SJOG Hospitaller Services

Exploring access to health support and treatment for people subject to modern-day slavery and trafficking

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Research Highlights

This study is part of a series of research projects commissioned by the UK Health Security Agency (UKHSA) and the UCLH Inclusion Health Outreach team. It aims to co-design a national service model that supports the elimination and control of key public health infection diseases across health inclusion groups[1].

- **This research aimed to explore access to health support and treatment, in particular for infectious diseases in England for people subject to modern-day slavery.**
- **25 participants were involved in focus groups and interviews. Data was analysed using thematic analysis.**
- **Key themes emerged identifying barriers to accessing health treatments within this health inclusion group.**
- **Recommendations are provided for overcoming barriers and include continuity of care, prevention and testing, peer workers, outreach models of support, and policy development.**

[1] Refers to 'people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers or people in contact with the justice system', NHS England, October 2023

TERMS

PLE – Participants with lived experience of modern-day slavery

PWP – Project worker participant who offer support to people subject to modern-day slavery

Acknowledgments

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Inclusion health care for modern-day slavery

Modern-day slavery (MDS) is a serious and often hidden crime, defined as 'an umbrella term encompassing slavery, servitude, forced or compulsory labour and human trafficking. (…) It violates human rights, denying people of their right to life, freedom and security'[2]. People subject to modern-day slavery and trafficking are unable to leave their situation of exploitation, being controlled by threats, punishment, violence, coercion and deception.

Poor or unsafe living and working conditions are common for people who experienced modern-day slavery. They may have been trafficked in stressful circumstances or exposed to previous health-damaging trauma such as war, torture, persecution and separation from family. As a result, there is a high burden of comorbidities among this group.

On a psychological level, high prevalence rates of depression, anxiety, PTSD and suicidal ideation have been identified, as well as unmet needs in relation to psychosis. For young people who have been trafficked, Attention Deficit Hyperactivity Disorder (ADHD) and adjustment disorders represent common issues. Significant physical health symptoms have been uncovered as well, such as headaches, stomach pain and back pain, and sexually transmitted infections[3].

Health implications depend on the nature, duration and severity of abuse, and require multiple interventions. However, studies suggest people with lived experience of modern-day slavery mistrust healthcare services because of stigma, fear of law enforcement, and experiences of discrimination[4].

[2] As defined by the Slavery Convention, 1926 and the Supplementary Slavery Convention, 1956 in Human Trafficking Foundation Report, 2020

[3] Brezeanu et al, 2022

[4] Such et al, 2020

People face several key barriers to accessing health services, such as a lack of documentation, language barriers, lack of knowledge of services or concerns about repercussions from traffickers, police, and/or immigration status[5].

Little is known about the experience of people subject to modern-day slavery when accessing healthcare services or how health professionals meet their needs. An inclusion health model would imply that health and care agencies and government departments work in partnership with people and communities and take practical actions to deliver accessible and integrated services.

Examples of stakeholders include people with lived experience, Voluntary, Community and Social Enterprise (VCSE) organisations and Integrated care system (ICSs).

To better engage MDS health inclusion groups who have experienced modern day slavery, health services need to meet each person's needs and help them to understand how the health system works.

This research aimed to explore the concept of outreach healthcare models for people who have experience modern day slavery in order to help them engage in health treatment.

Research methods

The study was conducted between February 2024 - April 2024. A mixed-methods approach was applied to the study, triangulating both theoretical perspectives and data collected through participatory approaches[6].

Three focus groups were held, one with people who have experienced modern-day slavery (PLE) and two with project workers (PWP) who provide direct support to this group. A further three one-to-one interviews were held with people who have been subject to modern-day slavery and one interview with an individual with operational experience delivering support services.

To follow best practice research ethics, focus groups and interviews used principles of The Trauma-Informed Code of Conduct (TICC) developed by Helen Bamber Foundation[7] and the Fulfilling Lives' Trauma-Informed Social Research Guide[8].

A participant information sheet was created along with a consent form. All participants had at least 24 hours to decide if they wished to participate. Any questions raised were answered by the research team.

Recordings of focus groups and interviews were transcribed, anonymised, analysed, and contrasted with relevant literature.

Participation was voluntary and participants could withdraw from the study at any time without giving a reason.

[5] Westwood et al, 2016; King's College London, News Centre, 2023

[6] Bergold and Thomas 2012

[7] Witkin et al, 2018

[8] Dowding, 2021

The study involved a total of n=25 participants. (See Table 1)

Table 1 – Basic demographic breakdown of participants

		Project worker participants (n=)	People with lived experience (n=)
GENDER	Male	7	6
	Female	6	6
AVERAGE AGE	18-25	3	2
	26-45	10	4
	46-65	n/a	6

SECTION 1

Immediate needs of people subject to modern day slavery

People supported in MDS services might have been subject to multiple traumatic experiences, both before and during slavery. Wright and colleagues estimate that a recovery period of minimum 9 months is required to address the most immediate needs such as safety, stable accommodation, gaining language and life-skills, receiving person-centred support, and addressing mental and physical health conditions[9].

These aspects are also highlighted by PWPs:
"accessing mainstream services if they have the right to remain is essential; but predominantly I would say accessing mental health services, physical health services, immigration matters, so getting legal representation… towards the end of their journey… it's looking at the accommodation aspect. And I would say the accommodation is predominantly the thing that ties everything together." (PWP1)

The lack of legal status comprises the sense of belonging, ability to integrate, access employment, education and future accommodation. This can lead to financial instability, lack of access to social and healthcare services and restriction of daily activities reinforcing isolation, anti-social behaviours or unhealthy coping mechanisms, such as substance misuse[10].

Incomplete pathways for long term support further exacerbate this. Benefits and employment are not available for people with no recourse to public funds and no right to work:

"I am talking about refugees, those who have no right to work and live in self-reliance accommodation. They're surviving about £9 a week and don't have other income." (PWP2)

[9] Wright, 2020

[10] Brezeanu et al, 2022

SECTION 2

Health needs of people subject to modern day slavery

People who are subject to modern-day slavery and human trafficking experience complex traumatic events on different levels: before, during or even after the modern-day slavery episode.

Before entering the National Referral Mechanism[11] (NRM), participants mentioned they did not have access to medical support, and relied on self-medication or other coping techniques:

"In the past, I was afraid I have hepatitis, and did not have where to go, I had no passport, no GP. I told myself: my family has only high blood pressure, is strong and heathy because this is. I am sure I am ok - I was encouraging myself." (PLE1)

"There was a time [before entering NRM programme] when I did not have treatment [for mental health]. In the past, I would have solved my problems with alcohol and drugs. I wouldn't even consider seeking for help or going to the doctor. I didn't even know where to go." (PLE2)

In addition to physical health issues, mental health emerged during interviews as a factor in the wider health needs. In total, n=8 participants reported being under treatment or receiving therapy:

"I need help with mental because [a charity] helped me with support, financial support, and [a charity] helped me too. And [a charity] accepted me and they helped me a lot with therapy and other things." (PLE3)

"I take medication for mental health but I don't do any therapy… I will start soon…" (PLE2)

Only n=3 PLE declared that they have no medical needs, and do attend regular appointments for prevention checks when required:

"I always receive support because the doctor is calling me for the blood check... you know for prevention. And I go. I speak little English but I go on my own. Doctor always nice. If I need medication, [I] go to the pharmacy." (PLE1)

> ***"Every three-six months I do regular blood test with the GP, so I keep my health under control. I always receive a notification, letting me know that is time for the test. They also check the level of substances in my blood, and receive clear information about everything."*** (PLE2).

> ***"I have been lucky; I don't have much to say about this. I am healthy person, I only go to the GP for minor issues, never had problems."*** (PLE4)

[11] The National Referral Mechanism is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

SECTION 3

Accessing health support: experiences and challenges

Registering with a GP

For people who are recognised survivors of MDS, the GP is the first and main contact point for addressing medical needs. Registration with the GP was not reported as an issue unless people are moved from one location to another as part of their support. Such movement can interfere with the duration of a diagnosis or treatment:

"One of the challenges we face is because people are placed in safe houses often at short notice. They usually move from one area to another [to be away from their danger areas]. That means registering with a GP, new pharmacy, new dentists… that is more often than not a challenge in itself." (PWP2)

PWPs also reported that continuity of care can be a challenge: ***"When moving to another area…[PLE] stated that they [health team] did this assessment and they advised that someone was going to call from [the] GP, but no one called so now I need to find another GP. When I call, they are saying that PLE would need to provide the name of that GP and other information which [the PLE] doesn't have access to."***

Accessing health services

Physical conditions also represented a barrier when accessing health support: ***"I've had PLE that are over the age of 80 who have physical disabilities, or are blind as well. I've not been able to find a single support service that can attend appointments with them because they're unable to attend by themselves and they're unable to get support from a taxi service".*** (PWP3). If support workers were not in place to support in these situations, health needs would not be addressed.

Language barriers and translation services are limited, and this caused further problems. ***"I have a PLE that has been moved from their previous accommodation to a new one. They should be providing them with the support, but PLE will come back to us to inform us that they didn't provide them with interpreter, so they have to reschedule."*** (PWP3)

"I know, from a number of health services, whether it's general health services or mental health, they do provide translation services…when it's an appointment in advance. But if someone's in need of that same day kind of assessment or triage (...) very difficult for them to do that." (PWP1)

Finally, finance and digital literacy skills of survivors were highlighted as another barrier: ***"IT skills sometimes if PLE have to book online or receive e-mails... and cost for the transportation in some cases especially because if they need specific care and they're living in another area, they will struggle to attend."*** (PWP2).

While the NRM covers the basic needs of people, some treatment can be only refunded if survivors can prove the condition is related to their modern-day slavery experience.

Attending appointments

PWPs spoke of the wider support needed for PLE to access healthcare. Delivering a person-centred approach implies accompanying people to appointments, filling in forms, submitting applications, providing support and advice and making referrals.

"I think on a lot of occasions project workers attend an initial appointment with PLE and once they feel comfortable, they can go by themselves but if there was a service that could provide that initial support, I think it would be really helpful. And that's not enough; there are times when at every appointment they will always be asked questions which they don't know what to say, and that means that they're not able to continue with that treatment because they don't know how to ask." (PWP4)

PWPs spoke of acting as mediators, not only from a linguistic point of view, but also for reassuring PLE about confidentiality, as they have a trusted relationship with them:

"I mean, we've had a referral recently where someone was transferred out of our service into another one [by a different provider]. We've requested to pass our details on to the new provider so we can book in a team's meeting to discuss some of the health concerns with that individual. If not, it would have been, you know, that person may not have disclosed this [health details] stuff." (PWP5)

PWPs also suggested that health information can be overwhelming and difficult to process for PLE. Giving PLE the opportunity to attend an appointment at different stages of their support journey would be a successful strategy. Health information / details translated in different languages, or less use of medical jargon may also help PLE better understand the purpose of the health support and treatment.

Awaiting treatment and diagnosis

Waiting for health appointments and results interfere with day to day living activities and one participant reported the anxiety that this brings. As people who have experienced modern-day slavery have been in situations of dependency and exploitation rather than agency, waiting may cause higher levels of anxiety and reinforce trauma already experienced.

"I explain again the whole story [of the health condition] and then they give an appointment to see them, but it all depends on the problem. The experience takes so so long. The appointments were cancelled because of constant doctor strikes. The suspense, the anxiety, the worry, the symptoms are there and seem to get worse I don't have any choice but to wait. The time between seeing the GP and the specialist is the real nightmare. I went to the hospital for gynaecologist. I went for an MRI and it was ok. But the problem is the waiting time. Nobody calls after the blood test. Diagnosis and treatment take a while. I didn't get any treatment, most of things are coping strategies." (PLE5)

Accessing health provision in a timely manner would positively impact wellbeing and would contribute to the opportunity of obtaining other benefits such as disability passes and benefit payments or fit notes for work-related purposes:

"I have a local GP…but if you don't chase them, if you don't push them...they aren't active. I actually contact them by phone. I call them all the time because they keep forgetting things, I need to remind them all the time. Mostly regarding my mental health medication, as they are prescribing the medication. I have to remind them. They keep you waiting and then they forget, they ask again the same questions. Especially for change of medication. It's difficult is when you make a request, they might forget and ignore. I took medicine today, but not the one I should and it has been six weeks since I've asked this change." (PLE2)

"I have back problem since 2021. I moved from [area 1] to [area 2]. It took 6 months minimum or a year to book an appointment. It affects my sleep. I cannot sleep on my back. They say they know I am struggling, but if no doctor is giving me an appointment, I cannot even ask for a bus pass for disability." (PLE6)

Mistrust in the healthcare system

Mistrust in the healthcare system was expressed by PLE. Online appointments, cancelled appointments, priority to one medical condition but not another, receiving poor interpretation service(s), or not being checked-on during the waiting process all contribute.

The mistrust translates in the perception that "the system is broken", "nobody cares about them", "they receive superficial treatment that does not address the cause" or "they are not in control of their life".

"[I] can only meet GP online, this is a problem. Last appointment was on the phone, I need to see them face-to-face. It's difficult to trust the doctor will understand the problem without seeing me." (PLE7)

"Yeah, if you have two problems, they will ask you to choose one and they will give you paracetamol. They don't care about you. It's because it's free, we are the last to be taken care of, who would care to respect and treat us well?" (PLE8)

"I have an account [for online appointments], they give me permission, but they didn't put it online. I call a lot of times and they didn't put my examination in the app. This doctor (is) not good to me." (PLE3)

"I don't know the exact word…they are…superficial…ask again and again, they don't make you a priority. It makes me feel angry and frustrated. I would suggest them to prioritise your condition, it would be nice when you ask them something, to take in consideration your concerns. For me this is the main challenge." (PLE2)

This mistrust may lead to disengagement from public health programmes, initiatives and access of health support should an acute problem arise, potentially exacerbating wider health problems.

SECTION 4

Improving the experience of accessing health support

Engaging people in healthcare activities

When engaging people with lived experience about different opportunities and/or events, such as health information, timing is important. Last-minute events are challenging. People require time to prepare. Giving enough notice (at least one week in advance) to inform and encourage groups to attend, for example, health awareness sessions, is necessary.

" People need at least one week before, for them to get used to the idea, to be able to give out information that's relevant for them." (PWP6)

Location represents another factor to consider when planning events such as prevention and testing operations. All 12 participants (PLE) have regular blood and other prevention checks through the GP. All participants (PWP and PLE) highlighted the importance of proximity and familiarity with the medical service due to language, transport costs, confidentiality, and trust.

Further to the points above, offering an incentive may make PLE more willing to get involved in public health schemes. Refunding transport costs, offering free vouchers, or other wellbeing services that are not accessible otherwise, are possibilities:

"I go sometimes to wellbeing fares, and they give you vouchers and some free services, and this helps. If they would come for checks and there would be more incentives like this, I would go. At least a five pounds voucher. You would get more people if you would give away more free treats, I had massages, hair-cut...I enjoyed it." (PLE2)

"If there is something going on, we can forward this to [PLE] saying that there's a particular camp doing this and that, you know? If... they may be reimbursed for the travel, then great, we can inform them of that. [PLE] can decide whether it would be in their best interest to attend it or not so that would be a good way." (PWP5)

Reducing waiting times

When asked what participants, both project workers and people with lived experience, would recommend for improving their experience of accessing health support, it was agreed that reducing waiting times would be most important. Being supported through the process with home visits, follow-ups, good interpretation service(s), more accessible blood screening sites, and better awareness of where to go in case of a medical emergency, would improve the experience further.

"I would recommend shorter waiting period, home visits. Blood screening is slow so if it could be done at GP surgery would be better, follow-ups and supporting waiting patients, finding out how people are doing, you know, people die during the waiting period. More awareness about the health system and prevention methods." (PLE10)

Consistency of support (with both physical and mental health) may help access wider recovery services needed for each person. For example, physical health symptoms such as sexually transmitted infections requiring fast diagnosis and treatment have been identified by researchers[12].

A challenge that emerged from the research focuses on creating outreach healthcare designed with an experience that feels part of the integrated system where each person feels valued and included in society.

"Definitely it would be useful to have a fast track, because we don't know how long we stay here, it impacts the mental health as well…then if you have mental health problem, it's the worst, they will treat you like a crazy person and will laugh at (with you). And you remain sick. The problem is they don't treat the cause, nobody cares. Just give you something for symptoms." (PLE11)

"I wouldn't feel comfortable to receive someone at home. Yeah, it wouldn't be like you don't feel safe. But I like the idea of a hub or van, I saw it once, but I was scared about it. I thought I can go there, but if I ask something, they say, you can't ask and send me away. I'm pretty sure." (PLE3)

The importance of listening

As one participant suggested, time to listen, provide direction, and information may be the first simple step in addressing this challenge:

"It would be enough if the doctor, uh, listens to me. Yes, because in my GP, they don't, you know, sometimes I prepare myself before. For example, I went to the psychologist, I don't know the name. And I prepared myself to talk about my problems. And when I went there, the doctor didn't listen to me. And he only said, you need to take amitriptyline. But sometimes we need to talk, you know, I usually cannot talk about my problems. When I was ready to talk, the doctor didn't listen to me. Sometimes you need therapy or exercise, is so good. And the doctor needs to listen because they don't know what we need if they don't listen. Or maybe sometimes you need someone to explain to you after, so you, you know what's going on and what (instructions) you have to follow." (PLE3)

Navigating the healthcare system

Navigating the medical system is not always easy, therefore, the role of peer support workers may help to improve the experience of accessing healthcare support. ***"Having someone who understands them [PLE] and can support with language barriers, to walk alongside as they are processed though the health system and wait for diagnosis or appropriate treatment was unanimously underlined during the focus sessions by all"*** (PWP)

"Waiting is bad, you can wait for months, and nothing happens. Then what do you do in the meantime? It would be helpful if we would be given more attention as patients. It would help with my anxiety." (PLE9)

People subject to MDS have a range of complex needs based on the trauma they have experienced. Each are individual to the person. As a result, experiences between people vary meaning that peer roles may not be able to relate to the lived experience of the person, but support should be delivered on a person-centred, trauma-informed basis.

[12] Such et al, 2020

SECTION 5 Recommendations

To make the research of practical benefit, a series of recommendations have been made for improving access to health care for people subject to modern-day slavery. These are:

Continuity of care

People who experienced modern-day slavery are often moved from one service to another, therefore, they might find themselves in the position of changing GPs regularly. This results in longer waiting times for receiving the necessary healthcare. In a context where their support under NRM is temporary, improvements should include:

- Access to a health inclusion service bridging the gaps of interruptive treatment due to delays in prescriptions and registration to new GP;
- Access a health inclusion service that would ensure continuity of care, regardless of their address, including after leaving the NRM programme;
- Information on the status of healthcare treatment and support so the healthcare pathway is known, potentially increasing the person's locus of control over their health needs and reducing anxiety as a result;
- Building trusted relationships between partner organisation to create seamless service transitions is necessary. The visibility of referral pathways and allied services on offer is needed so that service managers can link individuals to appropriate support quickly and efficiently. Visual maps of the referral pathway showing the journey the person is on is a simple way towards achieving this.

Prevention and testing

The delivery of screening and testing sessions is usually organised by local GPs. Although participants attend these sessions, the following recommendation may offer improved engagement particularly around the identification of diseases:

- To involve project workers or other VCSE workers, in the dissemination and prevention practices that understanding and awareness is started early before any screening may take place;
- To offer incentives such as refunding transport costs, free vouchers or other wellbeing services that are not accessible otherwise.

Peer workers

While the role of peers was not explicitly mentioned by people with lived experience, their involvement was considered useful by project workers. Peers can act as community mediators, facilitate the access to services, and support PWP and/or GPs with the registration, identification of local health services, attendance of appointments and follow-ups. Nevertheless, our study indicates that before involving peer workers it would be useful to:

- Provide training in modern-day slavery and complex needs, with an emphasis on access to healthcare to build trust between people accessing services and the peer workers. Training should include trauma-informed practices and lone workers policies.

Outreach health care

Outreach healthcare models have been shown to be effective in supporting homeless populations[13]. Outreach delivery is usually purposive, temporary, mobile, and collaborative and its aim is to address chronic health needs and to link people into appropriate primary or tertiary health services[14].

Whilst this is relevant and would address some challenges that emerged from discussion with participants, such is the need for faster diagnosis and treatment of infectious disease, consideration is needed. Before implementing an outreach model for people who experience MDS we recommend:

- To work closely with services and project workers to ensure information is disseminated in a timely manner. This includes providing clear instructions and information about the outreach healthcare event/facilities.
- To adopt outreach care models that can adapt to various locations (office, community hubs, safehouses, neighbourhood testing points);
- Ensure that pathways into primary or tertiary health and social services have a continuity of service experience for the person receiving support. This may help overcome the feeling of fragmented services which were highlighted by participants.

[13] Pathway, 2020

[14] Shin HY et al, 2020

Policy

The NRM programme is strictly linked to the process of recovery of people who experienced modern-day slavery. More broadly, this research has highlighted that rising awareness about the needs of inclusion health among people subject to modern-day slavery is needed. Recommendations include:

- Updated training resources for health professionals (including reception staff and practice administrators) to refer and care for people with lived experience. This should include the development and dissemination of user-friendly materials to inform about NHS services, registration with GP services, confidentiality and how modern slavery is defined;
- Consider a health care prevention and treatment service that is embedded in the recovery provision plan under NRM, and where people who receive positive reasonable grounds and positive conclusive grounds decisions are exempt from charges for primary and secondary NHS care, thereby, maintaining continuity of care;
- For the provision of an 'inclusion healthcare' passport that would allow practitioners to identify people with complex needs, to overcome health barriers and to ensure priority care;
- For the development of a health inclusion network that addresses the most pressuring needs of people who have experienced modern-day slavery and trafficking.

Limitations to the study

A total of n=25 participants made up of PWP and PLE is a small sample in the overall context of modern-day slavery and trafficking. It was noted that PLE required support to engage in research and time to build trust in the research process. Future research might wish to consider longer recruitment timescales and work across a number of different organisations offering support.

Final remarks

The study provides the foundation for key themes that underpin barriers to health treatment along with recommendations to address these. Further research can build on this, particularly focused on how information and expectations can be managed to help people who have been subject to modern-day slavery have a sense of control over their access to health treatments. The recommendations here provide avenues to explore and test improvements to health services and treatments for this health inclusion group.

ABOUT US

SJOG Hospitaller Services (SJOG) is currently the UK's largest provider of safe houses for people subject to Modern-Day Slavery and Trafficking (MDS), supporting more than 1000 people every year. SJOG provides specialist assistance to help people recover from their experiences, rehabilitate and rebuild their lives.

While services offer person-centred support, delivering accommodation and assistance for complex needs and experiences, people who experienced forced or compulsory labour and trafficking are at risk of both acute and chronic medical problems - yet encounter different barriers in accessing the necessary health support. A deeper understanding of these challenges is vital so comprehensive services for this population group are accessible and effective.

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