Population Health Needs Analysis: Victims of Modern Slavery and Human Trafficking in the UK

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Abstract
Modern slavery and human trafficking in the United Kingdom presents a series of new challenges for those working within the healthcare sector (Dalphins 2016). Healthcare professionals have unique access to those involved in modern slavery, with over 88 percent of survivors reporting that they had accessed medical care on numerous occasions throughout their ordeal (Polaris Project 2016). The variation in victim demographic, the differing forms of exploitation experienced and the traumatic nature of their ordeal can greatly affect the health of modern slavery victims (Adams 2012). The enormity of the issue must be acknowledged and pre-emptive action taken to overcome barriers to satisfactory health and ultimately end the cycle of abuse.

Keywords
Human Trafficking, Modern Slavery, Health,

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Introduction

According to the All-Party Parliamentary Group on Human Trafficking and Modern Slavery (2017), there are more people entrapped in slavery today than in the entire 350-year history of the slave trade. The Global Slavery Index (2016a) estimates that there are 48.5 million modern slaves worldwide and approximately 1.3 million trafficked into Europe, with over 60 percent of victims aged between 18 and 34.

The Blue Campaign (2017) defines human trafficking as coercion with the intent to ensnare a person or people for exploitative means. The Borgen Project (2015) asserts that human trafficking is synonymous with modern slavery as over 90 percent of people that are trafficked find themselves entrapped in the modern slavery market: the third most lucrative criminal industry in the world, earning approximately $150 billion a year in profit - with only the illegal firearms trade and the illegal narcotics trade earning more per annum (Klobuchar 2016). Despite this, it is only in recent years that the ubiquity of the issue has been acknowledged by legislative action.

The population of victims of modern slavery and human trafficking in the United Kingdom (UK) is increasing and many of the victims have complex health needs. This health needs analysis will discuss health and illness in relation to this population and consider key concepts as regards improving their health and wellbeing by combatting health inequalities.

Population Demographics

Europol (2016) states that 70 percent of identified victims of modern slavery and human trafficking in Europe are European nationals, with 43 percent of these victims trafficked domestically within national borders. Victims across Europe originated from 108 countries (United Nations Office on Drugs and Crime 2016). Of those from outside Europe, 28 percent of victims within the UK are from Albania, which Carmichael (2016) believes is due to low average income thresholds and poverty throughout the country. However, Hodge (2014) believes that it is the lack of education and employment opportunities that feeds the victim pool of the human trafficking industry. Additionally, Hernandez and Rudolph (2015) demonstrate that unstable social and political conditions within a country act as a breeding ground for corrupt or illegal practices, with the Freedom Fund (2016) highlighting conflict as a crucial factor in the exploitation of vulnerable people for modern slavery. McGhee, Moreh and Vlachantoni (2017) conclude that an increase in the number of victims trafficked into the UK is a direct result of poverty, conflict and a lack of education and employment opportunities in origin countries.

The prevalence of modern slavery and human trafficking in the UK has steadily increased over the last few years, with an increase of 17 percent in reported incidents since 2015 and a 245 percent increase since 2011 (Unseen 2017). Rudd (2017) states that despite 3805 reported incidents of human trafficking and modern slavery last year, the UK Government estimates that there are between 10,000 and 13,000 people currently living in the UK as modern slaves, whilst The NSPCC (2017) estimates that one in five victims are minors - a potential increase of 30 percent since 2015.

Many believe the increase in prevalence of modern slavery and human trafficking is in direct correlation with the political movements of UK society. The Thomson Reuters Foundation (2016) attributes the increase in numbers to Brexit creating uncertainty about the economic future of the UK. Crane (2017) concurs that in the wake of the exit, smaller companies will be looking to reduce expenses; creating demand for cheaper labour, potentially increasing the number of victims trafficked into the UK for forced labour exploitation. Townsend (2016) agrees, stating that economic uncertainty has already led to a rapacious demand for cheaper goods, labour and commercial sex – creating an environment for opportunistic traffickers to flourish in the UK.

The UK Home Office has been inundated with residency applications in the last year, receiving over 140 times more applications than the number of visas granted (Forum for Expatriate Management 2016). The number of visa applications rejected has led those applicants to explore other methods of gaining residency within the UK (Smith 2016). A recent investigation by the Home Office found that marriage fraud is a particularly common method, in which European nationals are trafficked into the UK and then married to non-European nationals who subsequently gain residency status by proxy (Department of UK Visas and Immigration 2015). This has led to a dramatic increase in the number of European nationals trafficked into the UK for exploitation, with the number of reports regarding marriages such as this doubling between 2010 and 2014 (Holehouse 2014).

In terms of population location, the Crown Prosecution Service (2016) states that reported incidents of human trafficking and modern slavery generally occurr in multicultural areas such as large cities or industrial towns. The Independent Anti-Slavery Commissioner

(2016) claims that reports in England accounted for 92 percent of the total incidences within the UK in 2016, perhaps because the country is the most densely populated area in the UK (Industrial Communities Alliance 2015).

Forced labour is the most common form of exploitation reported in England (Bradley 2016). For example, in the North West of England, industrial cities such as Manchester noted increases of 197 percent and Liverpool of 733 percent in referrals from businesses regarding forced labour between 2014 and 2015 alone (Bulman 2017). A recent documentary on BBC One Scotland found that the most common form of exploitation in Scotland was of a sexual nature, uncovering an enormous network of organised crime and marriage fraud in Glasgow (BBC Scotland Investigates: Humans for Sale 2017). Bloomer (2016) explains that Glasgow is a city with many multicultural communities and known ties to Eastern European and Asian crime gangs, creating a perfect setting for traffickers to exploit their victims for maximum profit. In Wales, criminal exploitation is particularly prevalent with over 80 percent of victims believed to be minors (RED 2016) and in Northern Ireland, the most common form of exploitation was forced labour, closely followed by sexual exploitation (Department of Justice 2016).

Therefore, it can be argued that victims living as modern slaves exist in these multicultural pockets due to the type of exploitation the victims are facing. However, until the number of reported incidents begins to reflect the true enormity of the situation in line with government estimates, there is no method of accurately determining either the size or the location of the population of victims of modern slavery and human trafficking in the UK.

Health Needs

The World Health Organization (1948) conceptualises health, describing a holistic perception in the place of a merely physical focus. However, Brun et al. (2017) believe that this definition should be built upon to incorporate factors such as environmental equilibrium; the idea being that if our surroundings are unhealthy so are we. Morton (2016) combines both concepts and contextualises them by relating them to the population of victims of modern slavery and human trafficking, who have a variety of complex health needs due to the nature of the ordeal they experience and the environment in which they live.

Robjant, Roberts and Katona (2017) believe that modern slavery and human trafficking victims suffer chronic exposure to psychological trauma and abuse throughout their ordeal, leading to a sense of hopelessness and mental defeat. A recent study conducted by the Helen Bamber Foundation (2015) found that anxiety, depression and post-traumatic stress disorder (PTSD) were more prevalent in victims of modern slavery and human trafficking, when compared to the general population of the UK. Abas et al. (2016) concur, finding that 78 percent of female victims and 40 percent of male victims suffered with anxiety and depression more than a year after their ordeal and over half of all victims displayed symptoms indicative of PTSD. In comparison, a survey of the UK general population found that 19.7 percent of people over the age of sixteen had displayed symptoms of anxiety or depression and only 1.9 percent of participants involved had been diagnosed with PTSD by a healthcare professional (Mental Health Foundation 2016). While it is evident that the population of victims of modern slavery and human trafficking

have similar mental health needs to those of the UK population, the prevalence is higher in those who have experienced trafficking and slavery.

Hemmings et al. (2016) report that victims of modern slavery and human trafficking are at increased risk of sustained maltreatment, neglect and violence which can lead to the development of complex physical health needs. The Department of Health (2015a) states that 80 percent of female victims and 45 percent of male victims claim to have endured multiple incidences of physical violence throughout their ordeal at the hands of their captors. In comparison, 8.2 percent of women and 4 percent of men in the general population of the UK reported similar violence at the hands of someone close to them (Office for National Statistics 2016). Gibbons and Stoklosa (2016) acknowledge the correlation between modern slavery and domestic violence but state that modern slavery and human trafficking victims most commonly present with symptoms associated with prolonged malnutrition, abuse and neglect, such as severe weight loss, headaches, poorly healed older injuries and dental issues. On the other hand, Bagness and Donovan (2016) suggest that in contrast a minority of the UK population present with similar symptoms. Thus, it can be argued that although there are some similarities between the physical health needs of modern slavery victims and a minority of the UK population, ultimately victims of modern slavery and human trafficking require different forms of care provision in contrast to the indigenous UK population.

Public Health England (2017a) states that victims of modern slavery and human trafficking are at greater risk of acquiring sexually transmitted infections when compared

to the population of the UK due to the exploitative nature of their ordeal. A study conducted by Dhavan et al. (2015) found that 60 percent of modern slavery and human trafficking victims reported experience of sexual violence and rape throughout their entrapment. The British Association for Sexual Health and HIV (2016) reports that 23 percent of female victims and 8 percent of male victims were diagnosed with sexually transmitted infections upon liberation from trafficking and slavery, perhaps because 67 percent of victims were never or very rarely allowed to use condoms whilst having sex throughout their ordeal. Moreover, Debaca and Sigmon (2014) discovered that approximately 30 percent of victims in post-trafficking services had been diagnosed as HIV positive. In contrast, Public Health England (2017b) reports that approximately 1 percent of the UK general population were diagnosed with a sexually transmitted infection in 2016, 0.2 percent of which were diagnosed as HIV positive. Thus, it is evident that the sexual health needs of victims of modern slavery and human trafficking trend in far greater intensity and prevalence than the sexual health needs of the UK population. Ultimately, the combination of all of these factors leads to victims of modern slavery and human trafficking requiring a more multi-faceted and comprehensive approach to care provision in comparison to the general population of the UK.

Modern slavery and human trafficking has recently been acknowledged as a global issue by legislative action and although the Global Slavery Index (2016b) reports that preventative and combative action has been taken by 124 countries, efforts to cater to the health needs of victims involved is distinctly lacking. As a result of UK Government policy, identified victims of modern slavery and human trafficking are enrolled in a state-

funded 45 day ‘decompression period,’ in which the victims are housed in secure accommodation and receive targeted support from healthcare professionals for both their mental and physical health needs (National Crime Agency 2017). However, the Human Trafficking Foundation (2016) believes that this is not enough, stating that just as the victims manage to acclimatise and begin to receive the help they need, the support ends and victims are vulnerable once more to being re-trafficked and entrapped in the modern slavery cycle. It can be argued that following the 45 day decompression period, local charities and organisations are left to pick up the slack.

In 2016 alone, 2013 adult victims accessed long term accommodation in safe houses and specialist support from psychologists, healthcare clinicians and legal aid workers through the Salvation Army – an increase of 27 percent from 2015 (Salvation Army 2016). There are also three specialist support centres for adolescent victims of modern slavery and human trafficking in the UK, in which victims receive support regarding housing, education and health needs from trained volunteers (Barnardo’s 2017). However, Ventrella (2016) admits that more could be done to support both adult and adolescent victims of modern slavery and trafficking but a lack of funding has led to the closure of vital support services previously available to the victims. Therefore, it can be argued that more can be done to provide satisfactory support for victims of human trafficking and modern slavery in the UK.

Barriers

Maslow (1954) created a hierarchy of human needs fundamental to survival and personal development, believing that denial of any or all of these needs negatively influenced a

person's health and ultimately quality of life. Dahlgren and Whitehead (1991) developed this idea, believing that socioeconomic, cultural and environmental factors had a significant impact on health and wellbeing. The Department of Health (2015b) states that victims of modern slavery and human trafficking generally have poorer health than the UK population as they are denied basic human needs such as food, shelter and rest, with most victims living in squalid conditions. Thus, it can be argued that factors that influence health can become barriers to satisfactory health and wellbeing.

Effective communication between healthcare professionals and their patients is key to the provision of patient-centred holistic care. However, Tugcu (2017) explains that funding reductions in the UK healthcare sector have led to a reduction in the amount of time clinicians can spend assessing, treating and communicating with their patients. Cassidy et al. (2013) agree and go on to explain that, if a significant language barrier is present, the quality of care provided may be substantially affected, as the clinician is unable to conduct a comprehensive patient assessment unless an interpreter is present.

Many victims of modern slavery and human trafficking originate outside the UK so English may not be their first language. If they are unable to acquire an interpreter when accessing the National Health Service (NHS) victims can find themselves unable to explain their situation and health issues (King's College London 2017). Gallois et al. (2015) believe that this means healthcare clinicians often resort to utilising the biomedical model of treatment – treating only the manifestation of symptoms – in the place of the preferred biopsychosocial model which encourages a holistic approach to healthcare (Engel 1977).

It is evident that communication can be a barrier to good health for victims of modern slavery and human trafficking as English is rarely their first language and limited access to interpreters when accessing the NHS leads to a lack of holism in healthcare clinicians' approach to the assessment and treatment of victims.

NHS England (2015) states that one in eight healthcare professionals has interacted with a patient they suspected or knew to have been a victim of modern slavery and human trafficking. Davies (2017) believes that NHS healthcare professionals are in a unique position to identify and aid victims of modern slavery and human trafficking within the UK; however, many staff lack the knowledge to do so effectively. The Department of Health (2017) agrees, stating that 87 percent of NHS staff do not know how to identify potential victims of modern slavery and human trafficking, with 78 percent of staff believing that there is insufficient training regarding the issue.

If NHS staff are unable to identify potential victims in order to initiate safeguarding and specific care pathways, victims of modern slavery and human trafficking within the UK remain vulnerable to maltreatment, abuse and violence (Royal College of Nursing 2017). Therefore, a lack of education and training for NHS staff surrounding the issue of modern slavery and human trafficking can act as a barrier to satisfactory health for the population of victims within the UK.

Berkman and Syme (1976) propose that there is a direct correlation between a person's environment and their health, assuming that a negative living environment increases

illness susceptibility. Richards (2014) concurs, attributing the poor health of victims of modern slavery and human trafficking to the fact that they are generally forced to live in squalor - in addition to a culture of violence and abuse from their traffickers. Furthermore, Baldwin et al. (2013) claim that traffickers remove identity documents from the possession of their victims and use psychological scaremongering tactics to dissuade victims from accessing healthcare services, community outreach programmes or attempting to escape their exploitation. Thus, environmental factors such as poor living conditions and manipulation by traffickers act as barriers to good health for victims of modern slavery and human trafficking by increasing susceptibility to illness whilst simultaneously preventing victims from seeking access to healthcare services.

Victims of human trafficking and modern slavery have complex health needs that require comprehensive support and treatment. Many factors influence their health, including their environment, domestic situation and limited social interaction which already disadvantages them in respect to achieving satisfactory health or accessing treatment. It is imperative that barriers such as inadequate NHS staff training or failed communication are overcome to prevent the continuation of the exploitative cycle that is so evidently detrimental to their health.

Moving Forward

According to Albright and D'Adamo (2017) the human trafficking for exploitation industry is booming on a global scale. Raphael (2017) believes that the number of victims of modern slavery and human trafficking within the UK will increase, as will the prevalence

of significant health needs within the population. It is only recently that legislative action has been taken to address the issue within the UK; however, Fry and Muraya (2016) maintain that there is a distinct lack of legislation regarding the management of the health needs of victims. Konstantopoulos (2016) feels that more must be done to break down the barriers to good health faced by the population of victims of modern slavery and human trafficking within the UK, which ultimately requires the allocation of sufficient funding by the government.

More funding is necessary to ensure the provision of high quality interpreters within the NHS to break down the communication barriers many victims face when accessing services (Curran, Mchunu and Naidoo 2017). However, Gerada et al. (2016) believe that this would be futile unless specific and accessible training for all NHS staff surrounding the identification and support of victims is implemented nationally. Vigar (2017) agrees, stating that frontline NHS staff are at a unique advantage in terms of access to victims and so should be trained accordingly through practical sessions and online modules. Helton (2016) suggests a multi-faceted approach to victim identification and assistance in terms of a joint task force between healthcare professionals and the police. Although Chacon (2017) questions whether this would be effective in breaking the barriers to good health faced by victims or merely create further barriers in the form of bureaucratic limitations.

Modern slavery and human trafficking victims are non-specific in terms of geographical location and can be found across the UK but Atkins et al. (2017) feel that local

neighbourhoods are failing victims, as targeted support is non-existent at a community level. Alpert and Chin (2017) believe that the creation of accessible community outreach programmes will not only aid in the identification of victims but also significantly improve health outcomes for the majority of a population unable to access mainstream healthcare. Chang and Hayashi (2017) agree, reporting that community outreach programmes in America have been successful in improving the health of victims through the provision of anonymous healthcare clinics accessible to all. However, Chisolm-Straker et al. (2016) are mindful that limited resources and funding greatly deter innovation and discourage governmental action.

Conclusion

In conclusion, it is evident that the population of victims of modern slavery and human trafficking within the UK is likely to increase. As the population grows, so will the intensity and prevalence of complex health needs requiring comprehensive and specialist care provision. It is apparent that healthcare services must become more accessible and support must be more readily available as the victims face many barriers to good health and lack the means and resources to overcome these barriers themselves. Therefore, as a society we must accept responsibility for breaking down these barriers by taking pre-emptive action and allocating more funding towards research, frontline staff training and community outreach programmes to break the exploitative cycle. It is only then that victims of modern slavery and human trafficking can equal the UK population in terms of health and wellbeing.

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