speech and language therapist, audiologist dietician, social worker, operating department practitioner, radiographer, phlebotomy, pharmacist, safeguarding lead, prison link worker, chaplain.

Knowledge and preparedness to respond: Over three-fifths of respondents reported “very little” knowledge regarding their role in identifying and responding to human trafficking, questions to ask to identify potential cases, what to say or not say to a patient who has experienced human trafficking, documenting human trafficking in a medical record, assessing danger for a patient who may have been trafficked, local and national support services for trafficked people, and policies on responding to human trafficking (see Figure 1).

Perceived knowledge was slightly higher with respect of indicators of human trafficking and health problems commonly experienced by trafficked people, with 44% and 54% reporting “a little” knowledge of these aspects, respectively. This was reflected in scores on nineteen true or false questions measuring actual knowledge regarding the definition of human trafficking and associated health consequences: the median number of correctly answered questions was 14 (IQR 12-15). The results of these questions also highlighted, however, that 95.3% of respondents were unaware of the scale of human trafficking in the UK and that 76.4% were unaware that calling the police could put the patient in more danger.

As shown by Figure 2, although 91% (n=697) respondents agreed that healthcare professionals have a responsibility to respond to suspected cases of human trafficking, 80% reported that they had not received sufficient training to enable them to assist individuals in such situations. The majority did not feel confident to make appropriate referrals for women, men and children who have been trafficked or exploited (69%; 73%; and 55%; respectively). Three-quarters of respondents (74.6%) reported that they would be interested in receiving such training in the future, with the highest levels of interest expressed by professionals working in mental health (88.2%) and emergency medicine (81.6%).

Figure 1– Perceived knowledge of human trafficking (n=782)

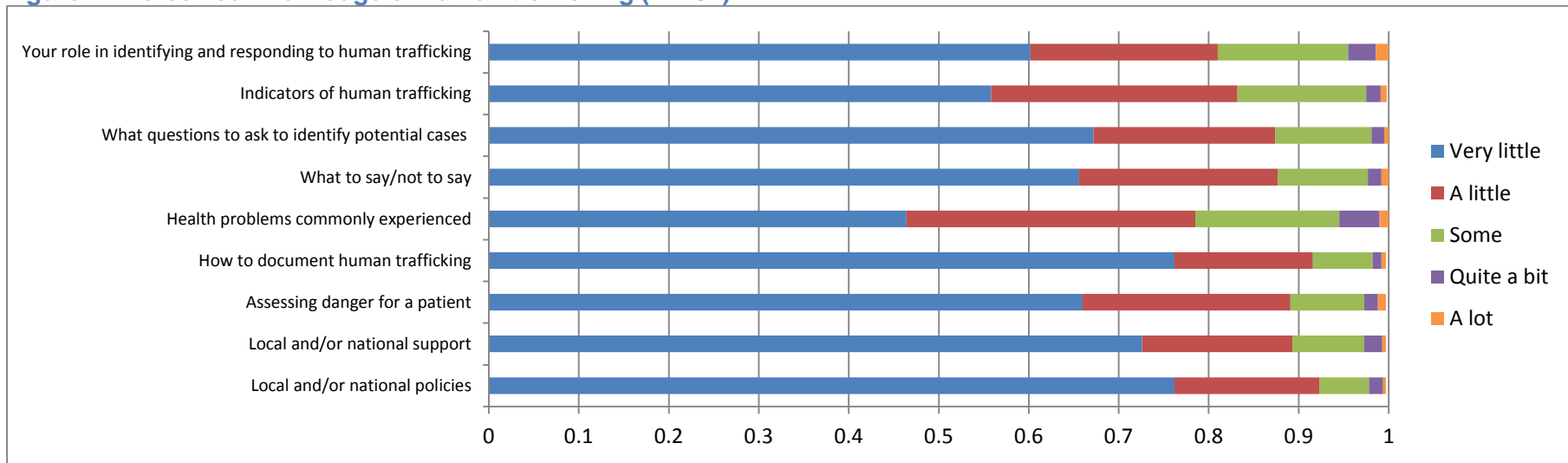
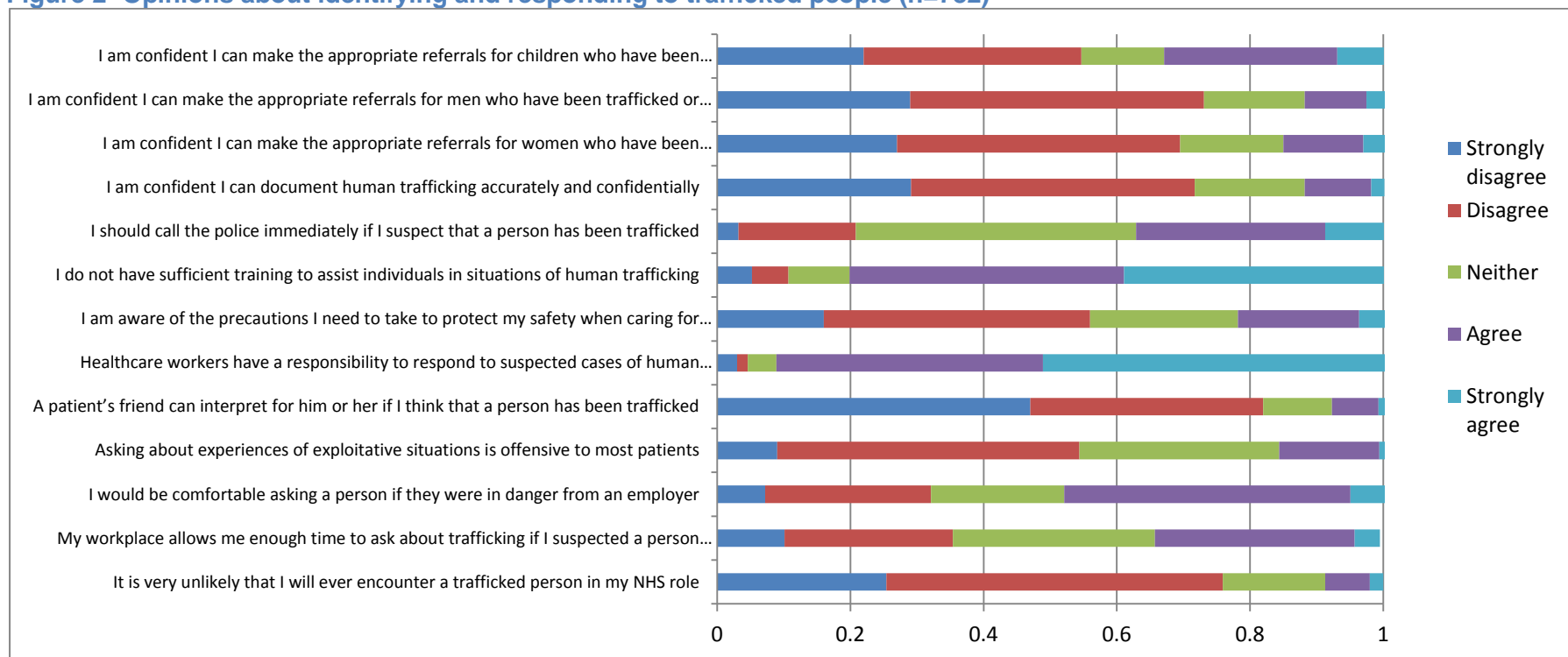


Figure 2- Opinions about identifying and responding to trafficked people (n=782)



4.8 Qualitative interviews with NHS and non-NHS professionals

Summary

Interviews were conducted with 29 NHS professionals and 23 professionals working outside the health sector, including civil servants, voluntary sector organisations, police officers, and members of the UK Human Trafficking Centre. Interviews with NHS professionals highlighted their willingness, interest, and some experience in identifying cases and providing care in cases of human trafficking, including individual attempts to manage and/or find assistance for suspected and reported cases of trafficking. However, professionals found that they were insufficiently informed about the available resources and struggled with the dilemmas raised by individuals' immigration status and how their entitlements (or lack of) might affect the types of care they could or should be receiving. Interviews with non-NHS professionals highlighted immigration issues as a major barrier to trafficked people's access to healthcare, including because of a lack of staff awareness of trafficked people's entitlements to care and also because trafficked people had particular challenges in providing documentation to prove their identity and eligibility for care. Language barriers posed an additional problem in accessing care. Voluntary sector organisations described providing considerable support to trafficked people to enable them to register with and use healthcare services. They reported, however, that accessing counselling and secondary mental health services was challenging and that addressing trafficked people's needs for formal psychological support within the 45 day NRM reflection and recovery period was often not possible.

Implications

The findings indicate that NHS professionals would benefit from training on identifying and responding to human trafficking and clearer guidance on referral and support options for trafficked people and on trafficked people's entitlements to medical care. Similarly, trafficked people require information about NHS care and how to register with GPs: primary care is the initial point of entry into services for most trafficked people but many face challenges in registering. As individuals can enter into the NRM without accepting support from the Salvation Army or other services, Competent Authorities are best placed to provide this information about entitlements to NHS care to potential victims of trafficking. We recommend that information about entitlements to NHS care is included within all positive reasonable grounds and conclusive grounds NRM decision letters; our Research Advisory Group has advised that NRM decision letters do not currently include this information. Findings also suggest that for many trafficked people with high levels of mental health need,

the minimum 45 day reflection and recovery period provided by a positive reasonable grounds decision within the NRM may be insufficient to access appropriate care. The Victims of Modern Slavery Competent Authority Guidance states that “a potential victim’s specific circumstances could mean they need more than 45 days to recover and reflect. If representations are made for more time, you must consider whether an extension is appropriate. The length of extension will be considered on a case by case basis depending on the facts of the individual case. Contacting the agencies listed above will help the Competent Authority decide if an extension of the recovery and reflection period is warranted. Likely reasons for an extension include: serious health issues; severe mental health or psychological issues (including post-traumatic stress disorder) requiring a longer period of recovery and reflection; high levels of victim intimidation” (104). However, we are not aware of guidance for The Salvation Army and support organisations on making representations to extend the reflection and recovery period and recommend that this be provided.

Recommendations

1. Department of Health should consider the impact of policy decisions on trafficked people regarding equality, and health inequalities and equity impact assessments.
2. Department of Health should ensure trafficked individuals are not unjustifiably denied medical care by informing relevant healthcare stakeholders of individuals’ full range of rights and entitlements to services, and by discouraging racism and bias to prevent refusal of services based on nationality, sex, language, race, or stigma or other protected characteristics as defined under the Equality Act 2010. Monitor regularly to ensure that individuals’ rights to services are respected;
3. Department of Health and GPs and surgeries should remove any barriers to GP registration that would prohibit trafficked people from registering;
4. Department of Health should hold providers of interpreting services accountable to quality assurance standards;
5. Department of Health should lead the development and dissemination of user-friendly materials to inform trafficked people about NHS services; registration with GP services, and confidentiality and how it is defined;
6. Home Office should ensure that people referred into the NRM are provided with user-friendly information about NHS services, registration with GP services, and confidentiality and how it is defined.
7. Home Office should amend NRM decision letters issued following positive reasonable grounds and positive conclusive grounds decisions to state specifically

that as a potential/identified trafficked person the person is exempt from charges for primary and secondary NHS care as per the NHS (Charges to Overseas Visitors) Regulations 2015;

8. Home Office should ensure that those who make an immigration application for leave to remain will have a 'Green: Paid or exempt from the health surcharge' banner on their NHS record, to reduce any difficulty accessing healthcare.
9. Home Office should provide guidance for relevant organisations (e.g. The Salvation Army and support providers) on making representations to extend the minimum 45-day reflection and recovery period for potentially trafficked people, including with regards to physical and mental health issues, pregnancy, and complex social needs, and review guidance for Competent Authorities on considering such representations¹⁴.
10. Clinical Commissioning Groups, Local Authority Partners, and NHS Trusts should incorporate responding to concerns that a patient may have been trafficked into the role of NHS safeguarding leads;
11. NHS England should ensure that GP practices are made aware that identity documents and proof of address are not an essential requirement to register a patient;
12. NHS England should ensure that health professionals have access to confidential and expert advice where they are concerned that a patient might be a trafficked person. This could be incorporated into the role of safeguarding leads;
13. NHS England should ensure trafficked people are not charged to access their medical and healthcare documents so that they have information about the medical care they received while in the UK, especially if returning to their country of origin.

¹⁴ A revised NRM is currently being piloted, including testing decision-making by multi-agency panels. Guidance on considering representations to extend reflection and recovery periods should be provided to multi-agency panels, if rolled out.

Aim

This study aimed to explore NHS and non-NHS professionals' experience of responding to trafficked people's health needs.

Methods

Study design and setting: Qualitative interviews conducted with NHS and non-NHS professionals across England.

Participants: Individuals were eligible for inclusion if they met one of the following criteria: (1) NHS professionals with previous experience of treating trafficked people, or people suspected of being trafficked.; (2) NHS professionals with adult or child safeguarding lead responsibilities; (3) non-NHS frontline professionals who have assisted trafficked people (including the named trafficking leads of local police forces, asylum caseworkers, and regional National Referral Mechanism managers and caseworkers); (4) National stakeholders with relevant expertise or influence (e.g., UK Human Trafficking Centre, Department of Health, Home Office, UK Visas and Immigration).

Potentially eligible professionals were identified with assistance from the Research Advisory Group, Project Steering Group, and NHS Local Collaborators, and by snowball sampling. NHS professionals were purposively sampled to include clinical and managerial staff from different disciplines and grades, e.g. from general practice, sexual health, maternity, mental health, Emergency Departments, and Sexual Assault Referral Centres. Non-NHS professionals were also purposively sampled to ensure representation of a range of organisations across England. We aimed to recruit approximately 20 interviews with NHS professionals and 20 interviews with non-NHS local and national stakeholders.

Data collection: Interviews followed topics guides which were reviewed and revised by the Project Steering Group. Example topic guides are provided in Appendix K. Interviews with NHS professionals explored: (1) Experiences of identifying, referring and providing care to trafficked people; (2) Knowledge of trafficking indicators, referral options, care pathways and barriers, and treatment approaches; (3) Knowledge gaps and training needs; (4) Opportunities, barriers, feasibility and recommendations for the integration of services for trafficked people into current practice and coordinating with other aspects of the UK response to human trafficking, and (5) Examples of multi-disciplinary support and health care approaches for other vulnerable populations (e.g., sexual violence survivors, domestic violence survivors, refugees and asylum-seekers). Interviews with non-NHS professionals explored (1) experiences of referring and assisting trafficked people to access healthcare

(where relevant to professional role); (2) opportunities, barriers, feasibility and recommendations for coordination between the NHS and other aspects of the UK response to human trafficking, including the NRM; and (3) examples of multi-disciplinary support and health care approaches for other vulnerable populations. Interviews were conducted face to face and lasted between 30 and 90 minutes. Interviews were digitally recorded and transcribed verbatim.

Analysis: Framework analysis was used to analyse interview data in NVivo and MS Excel (105). Transcripts were read and reread, and a priori themes refined and new themes identified based on an initial sample of transcripts. An initial thematic framework was applied to the remaining transcripts and iteratively refined, followed by within-case and between-case analysis of the themes.

Ethics: Ethical approval for this study was provided by the National Research Ethics Service Committee South East Coast-Kent (13/LO/0113).

Findings

Interviews were conducted with 52 professionals (see Table 17), including 29 health sector professionals working in the civil service and across a range of clinical disciplines and 23 professionals involved in responding to human trafficking through their work in other departments of the civil service, non-governmental organisations (NGOs) providing accommodation, outreach, or advocacy support to trafficked adults and children, police, and the UK Human Trafficking Centre.

Table 17: Professionals participating in qualitative interviews

| Health Sector Professionals | | Other Professionals | |
|--|-----------|-----------------------------|-----------|
| Civil Service ^a | 4 | Civil Service ^b | 3 |
| Forensics and Sexual Assault Referral Centres | 5 | NGO (Adults) | 8 |
| General Practitioners | 5 | NGO (Children) | 2 |
| Maternity | 5 | Police | 6 |
| Mental Health | 2 | UK Human Trafficking Centre | 4 |
| Paediatrics | 2 | | |
| Sexual Health | 3 | | |
| Other (Incl. emergency medicine, safeguarding, training) | 3 | | |
| Total | 29 | Total | 23 |

^a Department of Health, Public Health England

^b Home Office, UK Visas and Immigration

Barriers to care (NHS professionals)

The NHS professionals described several barriers to responding to human trafficking. Confusion around foreign nationals' entitlements to NHS care, and the difficulty and discomfort NHS professionals experienced in trying to establish whether a person was entitled to access care was a common theme throughout the interviews:

"I do think there is an issue in the NHS in general, lack of understanding about who is entitled to what. I think that's a huge issue actually. Um, I'm not sure, if it is 100% clear. I mean I think that I've got it, having done quite a lot of work on trying to work out who is entitled to what." (Maternity)

"Sometimes when the families come you don't know what status they are... Do we know what their immigration status is? You have to work out what are they entitled to." (Paediatrics)

Further barriers to care include professionals' lack of confidence in how they could help trafficked people and lack of awareness of support and referral options. Despite being aware of potential cases of human trafficking, the majority of professionals interviewed for this research had not received training on human trafficking:

"I haven't had training on trafficking, no. informally, I've discussed it with colleagues." (General Practitioner).

"So I would say in terms of specific trafficking training, no. I don't think so. Um, what do I base my practice on, that is a really interesting point, I don't know" (Maternity).

Indeed, professionals described how they had little guidance on how to identify and refer patients they suspected might have been trafficked:

"You know, like, you're asking me the questions and I'm thinking I have to dig and dig to find out, you know." (Maternity)

One professional described, for example, having searched on the Internet for information about support services for trafficked people but not being able to find the information he needed:

“I had a quick Google, found the Salvation Army service, erm, looked at the website, found a 24 hour helpline, erm there wasn’t much more information on the, that I could find, on the website about who might be eligible and what the process might be”

(General Practitioner)

Others described situations in which they difficulties making referrals to voluntary sector organisations on behalf of trafficked people for whom they were providing care:

“I think my sister had suggested trying [one organisation]. So I called them and they were in West London and they had limited capacity to come all the way to East London. So we tried [another organisation]... and I didn’t have a very forthcoming response...they said they thought her needs were too high for them – which was unfortunate and that we should try calling [a third organisation]” (Sexual Health)

“First of all I was told about 3 months, and then I was told by somebody else about a month, and then I eventually, and it took a while, it’s taken 3 weeks of really hard trying to get hold of [an organisation]” (Maternity)

In the absence of guidance on how to respond to suspicions or disclosures of trafficking, and clear referral pathways, professionals suggested that many NHS staff would be reluctant to ask patients about their experiences:

“The problem is that unless you can come up with some relatively simple way of supporting the NHS to deal with patients in that situation, they’d rather not open the can of worms... staff just wouldn’t have asked the question, because what, what are you gonna do then?” (General Practitioner)

Interviewees advocated for access to clearer, more accessible information. In particular, interviewees recommended having a single number to call to access information and advice, and easily accessible information about how support services for trafficked people are structured:

“What would be helpful would be a helpline which is consistent ... which you can be confident of getting a response is helpful, ...so if there is such a service which is consistent and reliable, then, highlighting that, publicising that and you know, so if it was fairly simple” (General Practitioner)

“I think that people don’t know what to do in the majority of cases and they don’t know how to go about things. So then if we could have these people that you could call, this is the structure; just a few brief paragraphs that departments could have”
(Sexual Health)

Interviewees also suggested that NHS professionals should have access to written information and contact details that they could provide to trafficked people, available in a variety of languages:

“Here is a website, here are information leaflets in the main languages which could print off and then give to the person and this is the number that you can phone...ideally, you’d want to be able to put the person on the phone to somebody that spoke their language and could talk through with them what their, what their options are.” (General Practitioner)

Interviewees advocated for training to be available for NHS professionals on responding to human trafficking, though views varied on whether this training should be made mandatory. Several interviewees suggested that human trafficking should be included within safeguarding children and adults training and that, similar to safeguarding, training should be “stepped”, with basic information being provided to all staff and in-depth training provided to safeguarding leads and other key professionals:

“You’d want their safeguarding leads to have a knowledge about it, so that it becomes part of their role to give advice and support, but they don’t necessarily need to train every member of staff” (Safeguarding)

“You could imagine having you know, a longer session and possibly the erm, I don’t know, the lead safeguarding kind of named people went to that, so you had something perhaps that was a little bit longer. I don’t know, say a three hour session or, what a two hour session for some key people who could then disseminate information.” (General practitioner)

Barriers to care (non-NHS professionals)

Non-NHS professionals identified a range of factors that they observed hindered trafficked people’s access to healthcare services both during the time they were exploited and after

escaping their situation. Key barriers included trafficked people's immigration status, and their lack of familiarity with the NHS and their rights to care, documentation, and proficiency in English. The hidden nature of human trafficking was highlighted as a barrier to the identification of trafficked people within healthcare settings, although not as a barrier to accessing care per se.

Voluntary sector support providers described how trafficked people's immigration status – as, for example, an asylum seeker, an EU national, an undocumented migrant, or a temporarily admission under the NRM – impacted on access to care in a number of ways. Trafficked people who were in contact with healthcare services could find that their care was interrupted if they claimed asylum and were relocated by the National Asylum Support Service (NASS). Relocations disrupted continuity of care, and were described as particularly problematic in the context of mental health care:

“Somebody who's plugged into a variety of services in a particular area, then if they turn up in another area, they might struggle to get the same services. The same services might not exist. You might have a -- I don't know, discontinuation of, say, psychological support, which is going to have a massive impact on you, - you've got to start a new relationship” (Civil servant)

As his ID came, his 45 days was up, so he was moving on anyway. So you register with the doctor's and then they move area... and they've got to re-register” (NGO representative)

Immigration status also acted as a barrier to trafficked people coming into contact with healthcare services. Voluntary sector support providers described how many healthcare professionals were uncertain about different categories of migrants' entitlements to care, and suggested that a minority of staff held discriminatory attitudes towards particular groups of migrants.

“I guess it's just countering this thing of seeing everyone without the right set of papers as an illegal migrant” (NGO representative)

“A particular provider has just commented that you know, every time they've gone down there with a Nigerian victim, it's the same issue that they've had to face, you know, it's just a different response.” (NGO representative)

Providers explained that there was little awareness in the NHS of the entitlements of people recognised under the NRM as potentially trafficked, and some described how they frequently took copies of the NHS charging regulations which detailed the circumstances under which potentially trafficked people were exempt from healthcare charges. In line with the findings of the interviews with trafficked people reported in the previous chapter, most voluntary sector support organisations also reported they would generally send an advocate or key worker to accompany trafficked people to healthcare services in order to overcome registration problems and confusion regarding entitlement to care. However, receptionists were repeatedly described as obstacles to care:

“I think the main problem of accessing the health service is when people are trying to get into a GP surgery and they’re turned away by the receptionist.” (NGO representative)

Providers also described how many trafficked people were reluctant to access healthcare services because as undocumented migrants they were fearful of coming into contact with authorities:

“She hadn’t accessed any medical care because she was so worried because of her illegal immigrant status.” (NGO representative)

Participants described how trafficked people often had very little knowledge of how the NHS worked, whether they would be allowed to access care, and whether they would be charged for doing so. In some cases this was due to misinformation from their traffickers:

“She’d just come out of a situation ... you know, she couldn’t speak up for herself, she couldn’t demand her rights because she didn’t know, didn’t know really what she was entitled to.” (NGO representative)

“Often, you know, even incorrectly [traffickers] will say, ‘No, you’re not entitled to, to register with a doctor’.” (NGO representative)

Uncertainty regarding entitlement to care was often compounded by trafficked people lacking documents confirming their identity and residence, including because their traffickers had confiscated or provided them with fraudulent documentation and because they did not have a permanent address in the UK:

"I took him to a local doctor, who refused to see him, because he had no ID". (NGO representative)

"One of them had been repeatedly turned away from, um, clinics, because she couldn't provide the second form of evidence which is the utility bill or whatever because her living situation was not conducive to that." (NGO representative)

Once trafficked people were registered with healthcare services, providers described how language difficulties became a barrier to accessing care:

"I took a girl who had been trafficked and they weren't really understanding her, she didn't speak much English. I asked for an interpreter to be there. And they, um, the GP got an interpreter on the phone, but she had really little training I would say of how to use interpreters." (NGO representative)

Although a range of barriers to trafficked people's access to healthcare were described during interviews with non-NHS professionals, voluntary sector support providers reported that they were generally able to overcome these problems through advocacy and by accompanying their clients to appointments. This often required a substantial investment of time on the part of support organisations, and providers expressed concern regarding the ability of trafficked people who were not in contact with support services to access NHS care. Interviewees reported, however, that the difficulties they experienced were harder to overcome in relation to access to mental healthcare.

Access to mental healthcare was made difficult by the long waiting lists for care and lack of specialist trauma services:

"I think the last time I rang and referred somebody, they said there are 30 people on the waiting list." (NGO representative)

"They have counsellors, but not - I don't think any specialist trauma counsellors." (NGO representative)

Long waiting lists for mental healthcare were described as particularly problematic for trafficked people accessing support through the NRM, because the standard duration of support provision is forty-five days. Participants described that addressing trafficked people's needs for formal psychological support within this timeframe was often not possible:

"I mean in the forty-five days, through the shelters and the outreach, they will get, sort of, forms of support, but it's not, sort of -- it's not psychological or psychotherapy or anything on those lines, it's counselling from support workers, which is quite different to what some of those individuals might need." (Civil servant)

"[The waiting list is] 3 months, and considering sometimes we've only got 45 days, you know what I mean." (NGO representative)

Language barriers – highlighted generally as a barrier to trafficked people's access to care – were described as being particularly problematic in the context of mental healthcare. Professionals described both the lack of interpretation within counselling services and the problems of discussing sensitive and traumatic experiences via an interpreter:

"First of all, when you're talking to an interpreter about sensitive issues it's really really hard. If you're talking in your own language it's a lot easier." (Police officer)

"I think there's certainly a need for more counselling services, more specialist counselling services. But I think it's this whole big block with, 'Yes, we provide counselling, but we don't have interpreters'." (NGO representative)

Providers also noted that although some trafficked people were very keen to access counselling and other forms of mental health support, others were reluctant to seek counselling. This was typically attributed to people coming from countries in which mental health problems were heavily stigmatised and counselling was culturally alien.

4.9 Stakeholder Workshop

Summary

Frontline health professionals and key stakeholders with expertise on health education were invited to participate in a one day stakeholder workshop to inform the future development of NHS training materials on human trafficking. NGOs and other organisations represented on the PROTECT Research Advisory Group were also invited to attend. Fifty representatives of over 35 organisations attended. Awareness and use of existing training materials, such as the e-learning module hosted by E-Learning for Health, was low. In discussing priorities for training content, participants emphasised the importance of training NHS professionals not only to know what human trafficking was but also what they should do in response to suspected cases. Participants also highlighted the importance of having a single number to call for referral, support, and advice and also the potential relevance of existing resource and training materials on asylum seekers and refugees and on domestic and sexual violence. E-learning was noted to be a convenient training format for NHS professionals, but participants recommended that additional training also be made available in alternative formats. Participants were asked to discuss how training should be targeted, and recommended targeting safeguarding leads and overseas visitors managers and key clinical disciplines including emergency medicine, maternity, dentistry.

Implications

NHS professionals should be provided with easily accessible information about responding to human trafficking in healthcare settings (e.g. via internet, Google search, etc.). Information needs include details of support options, referral pathways, and a point of contact for information and advice. While it might seem that online training resources would be most convenient for NHS staff, in general, participants seemed to indicate that online learning would not be their favoured way to receive training on trafficking, but instead, many believed that they would find in-person, interactive information and trainings sessions more engaging, more useful. Indeed, if in-person training were made available that included key resource people from other professionals and service providers (shelters, police, legal aid, etc.), these sessions might serve to build stronger and more supportive referral networks.

Recommendations

1. Department of Health should include human trafficking and modern slavery within adult safeguarding policies, and produce and promote guidance on responding to human trafficking in healthcare settings, including that NHS staff who may have

concerns that a patient they are treating or assessing for charges may have been trafficked should seek advice from their safeguarding lead. If the patient appears to be in danger, the relevant NHS body should contact the police.

2. Department for Education should include human trafficking and modern slavery within child safeguarding policies.
3. Department of Health should (i) develop strategies to raise awareness and recognition of human trafficking by healthcare and other professionals; (ii) update training resources (e.g. information leaflet and e-learning module launched in April 2013) for health professionals to identify, refer, and care for individuals they suspect have been trafficked, taking account of current evidence and working together with people with lived experience of trafficking and/or specialist voluntary organisations supporting trafficked people;
4. Health Education England, the Royal Colleges, and professional organisations responsible for setting training standards for NHS staff should target training at NHS safeguarding leads, at professionals working in maternity services, mental health, paediatrics, dentistry, emergency medicine, and overseas visitors charging departments¹⁵. NHS professionals should be trained to be aware of indicators of possible trafficking and how to respond appropriately to suspicions or disclosures of abuse; to conduct identification and referral – including to NRM First Responders – in safe and linguistically appropriate ways that prioritise providers’ and trafficked people’s safety;

¹⁵ Existing resources include the e-Learning for Healthcare online module “Identifying and Supporting Victims of Modern Slavery” and the Equalities and Vulnerable Groups e-learning module.

5. NHS Trusts should ensure that staff have access to training resources on identifying and responding to human trafficking in healthcare settings, including specific training for safeguarding leads. Hospital staff receiving human trafficking training should include, as a minimum, the named doctor and nurse for child safeguarding, the lead midwife for safeguarding, the hospital SOVA lead, and the emergency department safeguarding lead;
6. Clinical Commissioning Groups, Local Authority Partners, and NHS Trusts should incorporate responding to concerns that a patient may have been trafficked into the role of NHS safeguarding leads;
7. NHS England should ensure that GPs have access to training resources on identifying and responding to human trafficking in healthcare settings;
8. NHS England should ensure that health professionals have access to confidential and expert advice where they are concerned that a patient might be a trafficked person. This could be incorporated into the role of safeguarding leads;
9. Research community should conduct research to investigate the generalizability of guidelines for working with people who have experienced violence and with vulnerable migrants to trafficked people.

Aim

The aim of the workshop was to inform the future development of training materials on human trafficking for NHS professionals.

Methods

The PROTECT team identified frontline health professionals and key stakeholders with expertise on health education and invited them to participate in a 1 day stakeholder workshop. Organisations represented on the PROTECT Research Advisory Group were also invited to attend. Invitations were sent to 67 potential participants¹⁶, and over 50 representatives of 35 organisations attended, including the Department of Health, NHS England, Public Health England, Health Education England, British Association of Sexual Health and HIV, the Royal College of Midwives, voluntary sector organisations, and universities. A list of the organisations represented at the meeting is provided in Appendix L.

Presentations regarding the scale and nature of human trafficking in the UK, the UK policy context on responding to human trafficking, current evidence on health and human trafficking and case studies on the provision of human trafficking training to healthcare professionals were followed by breakout session. During breakout sessions delegates discussed the following questions in groups of five to ten people:

- (1) Current training options – what training materials and tools are you currently aware of? Which do you use? What works well and/or less well? What is missing?
- (2) Priorities for training content and format – what key topics should training materials cover? What should be the format of training materials? To whom should training be targeted?
- (3) Training delivery and access – how should training materials be made available? How can we raise awareness of the materials?

Findings

Currently available training materials and tools: In the first breakout session, delegates were asked to identify training materials and tools that they were aware currently existed, and to discuss which they used, what they found worked well and/or less well, and what they

¹⁶ Invitations were sent to members of the PROTECT Steering Group (n=12); NHS local collaborators (n=8); representatives of the Royal Colleges (n=8), Department of Health (n=6), Public Health England (n=4), NHS England (n=1), Health Education England (n=1), and Clinical Commissioning Groups (n=2); NHS Safeguarding Leads and Trainers (n=13); and PROTECT Research Advisory Group members (n=7) and clinicians and academics recommended by them (n=5).

felt was currently missing. Delegates reported that there were aware of a range of different materials that could have relevance for NHS professionals:

- Information leaflet, co-produced by the Department of Health and Platform 51 (<http://www.fsrh.org/pdfs/HumanTraffickingGuidanceLeaflet.pdf>);
- E-learning module, co-produced by the Department of Health and Platform 51 (<http://www.e-lfh.org.uk/programmes/modern-slavery/>);
- Awareness raising video (“Modern slavery is closer than you think”), produced by the Home Office and available to watch on YouTube (https://www.youtube.com/watch?v=Jv1H_fAoOG4);
- Trafficking Survivor Care Standards, produced by the Human Trafficking Foundation (http://www.humantraffickingfoundation.org/sites/default/files/Trafficking_Survivor_Care_Standards.pdf);
- Guidance from the IOM on caring for trafficked people in healthcare settings (http://publications.iom.int/bookstore/free/CT_Handbook.pdf);
- Information leaflet on working with refugees, produced by the South London Refugee Clinical Team;
- Resources from the Health Professional Education, Advocacy and Linkage (HEAL) website;
- Resources from the Anti-Trafficking Legal Project (ATLEP) website;
- Resources from the Victoria Climbié Foundation;
- Free training from the NSPCC Child Trafficking Advice Centre;

Delegates reported that key issues with regards to training materials were knowing what was available and how to access it. Very few delegates had, for example, accessed either the Department of Health/Platform 51 information leaflet or e-learning module.

Training content and format: In the second breakout session, delegates were asked to consider what topics should be prioritised for inclusion in NHS training materials and how training materials should be formatted. Participants highlighted several topics that would be important to cover in future training materials, including:

- Definition of human trafficking, with case examples;
- Information about the scale of human trafficking and high-risk groups;
- Health-relevant indicators of human trafficking;
- Information about trafficked people’s entitlement to care;
- Principles of trauma-informed care, including how to have conversations about sensitive topics in a time-pressured environment;

- Guidance regarding confidentiality and information sharing, including when to contact the police;
- Information about options for referral and further advice, including simplified information about the NRM process;

In discussing indicators of human trafficking, a number of delegates suggested that the authors of training materials should consider illnesses and injuries that trafficked people experience as a result of exploitative living and working conditions and that might prevent them from working, as these conditions were what trafficked people would be most likely to access care for while experiencing ongoing exploitation. However, delegates also argued that training materials should cover not just what NHS professionals should *know* about human trafficking but also what they should *do* in response to suspected cases of human trafficking. Awareness-raising was necessary but insufficient: training must be linked to the actions NHS professionals should take.

Delegates also suggested that training should emphasise the importance of scheduling follow-up appointments with patients suspected of being trafficked, in order to develop a trusting patient-provider relationship and provide an opportunity to arrange for appropriate interpreters, and should develop professionals' ability to identify and respond to forms of abuse that they may view as cultural issues, such as witchcraft and exorcism. There was consensus on the need for clear information about referral options and what support was available for trafficked people, including through the NRM. Delegates suggested that training resources should include a single number to call for referral and support advice.

Delegates highlighted that the content, format, and targeting of training on domestic and sexual violence and on working with asylum seekers may be relevant to the future development of human trafficking training, which shouldn't seek to "reinvent the wheel". Participants also emphasised the importance of having input from people who had experienced trafficking when developing training materials to improve healthcare responses for trafficked people.

E-learning was highlighted as a training format that was convenient for NHS professionals, delegates noted that it lacked provision for learning through discussion and role-play. Delegates recommended that additional, supplementary training materials should be available in multiple formats. These included face to face training; free online talks, webinars, and videos; an online library of research articles; and an app with red flag indicators and referral information. Delegates also suggested that social media could be

used to raise awareness of human trafficking, particularly among future generations of health professionals. The development of a risk checklist to complement existing tools was recommended, although other delegates suggested that tick-box tools limited professionals' ability to assess risk and needs holistically. There was a general consensus that training materials should be freely available online, and that resources should be hosted on one easy to navigate website. Links to this website could be provided by the websites of the Royal Colleges and Trust Intranets.

Targeting and dissemination: Delegates suggested that training should initially be targeted at key clinical disciplines, suggesting frontline staff in maternity services, emergency departments, dental services, and overseas visitors charging departments. Participants also highlighted that abortion providers and counsellors were often left out of training on violence and abuse, but may have a role in identifying and responding to the needs of trafficked women. Delegates criticised the materials that were currently available as poorly differentiated, and highlighted the need for materials to give specific guidance for particular clinical disciplines and NHS roles. Also highlighted was the importance of including information about human trafficking in undergraduate medical training. As well as training the next generation of NHS professionals, this would help to overcome the challenges inherent in training a workforce that had high levels of staff turnover. Finally, delegates recommended that resources and guidance be produced for clinical commissioning groups (CCGs) and social services.

Although delegates spoke about the importance of training NHS professionals to regard identifying and responding to human trafficking as part of the role of all healthcare professionals, they also argued that not all healthcare professionals could or should be expected to be experts in this area. They recommended that training materials be developed at various levels ranging from a basic overview that would be broadly relevant for most NHS staff to more specialised content for professionals that were more likely to have contact with trafficked people. They also recommended that local "champions" or "link practitioners" should be in place to provide information and guidance about responding to human trafficking, particularly in high-risk areas,

Mixed views were held regarding whether training on human trafficking should be mandatory for health professionals. While some argued for this approach, others felt that such an approach would be deeply unpopular among NHS professionals. A suggested compromise was for human trafficking training to be included as one of several courses that could be taken for partial fulfilment of mandatory training (e.g. child and adult safeguarding).

5. Conclusions and further research

Findings from this large programme of work offer evidence upon which to build the Department of Health's strategy and the National Health Service's response to the health needs of people who have been trafficked. At the most fundamental level, the results indicate the diversity of individuals who have been trafficked within and into the UK and their multiple and often very complex and inter-dependent health and support needs. This finding corresponds with other research from around the world that has offered similar evidence about the range of sectors in which people are exploited and their often-acute *and* longer-enduring health problems (15, 21, 37) .

High levels of mental health problems among trafficked people were reported across several of the studies in this programme of work. Yet, as highlighted by our systematic review of guidance on responding to human trafficking in healthcare settings, we know very little about what helps trafficked people to recover from the psychological impact of human trafficking. Research is urgently needed to develop and test psychological interventions to promote recovery. Also striking were the numbers of trafficked people who were parents and the numbers of female survivors who reported having been pregnant while trafficked. Research is now needed to investigate trafficked people's experiences of pregnancy and parenting and to explore the intergenerational impact of human trafficking. The research struggled to recruit trafficked children and adolescents to the cross-sectional survey describing the health needs and healthcare experiences of trafficked people. There were also only small numbers of UK nationals participating in this study. Further research is needed to investigate the health needs and care experiences of internally trafficked adults and internally and both internationally trafficked children.

Our findings also highlight the challenges associated with access to care and to service provision for this population. These challenges are experienced by all parties involved: people who have been trafficked; the health care providers who are often in positions to provide medical care and/or help identify and refer individuals; law enforcement and non-governmental organisations providing shelter and other support services. Primary sources of difficulties centre on the coordination and communications between available resources. It is common for trafficked persons and service providers alike to be uncertain who is responsible for what, when and how. For health providers—and most others involved in care and protection—nervousness that they will be wholly responsible for a vulnerable person with complex and often urgent needs means that they may balk at first opportunities to become

involved or, once involved are likely to become frustrated and dismayed with the poor availability of other necessary assistance. At the same time, our research suggests that each of the actors who are in contact with trafficked people have an appetite for improvements to ensure their health and safety and there is willingness on the part of service providers both within the NHS and the non-health sectors to foster and implement better coordinated referral systems, care provision and clear avenues of collaboration.

The Department of Health, NHS, and other key stakeholders should capitalise on this willingness and sense of urgency to develop a coordinated strategy for the development of a robust health sector response to human trafficking. The Department of Health should draw on the evidence-based recommendations provided in this report and develop a departmental action plan regarding the health sector response to human trafficking, supplementing departmental and cross-departmental action plans on violence against women, human trafficking, and modern slavery. For maximum impact, the Department of Health should work closely with local authorities, the Local Government Association, Association of Directors of Social Services and Public Health England in developing these plans. As noted in the report's recommendations, plans need to address several key aspects: (1) the full participation of the Department of Health in human trafficking policymaking, including with regards to the structure and function of the NRM; (2) the development of the NHS's role in responding to human trafficking alongside other agencies; (3) the development and implementation of clear pathways and procedures within the NHS and between the NHS and the multi-sector services supporting trafficked people; and (4) the provision of information and training to support NHS professionals to be able to respond appropriately to human trafficking, including through making safe referrals within and beyond the NHS. The Department of Health should request departmental membership and participation of committees involved in the development of legislation, policy, and regulations pertaining to human trafficking, including the NRM, inviting representatives of the health sector as required. As the lead department on the development of policy on human trafficking and modern slavery, the Home Office should request the membership and participation of the Department of Health and arm's length bodies (e.g. NHS England, NICE, Public Health England, Health Education England, and Local Government) in these committees.

Trafficked people's health must be placed at the heart of the victim-centred approach to human trafficking. This means that not only recognising the central importance of trafficked people's health needs, but more importantly, putting systems in place to ensure that people can receive treatment to recover from abuses that most have come to agree amounts to modern slavery.

6. Dissemination plans

Work to disseminate findings arising from the PROTECT research will continue. We currently have a number of manuscripts published or submitted to peer-reviewed academic journals and several further manuscripts in preparation. Findings have also been presented at national and international conferences for academics and practitioners.

Papers published/in press

- Turner-Moss E, Zimmerman C, Howard LM, Oram S. (2014) Labour exploitation and health: a case series analysis of men and women seeking post-trafficking services. *Journal of Immigrant and Minority Health* 16(3):473-480.
- Ross C, Dimitrova S, Howard LM, Dewey M, Zimmerman C, Oram S (2015). Human trafficking and health: a cross-sectional survey of NHS professionals' contact with victims of human trafficking. *BMJ Open*;5,e008682.
- Oram S, Khondoker M, Abas M, Broadbent M, Howard LM (2015). Characteristics of trafficked adults and children with severe mental illness: a historical cohort study. *Lancet Psychiatry* 2(12):1084-1091.
- Domoney J, Howard LM, Abas M, Broadbent M, Oram S (2015). Mental health service responses to human trafficking: a qualitative study of professionals' experiences of providing care. *BMC Psychiatry* 15(1):289 doi:10.1186/s12888-015-0679-3.
- Oram S, Abas M, Bick D, Boyle A, French R, Jakobowitz S, Khondoker M, Stanley N, Trevillion K, Howard LM, Zimmerman C (2016). Human trafficking and health: a cross sectional survey of male and female survivors in contact with services in England. *American Journal of Public Health*. Online First, e1–e6. doi:10.2105/AJPH.016.303095.
- Ottisova L, Hemmings S, Zimmerman C, Howard LM, Oram S (In Press). Prevalence and risk of health problems among trafficked people: a systematic review. *Epidemiology and Psychiatric Sciences*

Submitted for peer review

- Hemmings S, Jakobowitz S, Bick D, Howard LM, Stanley N, Zimmerman C, Oram S. Responding to the needs of survivors of human trafficking: a systematic review. *BMC Health Services Research*.
- Stanley N et al. Health risks and outcomes of trafficked young people: a cross-sectional survey. *Child Abuse and Neglect*.

- Westwood J et al. Barriers and facilitators of trafficked people's access to healthcare services: a qualitative study. *British Journal of General Practice*.
- Borschmann R et al. Self harm in adult victims of trafficking accessing secondary mental health services in England. *Psychiatric Services*.

In preparation

Planned publications

Further academic dissemination activities will include the completion of additional academic research papers:

- Bick D et al. Pregnancy and parenting experiences of female survivors of trafficking in contact with support services in England.
- Borschmann et al. Responding to the health needs of trafficked people: a qualitative study of professionals' experiences of providing care.
- Oram et al. Exploring the health risks and outcomes associated with different forms of labour exploitation.

Conference papers (oral presentations)

- British Association for the Study and Prevention of Child Abuse and Neglect. Edinburgh, 2015. Young people's experiences of trafficking in the UK: health impacts. J Westwood et al.
- Violence Against Women and Children in Diverse Contexts. Johannesburg, 2015. Human trafficking: experiences of violence, and risks to health. S Oram et al.
- International Association for Women's Mental Health. Tokyo, 2015. Mental health and service needs of trafficked people in contact with health and support services in England. S Oram et al.
- World Association for Social Psychiatry. London, 2014. Human trafficking and mental health: findings from a survey of trafficked people in contact with health and support services in England. S Oram et al.
- World Association for Social Psychiatry. London, 2014. Pre-trafficking, trafficking, and post-trafficking risk factors for mental disorder among women survivors of human trafficking. S Oram et al.
- World Psychiatry Association. Madrid, 2014. Human trafficking and mental health: findings from a survey of trafficked people in contact with health and support services in England. S Oram et al.
- HERON, London 2014. Health risks and healthcare experiences of trafficked migrants. S Oram et al.

- European Psychiatric Association, Ulm 2014. Exploring the longer-term mental health needs of trafficked people. Sian Oram et al.
- ENMESH, Verona 2013. Pathways into care among victims of human trafficking in contact with a large inner city Mental Health Service. LM Howard et al.
- International Association for Women's Mental Health, Lima 2013. Health and human trafficking. LM Howard et al.
- International Conference on Mental Health, Cambridge 2013. Labour exploitation and health: a case series of men and women seeking post-trafficking services. E Turner-Moss et al.
- International Federation of Psychiatric Epidemiology, Leipzig 2013. Clinical characteristics of victims of human trafficking in contact with an inner city Mental Health Service. S Oram et al.

Conference papers (poster presentations)

- American Public Health Association Annual Meeting, 2014. A survey of the health risks and health problems of trafficked adults and adolescents in contact with health and support services in England. L Nellums et al.
- World Psychiatry Association, Madrid, 2014. Use of mental health services by victims of human trafficking: service use characteristics and costs. S Oram et al.
- HERON, London 2014. Responding to human trafficking: the role of sexual and reproductive health services. S Oram et al.
- International Federation of Psychiatric Epidemiology, Leipzig, 2013. Pathways into care among victims of human trafficking in contact with a large inner city Mental Health Trust. S Oram et al.
- Royal College of Psychiatry International Congress, Edinburgh, 2013. Clinical characteristics of child victims of human trafficking in contact with an inner city mental health trust. R Catalao et al.
- European Psychiatric Association, Nice 2013. Human trafficking and mental health. LM Howard et al.
- Royal College of Psychiatrists' Annual Perinatal Section Conference, London 2012. Use of perinatal psychiatry services among victims of human trafficking in contact with a large inner city Mental Health Trust. C MacKenzie et al.
- Faculty of General & Community Psychiatry Annual Residential Conference, London 2013. Mental disorders in victims of human trafficking in contact with a large inner city National Health Service Mental Health Trust. C MacKenzie et al.

Once published, lay summaries of each of these papers will be produced and made available for free download from the King's College London website. Briefing notes summarising the findings of the research programme and recommendations for key stakeholders are also planned, including for the Department of Health, NHS England, Health Education England, Public Health England, Clinical Commissioning Groups and Local Authority partners, and NHS senior managers and clinicians; Home Office, UK Visas and Immigration, and Police Chief Constables; and voluntary sector services. Links to the report, briefing notes, and recommendations will be sent to relevant medical, nursing and midwifery colleges (e.g. to the Royal College of General Practitioners, Royal College of Psychiatrists, Royal College of Emergency Medicine, Royal College of Nursing, Royal College of Midwives, British Association for Sexual Health/HIV, and the Faculty of Public Health), and directly to bodies to whom recommendations have been addressed. The launch of the study findings is took place at the House of Lords in September 2015. The research team will produce a lay summary of the research report and work with the Research Advisory Group to explore opportunities to disseminate and/or present the summary of findings to trafficked people.

We will also review and suggest revisions to existing training materials ("Identifying and Supporting Victims of Modern Slavery", hosted by e-Learning for Healthcare at <http://www.e-lfh.org.uk/programmes/modern-slavery>) based on the findings of the research programme.

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Appendices

Appendix A: Thematic summary of recommendations arising from the PROTECT programme

| RECOMMENDATION | RESPONSIBILITY |
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| Polymaking | |
| Department of Health and other health bodies (e.g. NHS England, Public Health England, and Health Education England, and Local Government) should have membership of and participate in committees involved in strategic planning and the development of legislation, policy and regulations pertaining to human trafficking and modern slavery, including the NRM. | Department of Health; Home Office; NHS England; Public Health England; Health Education England; Local Government. |
| Department of Health departmental action plan regarding the health sector response to human trafficking should be developed, supplementing departmental and cross-departmental action plans on violence against women and cross-departmental action plans on human trafficking and modern slavery. For maximum impact, to work closely with local authorities, the Local Government Association, Association of Directors of Social Services and Public Health England in developing these plans. | Department of Health, Local Authorities, Local Government Association, Association of Directors of Social Services, Public Health England. |
| The impact of policy decisions on the health of trafficked people should be considered regarding equality, and health inequalities and equity impact assessments. | Department of Health |
| Safeguarding | |
| Human trafficking and modern slavery should be included within safeguarding adults and children policies. | Department of Health, Department for Education |
| Responding to concerns that a patient may have been trafficked should be incorporated into the role of NHS safeguarding leads. | NHS England, Clinical Commissioning Groups and Local Authority Partners, NHS Trusts, Acute Trusts, Mental Health Trusts. |
| Safeguarding adults and children's boards should monitor local trends in human trafficking. | Safeguarding adults and children's boards |
| Guidance and training for NHS | |
| Strategies should be developed to raise awareness and recognition of human trafficking by healthcare and other professionals, including further encouraging engagement by Overseas Visitor Managers with local and national organisations that support trafficked people. | Department of Health |

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| <p>Guidance on responding to human trafficking in healthcare settings should be produce and promoted. Guidance should include that NHS staff who have concerns that a patient they are treating or assessing for charges may have been trafficked should seek advice from their safeguarding lead and that if the patient appears to be in danger, the relevant NHS body should contact the police.</p> | <p>Department of Health</p> |
| <p>Training resources for health professionals to identify, refer, and care for individuals they suspect have been trafficked (e.g. information leaflet and e-learning module launched in April 2013) should be updated, taking account of current evidence and working together with people with lived experience of trafficking and/or specialist voluntary organisations supporting trafficked people.</p> | <p>Department of Health</p> |
| <p>Training on identifying and responding to human trafficking in healthcare settings should be targeted at NHS safeguarding leads and at professionals working in general practice; maternity services, mental health, paediatrics, dentistry, emergency medicine, and overseas visitors charging departments.</p> <p>Training should include: indicators of possible trafficking and how to respond to suspicions or disclosures of this form of abuse; how to identify ad refer (including to NRM First Responders) in safe and appropriate ways; the needs of people with complex trauma and the impacts on their children; explaining to trafficked people the importance of confidentiality and how it is defined; offering a choice regarding the gender of health professionals and interpreters; obtaining a sexual history; understanding that trafficked people may continue to be vulnerable to exploitation and abuse after escaping trafficking and ensuring patients have safety plans and know how to access help if needed; being aware of the likelihood of high levels of mental health needs and high prevalence of abuse prior to and during trafficking.</p> | <p>Health Education England; Royal Colleges; Professional Organisations responsible for setting training standards for NHS staff;</p> <p>NHS Trusts; Acute Trusts; Mental Health Trusts; NHS England</p> |
| <p>Guidance for other professionals</p> | |
| <p>Guidance should be provided for relevant organisations (e.g. The Salvation Army and support providers) on making representations to extend the minimum 45-day reflection and recovery period for potentially trafficked people, including with regards to physical and mental health issues, pregnancy, and complex social needs. Guidance for Competent Authorities on considering such representations should be reviewed.</p> | <p>Home Office</p> |
| <p>Individuals suspected of having been trafficked should be asked in safe ways about their health concerns at the first point of contact with First Responders. The NRM referral form guidance should be revised to highlight that immediate medical needs should be met prior to an NRM referral form being completed.</p> | <p>Home Office</p> |

| Access to healthcare | |
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| Department of Health should ensure trafficked people are not unjustifiably denied medical care by informing relevant healthcare stakeholders of individuals' full range of rights and entitlements to services, and by discouraging racism and bias to prevent refusal of services based on nationality, sex, language, race, or stigma or other protected characteristics as defined under the Equality Act 2010. Monitor regularly to ensure that individuals' rights to services are respected. | Department of Health |
| Barriers to GP registration that would prohibit trafficked people from registering should be removed. | Department of Health; GP surgeries and professionals |
| Registration for GP services should be made as simple as possible and should not rely on providing proof of address. GP practices should be made aware that identity documents and proof of address are not an essential requirement to register a patient. | NHS England; GP surgeries and professionals |
| Individuals who make an immigration application for leave to remain as a trafficked person should have a 'Green: Paid or exempt from the health surcharge' banner on their NHS record, to reduce any difficulty accessing healthcare. | Home Office |
| NRM decision letters issued following positive reasonable grounds and positive conclusive grounds decisions should be amended to state specifically that as a potential/identified trafficked person or victim of modern slavery, the person is exempt from charges for primary and secondary NHS care as per the NHS (Charges to Overseas Visitors) Regulations 2015. | Home Office |
| Links and supported referral pathways should be developed at the local level between non-governmental organisations (NGOs) supporting trafficked people and health providers. | Voluntary sector services, sexual health services, GP surgeries and professionals. |
| Healthcare (general) | |
| Trafficked people should be recognised as a population with specific health needs in Joint Strategic Needs Assessments. | Clinical Commissioning Groups and Local Authority Partners |
| Trafficked people attending NHS care should be offered a choice regarding the gender of health professionals and interpreters. | NHS Trusts; GP surgeries and professionals |
| Providers of interpreting services should be held accountable to quality assurance standards. | Department of Health |
| Interpretation should not be provided by a person accompanying a patient who is suspected of being trafficked and that patients are seen privately. | NHS Trusts; GP surgeries and professionals |

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| NHS staff should obtain a sexual history from trafficked people who access health services. National guidelines on sexual history taking, which have been developed for all health professionals irrespective of whether or not they are working in sexual health services, should be followed. | NHS Trusts; GP surgeries and professionals |
| Sexual health | |
| Sexual health services should be available to trafficked people, regarding the type of exploitation suffered. | Commissioners of sexual health services |
| Provision of sexual healthcare should be appropriate to an individual's gender, age and culture. Sexual healthcare should be sensitive to an individual's culture and possible previous trauma and/or abuses and address both acute and longer term health needs, which may include counselling and treatment for STIs, HIV/AIDS, and sexual violence trauma, as well as for HIV post-exposure prophylaxis, hepatitis B vaccination, emergency contraception, contraceptive advice and supplies and abortion referral. | Commissioners of sexual health services; sexual health services. |
| Police officers should provide information about and offer referral to Sexual Assault Referral Centres for forensic examinations to support the prosecution of traffickers, where sexual abuse is suspected. | Police chief constables |
| Maternity | |
| Maternity services and professionals should recognise that indicators of trafficking include women who delay antenatal booking until their second or third trimester of pregnancy, or do not seek admission to a maternity unit until their labour is well established, especially those without English-language skills. In these cases midwives and other maternity professionals need to ask sensitively and in private about the woman's living and working situation, reproductive history, pregnancy history, and their general health and wellbeing. | Maternity services and professionals |
| Maternity services and professionals should consider safeguarding issues and involve appropriate agencies, ensuring women are at the centre of all decisions about their care and that of their infant and are aware of why their information may need to be shared with other carers. | Maternity services and professionals |
| Maternity services and professionals should recognise that in addition to core recommended care, trafficked women are likely to require additional care, such as that recommended by the National Institute for Health and Care Excellence (NICE) guideline on pregnancy and complex social factors, including information on how to access midwifery care outside of working hours. | Maternity services and professionals |
| Women who self-report or are suspected of being trafficked should have access to one-to-one midwifery care during and after their pregnancy. This is particularly important for younger women who may have been trafficked for sexual | Maternity services and professionals |

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| exploitation to promote continuity of care, co-ordinate appropriate services and avoid the need for women to retell their trafficking and medical history. | |
| Maternity services and professionals should be responsive to trafficked women's physical, psychological and social needs during and after pregnancy. Individual care plans should be developed and plans for timing and content of each contact discussed to ensure needs are addressed. | Maternity services and professionals |
| Maternity services and professionals should ensure that timing and duration of all contacts with women are flexible in terms of frequency and duration to allow more time to address complex needs if this is indicated, based on the individual needs of the woman. | Maternity services and professionals |
| Maternity services and professionals should discuss postnatal contacts with women, including duration of midwifery follow up, transfer to the primary health care team, and how care will be co-ordinated. All relevant members of the healthcare team should be aware of the woman's history, health and social needs and need for ongoing follow up. | Maternity services and professionals |
| Maternity services and professionals should ensure planned postnatal follow up, co-ordinated by one nominated lead across secondary and primary care sectors. If women move away from the local area, handover of care should be as detailed as possible, with documentation and details of how to re-register with relevant services discussed with the woman. | Maternity services and professionals |
| All trafficked women who come into contact with the maternity services should be treated with respect. Service providers need to ensure that all health professionals and support staff are aware of the importance of respectful, high quality care, as women who have experienced poor care, or have had contact with staff they perceived to be rude or critical of them may be reluctant to engage with services in the future. | Maternity services and professionals |
| Mental health | |
| Mental health trusts and professionals should recognise that people with severe mental illness may be vulnerable to being trafficked. | Mental health trusts and professionals |
| Mental health trusts and professionals should recognise that people with mental health problems with a history of being trafficked may have experienced abuse prior to, during, and since trafficking and undertake routine enquiry. | Mental health trusts and professionals |
| Mental health trusts and professionals should recognise people with mental health problems with a history of being trafficked may be vulnerable to further abuse, including re-trafficking and domestic and sexual violence. | Mental health trusts and professionals |
| Mental health trusts and professionals should explain clearly to trafficked people and support services the arrangements for care coordination, and duration of care, care plans, and care programme approach (CPA). | Mental health trusts and professionals |

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| Recognise the possible additional communication requirements needed by trafficked people. All relevant members of the healthcare team should be aware of the patient's history, health and social needs and ongoing need for follow up. | |
| Mental health trusts and professionals should be sensitive to the difficulties trafficked people could have if detention under the Mental Health Act is necessary. | Mental health trusts and professionals |
| Professionals who are making care arrangements for trafficked adults, children, and young people need to be aware of the likelihood of them having high levels of mental health needs and should make arrangements for their mental health to be assessed with a view to providing relevant services both immediately and also at a later date when they may be more ready to discuss their experiences. | Acute care trusts and professionals, social workers, voluntary sector services |
| Frontline voluntary sector support services staff working with trafficked people should be equipped with training to identify and respond to psychological distress. | Voluntary sector services |
| Health information and support for trafficked people | |
| User-friendly materials should be developed and disseminated to inform trafficked people about NHS services, registration with GP services, and confidentiality and how it is defined. | Department of Health |
| Trafficked people referred into the NRM are provided with user-friendly information about NHS services, registration with GP services, and confidentiality and how it is defined. | Home Office |
| Trafficked people in contact with voluntary sector services and social care should be provided with information and support to use healthcare services, including through the provision of information about the NHS and their rights to access care, and by providing assistance to access and coordinate healthcare, including sexual healthcare. Assistance may be required with: registering with services; booking appointments; ensuring provision of interpretation and translation services or advocacy; paying for prescriptions and/or applying for exemptions from prescription charges; accessing written medical information in an appropriate language and format; and providing healthcare professionals with basic information about human trafficking and appropriate referral pathways into and from support services. | Social care, voluntary sector services |
| Professionals working with trafficked adults, children, and young people should specifically enquire about health problems at first contact, and ensure that urgent problems are addressed as quickly as possible. | Social care, voluntary sector services, police chief constables. |
| Professionals working with trafficked adults, children, and young people should take account of the high levels of violence, sexual abuse and deprivation that trafficked adults, children, and young people may have experienced and the implications this may have for their ability to trust others and feel secure. | Social care, voluntary sector services |

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| Trafficked people should not be charged to access their medical and healthcare documents so they have information about the medical care they received while in the UK, especially if returning to their country of origin. | NHS England |
| Social support for trafficked people | |
| Outreach support should be commissioned for individuals who have left safe-house accommodation after the NRM reflection and recovery period. | Home Office |
| Research | |
| <p>Research should be conducted to:</p> <ul style="list-style-type: none"> (1) investigate the acceptability and effectiveness of psychological interventions to support the recovery of trafficked people (2) explore trafficked people's experiences of pregnancy and parenting (3) explore the intergenerational impact of human trafficking on children (4) investigate NHS primary care professionals' knowledge and experiences of human trafficking and associated information and support needs (5) refine indicators of human trafficking and develop and test screening tools to identify trafficked people in healthcare settings (6) investigate the effectiveness of training programmes in improving the identification and referral of potentially trafficked people (7) investigate the generalizability of multi-agency models and guidelines for working with victims of violence and with vulnerable migrants with regards to trafficked people | Research community |

Appendix B: Search information for systematic review of evidence on the health needs of trafficked people

Search terms

- 1) human trafficking.mp
- 2) people trafficking.mp
- 3) trafficking in people.mp
- 4) sex trafficking.mp
- 5) woman trafficking.mp
- 6) child trafficking.mp
- 7) trafficked people.mp
- 8) trafficked women.mp
- 9) trafficked men.mp
- 10) trafficked children.mp
- 11) trafficking in persons.mp
- 12) trafficking of men.mp
- 13) post-trafficking.mp
- 14) labour exploitation.mp
- 15) domestic workers.mp
- 16) forced labour.mp
- 17) forced labor.mp
- 18) forced prostitution.mp
- 19) sexual slavery.mp
- 20) 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14
OR 15 OR 16 OR 17 OR 18 OR 19
- 21) health/
- 22) health.mp
- 23) well-being.mp OR wellbeing.mp
- 24) illness.mp
- 25) "Wounds and injuries/" OR wound.mp OR injur\$.mp
- 26) disease/
- 27) disability.mp
- 28) infection/
- 29) symptom.mp
- 30) trauma.mp
- 31) "mental illness"/
- 32) "mental disorder"/

- 33) "mental health"/
- 34) (mental\$ adj2 (problem\$ OR difficult\$ OR disorder\$ OR ill\$ OR health).mp.)
- 35) anxiety/
- 36) depression/
- 37) "posttraumatic stress"/
- 38) PTSD/
- 39) Schiz\$/
- 40) Psychosis/
- 41) Psychotic/
- 42) Bipolar/
- 43) Depress\$/
- 44) Mania OR manic/
- 45) Neurosis OR psychoneurosis/
- 46) Obsessive OR compulsive
- 47) "Personality disorder"/
- 48) "Eating disorder"/
- 49) ((delusional OR paranoi\$ OR mood OR neurotic OR stress OR reactive OR combat
OR somatoform OR somatization OR somatisation OR anxiety OR phobic OR
obsessive-compulsive OR adjustment OR dissociat\$) adj2 disorder\$)
- 50) fear/
- 51) guilt/
- 52) hostility/
- 53) suicide/
- 54) "Behavioral symptom"/
- 55) "Self-injurious behaviour"/
- 56) "Reproductive behavior" OR "Risk taking"/
- 57) "sexual health"/
- 58) "Sexual behavior"/
- 59) "Social behavior"/
- 60) violence/
- 61) rape/
- 62) "sexually transmitted diseases"/
- 63) HIV/
- 64) pregnancy/
- 65) "abortion, induced"/
- 66) 16 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR
27 OR 28 OR 29 OR 30 OR 31 OR 32 OR 33 OR 34 OR 35 OR 36 OR 37 OR 38 OR

39 OR 40 OR 41 OR 42 OR 43 OR 44 OR 45 OR 46 OR 47 OR 48 OR 49 OR 50 OR
51 OR 52 OR 53 OR 54 OR 55 OR 56 OR 57 OR 58 OR 59 OR 60 OR 61 OR 62 OR
63 OR 64 OR 65

67) protein OR membrane OR cell

68) (20 AND 66) NOT 67

Databases searched

1) Academic databases

- PsycINFO
- MEDLINE
- EMBASE
- Web of Science
- CINAHL
- The Cochrane Central Register of Controlled Trials (CENTRAL)
- PILOTS (Published International Literature On Traumatic Stress)
- AMED
- British Nursing Index
- HMIC

2) Grey literature databases

- ORO
- EThOS,
- ProQuest
- Theses Canada Portal

3) Websites

- Online Library of the Rehabilitation and Research Centre for Torture Victims

Appendix C: Systematic review of health needs of trafficked people - characteristics of included papers

| Author and year | Study design | Sample | Outcomes of interest | Method of assessing outcomes | Definition of trafficking | Country |
|-----------------|--|---|------------------------------------|--|---|---------|
| Abas 2013 | Cross-sectional survey conducted 2-12 months post entry | N=120 sexually and labour exploited females who accessed NGO post-trafficking support services. | Mental health | Mental health assessed at baseline by a psychiatrist using ICD-10 criteria and at follow-up by a psychiatrist using the Structured Clinical Interview (SCID) for DSM-IV Axis I Disorders. | Defined solely as female post-trafficking service users. | Moldova |
| Oram 2012 | Cross sectional survey. | N=120 sexually and labour exploited females who accessed NGO post-trafficking support services. | Physical health | Physical health assessed using adapted version of the Miller Abuse Physical Symptoms and Injury Survey. | Female post-trafficking service users screened using standardised questionnaires, in accordance with UN Protocol. | Moldova |
| Ostrovski 2011 | Cohort study; mental health assessed 1- 5 days after registering with support service and re-assessed 2-12 months later. | N=120 sexually and labour exploited females who accessed NGO post-trafficking support services. | Physical health; Mental health. | Physical health assessed using adapted version of the Miller Abuse Physical Symptoms and Injury Survey. Mental health assessed at baseline by a psychiatrist using ICD-10 criteria and at follow-up by a psychiatrist using the Structured Clinical Interview (SCID) for DSM-IV Axis I Disorders. | Defined solely as female post-trafficking service users. | Moldova |
| Crawford 2008 | Case file review (20 of 80 eligible records randomly selected for review). | n=20 sexually exploited adolescent females receiving post-trafficking NGO support. | Physical health; Sexual health; | Physical and sexual health problems assessed by caseworkers who had “only basic training” and “not based on standard diagnostic criteria”. | Defined solely as female child and adolescent post-trafficking service users. | Nepal |

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| Cwikel 2004 | Case control study. | n=102 sexually exploited females (47 awaiting deportation and 55 working in brothels). 92 women are defined as trafficked: 47 from deportation sample and 45 from brothel sample. | Violence; Physical health; Mental health ; Sexual health. | Violence assessed using standardised (non-validated) questions. Physical health assessed using standardised (non-validated) questions. Sexual health (STI) assessed using standardised (non-validated) questions. Mental health assessed using the Centre for Epidemiologic Studies Depression Scale (depression) and the PTSD Checklist-Civilian Version (PTSD). | Illegally working in Israel in the sex industry. | Israel |
| Dal Conte 2011 | Case file review. | N=1,400 females brought to sexual health clinic by NGO post-trafficking support services | Sexual health. | Sexual health (HIV, syphilis, Hepatitis B, gonorrhoea, chlamydia and trichomonas) based on reported results from serological tests. | Defined solely as female patients brought in by trafficking support services. | Italy |
| Decker 2011 | Cross sectional survey. | N=815 female sex workers working in a variety of sex work venues. 85 women are defined as trafficked: 13 reported being forced or deceived into sex work. | Violence; Sexual health. | Workplace violence/ mistreatment in the past week assessed using standardised (non-validated) questions. Sexual health assessed using syndromic STI assessment. | Entry into sex work under the age of 18 and/or due to being forced or deceived. | Thailand |
| Decker 2009 | Cross sectional survey. | N=92 female sex workers accessing healthcare from an NGO. | Violence. | No details provided for the instrument/questions used to assess violence from clients in the past month. | Entry into sex work under the age of 18 and/or due to being forced or deceived. | Nicaragua |

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| | | 64 women are defined as trafficked; 38 reported being forced or deceived into sex work. | | | | |
| Di Tommasso 2009 | Case file review. | N=4,559 sexually exploited females who accessed NGO post-trafficking support services. | Violence. | No details provided for the instrument/questions used to assess violence. | Defined solely as female post-trafficking service users. | Multi-country |
| Falb 2011 | Case file review. | N=188 sexually exploited females who accessed NGO post-trafficking support services. | HIV/AIDS | HIV/AIDS assessment based on the results of serological tests as reported in case files. | Entry into sex work under the age of 18 and/or due to being forced, coerced or deceived or abducted. | India |
| George 2013 | Cross sectional survey. | N=1,137 female sex workers associated with local NGO. 574 were defined as trafficked. 173 were coerced or forced into sex work. | Violence; Sexual health. | Violence assessed using standardised, non-validated questions. Sexual health assessed based on self-reported symptoms. | Entry into sex work under the age of 18 and/or due to being forced or coerced. | India |
| Goldenberg 2013 | Cross sectional survey. | N=214 female sex workers working in a variety of sex work venues. 31 defined as trafficked. | Violence; Sexual health. | Violence assessed using standardised (non-validated) questions. Sexual health (HIV, gonorrhoea, syphilis and chlamydia) assessment based on reported results from serological tests. | Involuntary sex work due to being sold, traded, or forced to exchange sex at the orders of another person. | Mexico |
| Gray 2012 | Cross sectional survey. | N=approximately 24 sexually and labour exploited females | Mental health | Mental health assessed using the Hopkins Symptoms Checklist-25 (depression, | Defined solely as female post-trafficking service users. | Cambodia |

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| | | who accessed NGO post-trafficking support services. | | anxiety). | | |
| Gupta 2011 | Cross sectional survey. | N=812 female sex workers participating in a community-based HIV study. 157 women are defined as trafficked; 60 reported being forced or deceived into sex work. | Violence. | Violence assessed using questions modified from the Conflict Tactics Scale. | Entry into sex work under the age of 18 and/or due to being lured, cheated or forced. | India |
| Gupta 2009 | Case file review. | N=61 sexually exploited females who accessed NGO post-trafficking support services. | HIV/AIDS | HIV/AIDS assessment based on the results of serological tests (ELISA or Western Blot) as reported in case files. | Defined solely as female post-trafficking service users. | India |
| Joarder 2014 | Cross sectional survey. | N=476 illegal migrants. 386 considered trafficked. | Violence | Violence assessed using standardised (non-validated) questions to individual or head of household. | Experience of fraud, coercion, deceit, violation of contract, sexual assault or exploitation whilst working abroad. | Bangladesh |
| Kiss 2015 | Cross sectional survey. | N= 1015 men, women and children trafficked into a range of sectors | Physical health; Mental health; Violence | Violence assessed using standardised, non-validated questions. Physical health assessed using adapted version of the Miller Abuse Physical Symptoms and Injury Survey. Mental health assessed using the Hopkins Symptoms Checklist-25 (depression, | Defined solely as post-trafficking service users. | Cambodia, Thailand, Vietnam |

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| | | | | anxiety) and the Harvard Trauma Questionnaire (PTSD). | | |
| Kissane 2014 | Cross sectional survey. | N=29 asylum seeking women accessing support of NGO. 8 defined as trafficked. | Mental health | Complex post-traumatic stress disorder assessed using Structured Interview for Disorders of Extreme Stress. | Defined as victims of human trafficking based on United Nations and Home Office definitions. | United Kingdom |
| Le 2014 | Cross sectional survey. | N=73 females who accessed NGO post-trafficking support services. | Mental health; Violence. | Violence assessed using standardised, non-validated questions. Mental health assessed using the Self Reporting Questionnaire-20. | Defined solely as post-trafficking service users. | Vietnam |
| McCauley 2010 | Case file review | N=136 sexually exploited females who accessed NGO post-trafficking support services. | Violence; Sexual health. | No details provided for the instrument/questions used to assess violence. No details provided for the instrument/questions used to assess self-reported STI. | Entry into sex work under the age of 18 and/or due to being tricked or forced. | Cambodia |
| Sarkar 2008 | Cross sectional survey | N=580 female sex workers working in sex work venues. 185/580 (31.5%) sample are defined as trafficked. | Violence; HIV/AIDS | Violence assessed using standardised (non-validated) questions. HIV/AIDS assessed using serological tests (ELISA and tri-dot). | Entry into sex work due to being cheated, forced, or sold by their families. | India |
| Silverman 2011 | Cross sectional survey. | N=211 HIV-infected female sex workers accessing support from a sex-worker led community organisation. | Violence. | Violence in the first month of sex work assessed using non-validated standardised questions. | Entry into sex work due to force or coercion. | India |

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| | | 88/211 (41.7%) sample are defined as trafficked. | | | | |
| Silverman 2014 | Cross sectional survey. | N=211 HIV-infected female sex workers accessing support from a sex-worker led community organisation. N=88 (41.7%) reported being forced or deceived into sex work. | Sexual health; Violence. | Sexual health (STI) assessed using standardised (non-validated) questions. Violence in the last 12 months assessed using non-validated standardised questions. | Entry into sex work due to force or coercion or under the age of 18. | India |
| Silverman 2007 | Case file review. | N=287 sexually exploited females who accessed NGO post-trafficking support services. | HIV/AIDS. | HIV/AIDS assessment based on the results of serological tests (ELISA, Western blot, or rapid testing for HIV-I and HIV-II) as reported in case files. | Entry into sex work due to force or coercion. | Nepal |
| Silverman 2008 | Case file review. | N=246 sexually exploited females who accessed NGO post-trafficking support services. | HIV/AIDS Sexual health (other) | HIV/AIDS assessment based on the results of serological tests (ELISA, Western blot, or rapid testing for HIV-I and HIV-II) as reported in case files. Sexual health (syphilis and hepatitis B) assessment based on reported results from serological tests (Venereal Disease Research Laboratory test, detection of hepatitis B surface antigen). | Entry into sex work due to force or coercion. | Nepal |
| Dharmadhikari 2009 | Case file review. | N=287 sexually exploited females who accessed NGO post-trafficking | HIV/AIDS Physical health | HIV/AIDS assessment based on the results of serological tests (ELISA, Western blot, or rapid testing for HIV-I and HIV-II) as | Entry into sex work due to force or coercion. | Nepal |

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| | | support services. | | reported in case files. TB assessment based on reported results from sputum smears for acid-fast bacilli, radiographs or histories. | | |
| Silverman 2006 | Case file review. | N=175 sexually exploited females who accessed NGO post-trafficking support services. | HIV/AIDS | HIV/AIDS assessment based on the results of serological tests (ELISA or rapid testing for HIV-I and HIV-II) as reported in case files. | Entry into sex work due to force or coercion. | India |
| Servin 2015 | Cross sectional survey. | N=20 female sex workers working in a variety of sex work venues. | Sexual health | HIV and other STI assessment based on the results of serological tests. | Entry into sex work under the age of 18. | Mexico |
| Tsutsumi 2008 | Cross sectional survey. | N=164 sexually and labour exploited females who accessed NGO post-trafficking support services. | Mental health; HIV/AIDS | Mental health assessed using the Hopkins Symptoms Checklist-25 (depression, anxiety) and the PTSD Checklist Civilian Version (PTSD). HIV/AIDS assessment based on self-report. | Defined solely as female post-trafficking service users. | Nepal |
| Turner-Moss 2013 | Case file review. | N=35 men and women trafficked for labour exploitation. | Physical health; Mental health; Violence. | Physical health assessed using adapted version of the Miller Abuse Physical Symptoms and Injury Survey. Mental health assessed using the Brief Symptom Inventory (depression, anxiety) and the Harvard Trauma Questionnaire (PTSD). Violence assessed using standardised, non-validated questions. | Defined as post-trafficking service users. | United Kingdom |

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| Urada 2014 | Cross sectional survey. | N=770 female sex workers working in a variety of sex work venues. 56 defined as trafficked. | Sexual health; | Sexual health (STI) assessed using standardised (non-validated) questions. | Entry into sex work under the age of 18. | Philippines |
| Varma 2015 | Case file review. | N=84 children presenting in ED or child protection clinic. 27 defined as trafficked. | Physical health; Mental health; sexual health; Violence. | Physical, mental and sexual health assessed using standardised (non-validated) questions. Violence assessed using standardised, non-validated questions. | Defined as victims of child sex trafficking based on Institute of Medicine and National Research Council definition. | United States |
| Wirth 2013 | Cross sectional survey. | N=1.184 female sex workers working in a variety of sex work venues. 372 defined as sex trafficked. 107 reported being forcibly prostituted. | Sexual health; Violence. | HIV/AIDS assessment based on the results of serological tests (ELISA). Violence assessed using standardised, non-validated question. | Entry into sex work due to force or coercion or under the age of 18. | India. |
| Zimmerman 2008 | Cross sectional survey conducted at 0-14, 28-56, and 90+ days after entry into support. | N=192 sexually exploited females who accessed NGO post-trafficking support services. | Violence; Physical health; Mental health; Sexual health. | Violence assessed using standardised, non-validated questions. Physical health assessed using adapted version of the Miller Abuse Physical Symptoms and Injury Survey. Mental health assessed using the Brief Symptom Inventory (depression, anxiety) and the Harvard Trauma Questionnaire | Defined solely as female post-trafficking service users. | Belgium, Bulgaria, Czech Republic, Italy, Moldova, Ukraine, UK |

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| | | | | (PTSD). Sexual health assessed based on self-reported symptoms. | | |
| Hossain 2010 | Cross sectional survey conducted at 0-14, 28-56, and 90+ days after entry into support. | N=204 sexually exploited females who accessed post-trafficking support services. | Violence; Mental health | Violence assessed using standardised, non-validated questions. Mental health assessed using the Brief Symptom Inventory (depression, anxiety) and the Harvard Trauma Questionnaire (PTSD). | Defined solely as female post-trafficking service users. | Belgium, Bulgaria, Czech Republic, Italy, Moldova, Ukraine, UK |

Appendix D: Organisations assisting with recruitment to the cross-sectional survey of trafficked people.

Voluntary sector organisations

- 1) City Hearts
- 2) ECPAT UK
- 3) Helen Bamber Foundation
- 4) Kalayaan
- 5) Medaille Trust
- 6) Migrant Helpline
- 7) NSPCC
- 8) Poppy Project
- 9) Refugee Council
- 10)

Secondary healthcare provider organisations

- 1) Birmingham Women's NHS Foundation Trust
- 2) Cambridge University Hospitals NHS Foundation Trust
- 3) Croydon Health Services NHS Trust
- 4) East Kent Hospitals University NHS Foundation Trust
- 5) Greater Manchester West Mental Health NHS Foundation Trust
- 6) Guy's and St Thomas' NHS Foundation Trust
- 7) Homerton University Hospital NHS Foundation Trust
- 8) Hillingdon Hospitals NHS Foundation Trust
- 9) King's College Hospital NHS Foundation Trust
- 10) South London and Maudsley NHS Foundation Trust

Local authority children's services

- 1) Birmingham City Council Children's Services
- 2) Cambridgeshire County Council Children's Services
- 3) Hackney Council Children's Services
- 4) Kent County Council Children's Service
- 5) Lambeth Council Children's Services
- 6) Lewisham Council Children's Services
- 7) London Borough of Croydon Children's Services
- 8) London Borough of Havering Children's Services
- 9) London Borough of Hillingdon Children's Services
- 10) Manchester City Council Children's Services

- 11) Redbridge Children's Services
- 12) Royal Borough of Greenwich Children's Services
- 13) Solihull Metropolitan Borough Council Children's Services
- 14) Southwark Council Children's Services
- 15) Tower Hamlets Council Children's Services

Appendix E: Cross-sectional survey of trafficked people - participant information sheet and consent form.



PARTICIPANT INFORMATION SHEET

We would like to invite you to take part in a study about the health needs of people who have been trafficked and what health services should do to respond to these needs. Please take time to consider the following information and discuss it with other people if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

Title of Project: Health of trafficked people: survey of trafficked people

What is the purpose of the study? The study will help us to have a better understanding of the health problems experienced by trafficked people and to find better ways to provide them with health services.

Do I have to take part? No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to leave the study at any time and without giving a reason. This would not affect the care you receive either now or at any time in the future.

What will happen to me if I take part? We will ask you to participate in an interview. The interview usually takes about one hour and will happen at a time and place that is convenient for you. At the start of the interview we will ask you to sign a consent form to show you have agreed to take part. Then we will ask you questions about your health and about your experiences of using health services. There are no right or wrong answers. We will give you a £20 Love2Shop voucher to thank you for taking part in the research. We will also ask if we can contact you in the future for the purposes of research. You can take part in the study even if you do not want to be contacted in the future.

What are the possible disadvantages of taking part? Some of the questions may bring up distressing memories or feelings. You can take your time answering and can choose not to answer

questions. At the beginning of the interview we will ask you if there is anyone you would like us to contact for support for you if you become very distressed.

What if I need help to take part in the research? You can invite your support worker or a carer to be with you during the interview if that would be helpful. We will provide an interpreter if you need help with speaking English.

What if there is a problem? If you have any concerns about the study, you should ask to speak to the researchers, who will do their best to answer your questions (Telephone: 07806 667421 or 07806 667423). If you are unhappy about the research and would like to make a formal complaint, you can do this through the NHS Complaint Procedure. Details are available from the South London and Maudsley NHS Foundation Trust.

Will my information be confidential? The information you provide will be confidential and your name and contact details will be stored separately from the answers you give during the interview. The only exception to this is if you tell us information which suggests a risk of serious danger to yourself or others. If this happens, we will inform the staff involved in your care. We will not pass on your information to any government office or to people outside of the organisations that are supporting you.

What will happen to the results of the study? The results of this study are likely to be published as a report and as an academic publication. We will not use your name or details that could identify you in any publication. Copies of all publications will be available from the researchers.

Who is funding and organising the study? The study is funded and commissioned by the Department of Health. King's College London is organising the study.

Who has reviewed the study? All research in the NHS is looked at by an independent group of people called a Research Ethics Committee, to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by the South East Coast-Kent NHS Research Ethics Committee (reference number: 13/LO/0099).

Contact for further information: Siân Oram, PO31 Institute of Psychiatry, De Crespigny Park, London, SE5 8AF. Email: protect@kcl.ac.uk / telephone: 020 7848 5129 / 07806 667421.



Study number:

Participant identification number:

CONSENT FORM

Title of Project: Health of trafficked people; survey of trafficked people.

Chief Investigator: Louise Howard

Please
initial
box

1. I have read and understood the Participant Information Sheet (dated 14.3.13, version 2).

2. I have had the opportunity to think about the information on the Participant Information Sheet, ask questions about the study, and have had my questions answered.

3. I understand that taking part in the study is voluntary and that I can leave at any time, without giving any reason, and without any consequences.

4. I agree to take part in this study.

5. I agree to my general practitioner (GP) being informed of my participation in this study.

6. I would like to be sent a summary of the research findings upon completion of the study

7. I agree to be contacted in the future for the purposes of research.

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

Appendix F: Cross-sectional survey of trafficked people - qualitative questions about use of healthcare services

- **Can you describe to me your experience of your first contact with health services in the UK?**
- What did you access care for? From whom? Did you have to pay for it? How did you know where to go? Can you tell me what they did for you? *If you were at home, what would you have done?*
- **During the time you were in the trafficking situation, did you have any problems for which you thought you needed to see a doctor or nurse? What type of problems did you want to get care for?**
- **During that time did you receive medical care?**

IF YES

- From whom? Did you have to pay for it?
- Did you organize the care or did someone else sort out medical care for you?
- If you organized the care, how did you decide where to go for treatment?
- If someone else organized the care, who was it? Can you explain what they did for you?
- At any time did you see the [name of the healthcare professional] alone (i.e. not accompanied)?
- **Since you have been away from the trafficking situation, have had any problems for which you wanted to see a doctor or nurse? If yes, what type of health problems did you want to get care for?**
- **Have you received medical care since you left the trafficking situation?**

IF YES

- What problems did you receive care for? From whom? Did you have to pay for it? How did you know where to go? Can you tell me what they did for you? *If you were at home, what would you have done?*
- What did you think of the service/advice/treatment they gave to you? Can you tell me what was good about the care you received? Can you tell me what you thought could have been better or improved?

Probes: Were they polite to you? Could you choose whether you wanted to see a man or a woman? Some people prefer to see either a male or a female doctor/nurse – is that something that is important you? Did the person explain things to you in a way you could understand? Was an interpreter available for you? Was the interpreter helpful? If you were at home, what would you have expected the [type of health professional] to have done?

- Do you have any suggestions about how they could have given you better care?
Probes: What would make it easier to find out about this place? What would make it easier to use this service? If you had a friend who was in a similar situation, how do you think health services should support/help them?
- **Has any doctor, nurse or other health worker ever asked you about trafficking or abuses while you were in this country?**

IF YES

- Who asked you? Was this during the time you were trafficked or afterwards?
- How did it make you feel? Did you want to be asked?
- Was there anything you felt you couldn't tell them? Why?
- What did they say/do?
- What would you have liked them to have done?

IF NO

- Would you have wanted someone to ask you about your story and the trafficking situation?
- **Has any other doctor, nurse or other health worker known that you have experienced trafficking?**

IF YES

- Where did you see them?
- How did they find out?
- What did they say/do? Did they offer any help?
- What would you have liked them to have done?

- **I would also like to ask you about other situations in which you may have received medical care in the UK. Have you ever been detained in the UK by any authorities, such as the immigration or police services?**

IF YES

- How was your health while you were held? Did you have any problems that you needed to see a doctor or a nurse about?
- Did they offer you any medical care? Did you see a doctor, nurse, or other health worker while you were there?
- How long were you detained for?

- **Where would you go for help now if you wanted help with a health problem?**

Why?

Probes: *What about other types of health problems (e.g. sexual health, mental health)? If a friend was newly arrived in the UK, how would you describe to them how to use the health service in the UK? Can you give an example? If you couldn't get an appointment with your GP and needed to see someone quickly, what would you do?*

Appendix G: Search terms for trafficking and severe mental illness clinical informatics study

The following search terms were used to search free text sections (event notes and correspondence) of the South London and Maudsley NHS Foundation Trust psychiatric case register:

1. Victim of trafficking
2. Sex trafficking
3. Trafficked
4. Traffiked
5. Poppy project
6. Sex traffickers
7. Human trafficking
8. Forced prostitution
9. Child trafficking
10. People trafficking
11. Trafiked
12. Forced labour
13. Trafficking
14. Sexual slavery

Appendix H: Search information for systematic review of guidance on responding to the needs of trafficked people in healthcare settings.

Search terms:

- 1) "human trafficking" OR "people trafficking" OR "sex trafficking" OR "child trafficking" OR "trafficking in people" OR "victim of trafficking" OR "survivor of trafficking" OR "trafficking for sexual exploitation" OR "trafficking for labour exploitation" OR "trafficked people" OR "trafficked women" OR "trafficked men" OR "trafficked children" OR "trafficked person\$" OR "domestic servitude" OR "domestic slavery" OR "forced labour" OR "forced labor" OR "forced prostitution" OR "sexual slavery" OR "sex slave"
- 2) Health\$ OR service OR care OR medic\$ OR therap\$ OR hospital OR clinic OR reprod\$ OR abort\$ OR contracept\$ OR pregnan\$ OR terminat\$ OR family planning OR emergency OR psycho\$ OR psychiatr\$ OR antenatal OR neonatal OR obstetr\$ OR gynecol\$ OR gynaecol\$ OR drug OR alcohol OR substance OR trauma\$ OR injury OR accident OR welfare OR safeguard\$ OR Health Services/ OR clinician OR community health worker OR dentist OR doctor OR general practitioner OR health provider OR health visitor OR nurs\$ OR pharmacist OR physician OR healthcare worker OR health professional OR healthcare professional OR Health personnel/
- 3) identif\$ OR recogni\$ OR respon\$ OR disclos\$ OR screen\$ OR assess\$ OR aftercare OR treat\$ OR examin\$ OR monitor\$ OR protect\$ OR Outreach OR assist\$ OR Interven\$ OR prevent\$ OR notifi\$ OR help OR Harm reduction OR support OR advi\$e OR advoca\$ OR counseling OR counselling OR hotline OR helpline OR Refer\$ Or coordinat\$ OR information sharing OR training OR awareness OR knowledge OR guidance OR guide\$ OR protocol OR tool\$ OR practice OR manual OR curric\$ OR educ\$ OR case study OR policy OR strateg\$ OR approach OR evaluat\$ OR feasibility OR pilot OR validat\$ OR efficacy OR efficient OR effective OR impact OR Disclosure/ OR Mass Screening/ OR Harm reduction/ OR Referral and Consultation/ OR Attitude of health professional/ OR Clinical competence/ OR Education, Medical, Continuing/ OR General Practice/education/ OR Physician's Practice Patterns/ OR Quality Assurance, Health Care/ OR Evaluation Studies/ OR Feasibility Studies/ OR Outcome Assessment (Healthcare)/ OR Outcome and Process Assessment (Health Care)/ OR Pilot Projects/ OR Project Evaluation/ OR Treatment Outcome/ OR Validation Studies/ OR Professional-Patient Relations/ OR Qualitative research/ OR Health services accessibility/ OR Patient acceptance of healthcare/
- 4) Protein OR membrane OR call

5) (1 AND (2 OR 3)) NOT 4

Databases and websites searched

1) General Databases

- ASSIA (Applied Social Science Index and Abstracts);
- British Nursing Index;
- Campbell Collaboration;
- Cochrane Database of Systematic Reviews;
- CINAHL (Cumulative Index of Nursing and Allied Health Literature);
- EMBASE;
- ERIC (Education Resources Information Centre);
- HMIC;
- MEDLINE;
- Prospero;
- PsycINFO;
- Scopus;
- Social Policy and Practice;
- Social Science Citation Index;
- Sociological Abstracts;
- UK Clinical Research Network;

2) Grey Literature Databases

- National Technical Information Service;
- OpenGrey;
- SCIE (Social Care Institute for Excellence);
- Conference Proceedings Index (Science/Social Science & Humanities);
- DART;
- ETHOS;
- PapersFirst;
- ProceedingsFirst;
- Theses Canada Portal

3) Websites

- Department of Health (UK);
- Department of Health and Human Services (USA)

- ECPAT UK
- EU Daphne II Programme;
- Global Alliance Against Trafficking in Women;
- Helen Bamber Foundation
- Humantrafficking.org;
- Innocenti Project;
- International Labour Organization;
- International Organization for Migration;
- La Strata International Documentation Centre;
- NHS Evidence;
- Poppy Project
- World Health Organization.

Appendix I: Systematic review of guidance on responding to the needs of trafficked people in healthcare settings – characteristics of included studies

| Study Characteristics | | | | | | | Appraisal |
|---|------------------|---|--------------------------|-------------------------------|--|--|-----------|
| Source | Study Type | Study Aims | Study country | Type of Health Setting | Method | Type of Trafficking | Appraisal |
| Abu-Ali & Ali-Bahar (2011) | Narrative | To discuss the social aspects of child trafficking and the psychological consequences experienced. | United Arab Emirates | Mental Health - Psychotherapy | Narrative | Not Specified | 14/14 |
| Ahn <i>et al.</i> (2013) | Review | To review identified educational resources about human trafficking for healthcare providers. | United States of America | Not Specified | Review | Not Specified | 18/20 |
| American Psychological Association (2014) | Review | To raise awareness amongst psychologists of human trafficking and to make recommendations to enhance research, education/training and policy from psychologists in relation to human trafficking. | United States of America | Mental Health | Review | Not Specified | 16/20 |
| Aron <i>et al.</i> (2006) | Primary Research | To learn more about the victim services being provided by the Office for Victims of Crime for victims of human trafficking. | United States of America | Not Specified | In-depth interviews with 32 female survivors and 2 male survivors. | Labour trafficking including domestic servitude; Sex trafficking including forced sex work and servile marriage) | 17/28 |
| Baldwin <i>et al.</i> (2009) | Primary Research | To characterise human trafficking victims interactions | United States of America | Not Specified | Semi-Structured interview with 6 | Not Specified | 22/28 |

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| | | with the healthcare systems in order to facilitate identification. | | | survivors and 12 key informants | | |
| Baldwin <i>et al.</i> (2011) | Primary Research | To explore and characterise encounters in healthcare settings by victims of human trafficking. | United States of America | Not Specified | Semi-Structured Interviews with 6 key informants and 12 female survivors. | Domestic Servitude; Sex Trafficking | 14/14 |
| Barath <i>et al.</i> (2004) | Guidance | Set of minimum standards for mental health provision for victims of human trafficking. | Switzerland | Mental Health | Guidance | Not Specified | 14/14 |
| Bennett-Murphy (2012) | Narrative | To examine challenges in the psychological treatment of child survivors of human trafficking. | United States of America | Mental Health-Psychotherapy | Narrative | Child Trafficking | 24/28 |
| Cecchett (2012) | Primary Research | To assess the ability of child sex trafficking survivors to survive, leave the sex trade and reintegrate into the community. | United States of America | Mental Health | In-depth Interviews with 6 female Survivors | Child Sex trafficking – Sex Work | 17/22 |
| Chisolm-Straker <i>et al.</i> (2007) | Primary Research | To develop and pilot a training intervention for emergency providers on human trafficking and how to identify and treat survivors. | United States of America | Emergency Department | Cross Sectional Survey – Training Evaluation | Not Specified | 14/14 |
| Chisolm-Straker <i>et al.</i> (2014) | Primary Research | To describe the healthcare experiences of those being trafficked. | United States of America | Emergency Department | Cross Sectional Survey with 173 male and female Survivors | Sex and Forced Labour Trafficking | 11/22 |
| Clawson <i>et al.</i> (2009) | Primary Research | To provide a more in-depth understanding of human trafficking, victims and services provided to meet their needs. | United States of America | Not Specified | Qualitative Interviews with 341 service providers across 11 USA states. | Not Specified | 19/28 |

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| Council of Europe (2008) | Guidance | Recommendations on identification and referral to services for victims of human trafficking. | European Union | Not Specified | Guidance | Not Specified | 11/14 |
| Department for Children, Schools, and Families (2008) | Guidance | Practice guidance outlining reasons for child trafficking, the methods used by traffickers, the roles and functions of relevant agencies and how practitioners should follow procedures to ensure the safety and wellbeing of children. | United Kingdom | Not Specified | Guidance | Child Trafficking. | 14/14 |
| Department of Health & Platform 51 (2013) | Guidance | Guidance for healthcare staff on identifying and supporting victims of human trafficking. | United Kingdom | Not Specified | Guidance | Not Specified | 14/14 |
| Dottridge (2006) | Guidance | Guidance aimed to assist implementation of the UNICEF Guidelines on Protection of the Rights of Child Victims of Trafficking. | European Union | Not Specified | Guidance | Child Trafficking | 14/14 |
| Dovydaitis (2010) | Narrative | To provide clinicians with knowledge on human trafficking, and to give specific tools that they may use to assist victims in clinical settings. | United States of America | Not Specified | Case Study (Domestic Servitude) | Not specified | 14/14 |
| European Union (2009) | Guidance | To outline the challenges, perspectives and good practices on child trafficking in the European Union. | European Union | Not Specified | Guidance | Child Trafficking | 14/14 |

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|---|------------------|---|--------------------------|---------------|--|--|-------|
| European Union (2011) | Policy | Directive on preventing and combating trafficking in human beings and protecting its victims. | European Union | Not Specified | Policy | Not Specified | 14/14 |
| Family Violence Prevention Fund (2005) | Primary Research | To determine if healthcare settings were appropriate places to screen and intervene with trafficked women and children and to recommend strategies to improve the healthcare of trafficked victims. | United States of America | Not Specified | In-depth interviews with 19 female survivors and 2 male survivors. | Labour trafficking including domestic servitude; Sex trafficking including forced sex work and servile marriage) | 25/28 |
| Hardy <i>et al.</i> (2013) | Narrative | Discussion of the possible effects of domestic minor sex trafficking, implications for intervention and future research. | United States of America | Mental Health | Narrative | Domestic minor sex trafficking | 14/14 |
| Hom & Woods (2013) | Primary Research | To describe the experiences of trauma and its aftermath for women who have experienced commercial sexual exploitation as told by front line workers. | United States of America | Not Specified | Semi-Structured Interviews with 6 front line service providers. | Sex trafficking; forced sex work. | 23/28 |
| International Organisation for Migration (2007) | Guidance | Guidance on the provision of assistance to victims of human trafficking. | Switzerland | Not Specified | Guidance | Not Specified | 14/14 |
| International Organisation for Migration (2007) | Review | Review of European community law and council of Europe instruments in relation to migrants' right to health. | Switzerland | Not Specified | Review | Not Specified | 14/20 |
| Isaac <i>et al.</i> (2007) | Narrative | To explore health care issues | United States | Not Specified | Narrative | Not Specified | 13/14 |

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| | | associated with victims of human trafficking and the training that front line physicians and nurses require to screen and identify. | of America | | | | |
| Koleva (2011) | Narrative | To explore how psychodrama can respond to the therapeutic needs of female victims of human trafficking. | Netherlands | Mental Health - Psychotherapy | Case Study | Not Specified | 14/14 |
| Kung (2014) | Primary Research | To investigate clinicians perspectives on the type of clinical interventions used in therapy with sex trafficking victims. | United States of America | Mental Health | In-depth interviews with 11 clinicians. | Sex Trafficking | 21/28 |
| Lederer & Wetzel (2014) | Primary Research | To explore the health consequences and experience of women and girls trafficked in the United States for sex. | United States of America | Not Specified | Cross Sectional Survey, 107 semi-structured interviews with survivors, focus groups. | Domestic Sex Trafficking. | 30/48 |
| London Safeguarding Children Board (2011) | Guidance | To provide guidance to professionals and volunteers from all agencies in safeguarding and promoting the welfare of trafficked and exploited children. | United Kingdom | Not Specified | Guidance | Not Specified | 14/14 |
| Macy & Johns (2011) | Review | To review the needs of and services for international survivors of sex trafficking into the United States. | United States of America | After Care Services | Systematic Review | Sex Trafficking | 14/20 |
| Miller <i>et al.</i> (2007) | Primary Research | To describe the vulnerabilities to forced prostitution as a | United States of America | Community Health | Case Study – Forced Sex Work | Sex Trafficking – Forced Sex Work | 14/14 |

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| | | result of trafficking and the challenges to providing comprehensive responses to health needs. | | | | | |
| Malloch <i>et al.</i> (2012) | Review | A review of care and support for adult victims of human trafficking. | United Kingdom | Not Specified | Review | Not Specified | 10/20 |
| Patel <i>et al.</i> (2010) | Primary Research | To highlight a case example of a human trafficking patient in the complexities of identification in healthcare. | United States of America | Emergency Department | Case Study | Sex trafficking. | 14/14 |
| Riley (2013) | Primary Research | To pilot a non-paper training programme for healthcare professionals on human trafficking in the United Kingdom. | United Kingdom | Primary Healthcare | Cross Sectional Survey – Training Evaluation | Not Specified | 13/22 |
| Schaad <i>et al.</i> (2014) | Primary Research | To identify barriers to access, disclosure and identification in healthcare settings for potential trafficked youth in Vermont. | United States of America | Not Specified | Cross Sectional Survey with Healthcare Providers and At Risk Youth | Not Specified | 5/22 |
| Scottish Government (2014) | Guidance | National guidance on child protection in Scotland 2014. | United Kingdom | Not Specified | Guidance | Child Trafficking | 14/14 |
| Scholenhardt & Klug (2011) | Narrative | To explore the health problems experienced by victims of human trafficking in Australia and analyse the domestic support schemes established | Australia | Not Specified | Narrative | Not Specified | 14/14 |

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|---|------------------|---|--------------------------|------------------|---|---|-------|
| | | to assist victims. | | | | | |
| Sy <i>et al.</i> (2014) | Primary Research | To discuss the need for and development process of a screening tool for commercially sexually exploited children. | United States of America | Community Health | Interviews and Focus Groups with Survivors and Healthcare Staff | Sexual Exploitation; Child Trafficking. | 17/28 |
| Taskforce on the Health Aspects of Violence Against Women & Children (2010) | Guidance | Health taskforce recommendations in the role of the UK National Health Service in harmful traditional practices and human trafficking subgroup. | United Kingdom | Not Specified | Taskforce | Not Specified | 14/14 |
| Welsh Assembly (2008) | Guidance | To provide good practice guidance to professionals and volunteers from all agencies to help them safeguard children who have been trafficked. | United Kingdom | Not Specified | Guidance | Child Trafficking. | 14/14 |
| Women's National Commission (2009) | Primary Research | Recommendations on the prevention, provision and protection from violence against women and girls. | United Kingdom | Not Specified | Focus groups with female survivors of violence including trafficking. | Not Specified | 22/20 |
| Yakusho (2009) | Review | To review current research on human trafficking for mental health practitioners and scholars and suggestions for treatment. | United States of America | Mental Health | Review | Not Specified | 12/20 |
| Zimmerman <i>et al.</i> (2003) | Primary Research | To highlight the health risks and consequences of trafficking in women and to provide information on health needs. | United Kingdom | Not Specified | In-depth interviews with 28 female survivors and 107 key informants. | Forced sex work; Domestic Labour | 26/28 |

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|----------------------------|----------|--|-------------|---------------|----------|---------------|-------|
| Zimmerman & Borland (2009) | Guidance | To provide practical, non-clinical guidance to help healthcare providers recognise and consider approaches to providing care for victims of human trafficking. | Switzerland | Not Specified | Guidance | Not Specified | 14/14 |
|----------------------------|----------|--|-------------|---------------|----------|---------------|-------|

Appendix J: NHS professionals' knowledge and experience of human trafficking – survey instrument.

PROTECT: Provider Responses, Treatment and Care for Trafficked People

As part of the PROTECT research programme, we would like to know about your experiences, knowledge and opinions about human trafficking. Please answer the following questions, which will help us to understand NHS training needs. The survey is voluntary and should take approximately 10 minutes. This is not an exam; please record your first, instinctive answer. All information will be collected anonymously and used exclusively for research purposes.

| Background Information | | | | | | |
|---|---|--------------------------|---|--------------------------|---|--------------------------|
| 1 | Gender: Female <input type="checkbox"/> Male <input type="checkbox"/> Ethnicity: White <input type="checkbox"/> Mixed/multiple ethnic groups <input type="checkbox"/> Asian/Asian British <input type="checkbox"/> Black/ African/ Caribbean/ Black British <input type="checkbox"/> Other (please specify) _____ | | | | Age (years): <input type="checkbox"/> <input type="checkbox"/> | |
| 2 | Current NHS role (e.g. clinical psychologist/receptionist): _____ | | Year of qualification (if applicable): _____ | | | |
| Clinical setting/speciality (e.g. community mental health team, GP surgery): _____ | | | | | | |
| Training | | | | | | |
| 3a | Have you ever received training on human trafficking within your NHS role? Yes <input type="checkbox"/> (please answer below) No <input type="checkbox"/> (please go to Q4) If yes: Approximately how much training have you received? _____(hours) or _____ (days)_____ Who provided the training on human trafficking? _____ How long ago did you last receive this training (years)? _____ | | | | | |
| 3b | Which of the following areas were covered during the training on human trafficking? (Mark as many as apply) General information: definitions and case studies <input type="checkbox"/> Care approaches <input type="checkbox"/> Why people are trafficked, types of trafficking <input type="checkbox"/> Making referrals, giving information on national/local services <input type="checkbox"/> Health problems associated with trafficking <input type="checkbox"/> Local or international legislation on trafficking <input type="checkbox"/> Indicators of human trafficking <input type="checkbox"/> Other (please specify): _____ | | | | | |
| 4 | Have you ever received training on violence against women within your NHS role? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 5 | Have you ever received training on working with vulnerable migrants (e.g. asylum seekers, refugees) within your NHS role? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 6 | Have you ever been in contact with a patient whom you knew or suspected had been trafficked? Yes <input type="checkbox"/> No <input type="checkbox"/> (If no, go to Q7) If yes, why did you know or suspect that the patient(s) had been trafficked? Disclosure by patient <input type="checkbox"/> Disclosure by another professional <input type="checkbox"/> Patient displayed signs that indicated they had been trafficked <input type="checkbox"/> Other (please specify): _____ | | | | | |
| 7 | In your opinion, what are the three most important signs or indications that suggest a patient may have been trafficked? | 1. | _____ | | | |
| | | 2. | _____ | | | |
| | | 3. | _____ | | | |
| 8 | Do you have any data source within your NHS Trust that would allow the identification of the number of suspected cases of trafficking seen within your NHS Trust? Yes <input type="checkbox"/> No <input type="checkbox"/> (If no, go to next section) If yes, please name your NHS Trust and the relevant data source: _____ | | | | | |
| Please indicate how much you feel you know about the following | | Very Little | A Little | Some | Quite a bit | A Lot |
| 9 | Your role in identifying and responding to human trafficking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 | Indicators of human trafficking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 | What questions to ask to identify potential cases of human trafficking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | | | |
|---|--|--------------------------|---------------------------------|--------------------------|--------------------------|--------------------------|
| 12 | What to say/not say to a patient who has experienced human trafficking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 | Health problems commonly experienced by people who have been trafficked | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 | How to document human trafficking in a medical record | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 | Assessing danger for a patient who may have been trafficked | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16 | Local and/or national support services for people who have been trafficked | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17 | Local and/or national policies on responding to human trafficking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please answer True or False if you think you know the answer | | <i>True</i> | | <i>False</i> | | <i>Don't Know</i> |
| 18 | The definition of human trafficking is restricted to women and girls who have been forced into prostitution.. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19 | More than 100,000 trafficked people were identified in the UK in 2010-2011 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 | The majority of women who are trafficked for prostitution were sex workers before being trafficked. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21 | Children who are working for relatives in domestic situations cannot really be considered "trafficked" | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22 | Trafficking is associated with post-traumatic symptoms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23 | Trafficking is associated with chronic headaches. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24 | There are usually evident signs that a person is in a trafficking situation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25 | People who are being exploited often have difficulty reporting these situations to outsiders, especially professionals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26 | Health practitioners should <i>not</i> ask trafficked people about violence that they might have suffered, as it is too traumatic for them | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27 | Calling the police if I suspect a patient has been trafficked could put the patient in more danger | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28 | Which of the following health problems are NOT likely be related to situations of human trafficking? (please tick all that apply) | | | | | |
| | Depression | <input type="checkbox"/> | Hypothermia or dehydration | <input type="checkbox"/> | | |
| | Chemical burns and pesticide poisoning | <input type="checkbox"/> | Sexually Transmitted Infections | <input type="checkbox"/> | | |
| | Memory problems | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | | |
| | Coronary heart disease | <input type="checkbox"/> | Post-traumatic stress disorder | <input type="checkbox"/> | | |
| | Diabetes | <input type="checkbox"/> | | | | |
| Please indicate how much you agree with the following | | <i>Strongly Disagree</i> | <i>Disagree</i> | <i>Neither</i> | <i>Agree</i> | <i>Strongly Agree</i> |
| 29 | It is very unlikely that I will ever encounter a trafficked person in my NHS role | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30 | My workplace allows me enough time to ask about trafficking if I suspected a person might have been trafficked | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31 | I would be comfortable asking a person if they were in danger from an employer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32 | Asking about experiences of exploitative situations is offensive to most patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33 | A patient's friend can interpret for him or her if I think that a person has been trafficked. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 34 | Healthcare workers have a responsibility to respond to suspected cases of human trafficking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | | | |
|---|---|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| 35 | I am aware of the precautions I need to take to protect my safety when caring for trafficked people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 36 | I do not have sufficient training to assist individuals in situations of human trafficking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 37 | I should call the police immediately if I suspect that a person has been trafficked. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 38 | I am confident I can document human trafficking accurately and confidentially | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 39 | I am confident I can make the appropriate referrals for <u>women</u> who have been trafficked or exploited | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 40 | I am confident I can make the appropriate referrals for <u>men</u> who have been trafficked or exploited | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 41 | I am confident I can make the appropriate referrals for <u>children</u> who have been trafficked or exploited | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Interest | | | | | | |
| 42 | On a scale of 1 to 5, where 1 is "not at all" and 5 is "very", how interested are you in learning about providing care in cases of human trafficking? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 43 | Which do you think would be the most useful format for you to receive information or training on caring for people who may have been trafficked: | | | | | |
| | Online information and training (live), facilitated, at set times | <input type="checkbox"/> | Half-day training session | <input type="checkbox"/> | | |
| | Online information and training (recorded), self-directed, to watch/listen anytime | <input type="checkbox"/> | Full day training session | <input type="checkbox"/> | | |
| | Two hour training session (facilitated) | <input type="checkbox"/> | | | | |
| OPTIONAL: We are very interested in learning about any experience you may have had with any trafficking cases. Please, if you are willing, can you either write about your experience here or offer your contact details so we can get in touch with you to learn about these experiences? | | | | | | |
| Thank you very much for your time | | | | | | |

Appendix K: Qualitative study with NHS professionals – topic guide

Preamble

We have been commissioned by the Department of Health to help NHS prepare to provide healthcare to people who have been trafficked. We would like to ask you some questions about your experiences of responding to human trafficking or situations when you have suspected someone might have been trafficked. We realise that you may have had few or no encounters with trafficked people. We are still interested in hearing your impressions and ideas so we can learn what information NHS staff might need. There are no right or wrong answers to these questions – we are interested in your own experiences and also in your thoughts and opinions about service delivery in general.

Introductory questions

1. Could you start by telling me a little about the service you work in and your role there?
2. Can you tell me what you understand by the term human trafficking?
3. Have you ever been given any training or information about human trafficking? If yes – who provided the training, how many hours training did you receive, what did the training cover?

Experiences of responding to human trafficking

4. Have you ever been in contact with a person you knew or suspected to be trafficked [if no –skip to question 6]
5. Can you describe an experience with a patient who you knew or thought might have been trafficked?

Probes

- a. Why did you know or suspect that the person had been trafficked? If known on referral – where was the referral from? What were you told about the person's experiences? Did you discuss those experiences with the patient? If the patient disclosed – when was the disclosure made? Did you ask or did they tell you? If you asked – why did you ask and how did you ask? What did you do? If suspected trafficking but no disclosure – What did you ask the patient? What did the patient say? What did you do?
- b. What health needs did the patient present with? What did you do in response to these needs? (e.g. health assessments/tests, treatment, referrals)? If made referrals within the NHS or to external agencies: - where did you refer to the patient to? What worked well? What was challenging?

- c. How did you feel about providing assistance in this case(s)? Did you find that there were certain aspects of providing care (other than clinical medical treatment) that were particularly challenging or different? (e.g. continuity of care, language barriers, immigration status, seeing people by themselves); Have you experienced similar challenges when responding to the needs of other groups (e.g. sexual violence survivors, domestic violence survivors, asylum seekers and refugees)
 - d. What do you think you/the NHS did that was of most help to this patient? What do you think would have improved the patient's experience of the NHS?
 - e. Have you had any other experiences of cases of trafficking that you can describe for me?
6. What would you consider to be indicators that a person may have been trafficked?
7. What sort of questions would you ask a patient if you suspected that they had been trafficked? What would you do if they did not make disclosure but you continued to have concerns?
8. If a trafficked person came to you and wanted to escape their situation, what would you do?
9. If a trafficked person came to you who had escaped their situation but needed practical or emotional support, what would you do? Are you aware of services that can provide support to trafficked people?
10. Thinking again about a patient who you knew or thought might have been trafficked, what do you think may have helped them to access your service?
- Probes*
- a. While they were being exploited?
 - b. After they were no longer being exploited?
11. Thinking again about a patient who you knew or thought might have been trafficked, what do you think may have hindered their access your service?
- Probes*
- a. What barriers do you think trafficked people might experience while they are being exploited?
 - b. What barriers do you think trafficked people might experience after they are no longer being exploited?
 - c. What do you think might help to overcome these barriers?

- d. What services are available to trafficked people if they cannot provide documentation or if they have uncertain legal status?

Role of the NHS

12. What role do you think NHS staff have in responding to human trafficking?

Probes

- a. Identifying people who may have been trafficked? If yes: do you feel able to do this? What concerns do you have about doing this? What would help you be more confident in doing this? If no: why not? What concerns would you have about NHS staff taking on such a role? What would lessen these concerns?
- b. Referring trafficked people to other services? If yes: what types of services? Do you feel able to do this? What concerns do you have about doing this? What would help you be more confident in doing this? If no: why not? What concerns would you have about NHS staff taking on such a role? What would lessen these concerns?
- c. Collaborating with other services to respond to trafficked people? If yes: what types of services? Do you feel able to do this? What concerns do you have about doing this? What would help you be more confident in doing this? If no: why not? What concerns would you have about NHS staff taking on such a role? What would lessen these concerns?

Appendix L: Stakeholder workshop participants

Representatives of the following organisations attended the PROTECT Stakeholder Workshop on February 13th 2015.

- (1) Addenbrookes Hospital (PROTECT Team)
- (2) British Association of Sexual Health and HIV (BASHH), and Royal College of Physicians
- (3) Department of Health
- (4) East Kent Hospitals University NHS Foundation Trust
- (5) ECPAT UK
- (6) Epsom & St Helier University Hospitals NHS Trust
- (7) Greater Manchester NHS Values Group
- (8) Guy's and St Thomas NHS Foundation Trust
- (9) Health Education England
- (10) Helen Bamber Foundation
- (11) Homerton University Hospital NHS Foundation Trust
- (12) Human Trafficking Foundation
- (13) Kalayaan
- (14) King's College Hospital
- (15) King's College London
- (16) London School of Hygiene and Tropical Medicine (PROTECT TEAM)
- (17) Medaille Trust
- (18) Medical Justice
- (19) Migrant Helpline
- (20) NHS England
- (21) NHS England
- (22) NSPCC
- (23) Open Doors
- (24) Poppy Project
- (25) Public Health England
- (26) Royal College of Midwives
- (27) Salvation Army
- (28) South London and Maudsley NHS Foundation Trust
- (29) St Mary's Sexual Assault Referral Centre (SARC)
- (30) The Greenhouse Practice, and Freedom from Torture

- (31) UK Human Trafficking Centre
- (32) University of Bedfordshire
- (33) University of Bristol
- (34) University of Central Lancashire (PROTECT Team)
- (35) Victoria Climbié Foundation

