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Original Research

A public health approach to modern slavery in the United Kingdom: a codeveloped framework

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ABSTRACT

Objectives: Modern slavery is a public health challenge. The objective of this research was to build and refine a public health approach to addressing it.
Study design: This was a participatory qualitative study with a proof-of-concept exercise.
Methods: Nine deliberative workshops with 65 people working across the antislavery sector. Thematic analysis of qualitative data. Of the nine workshops, two were proof of concept. These explored and tested the public health framework devised.
Results: Participants contributed to the development of a public health framework to modern slavery that included multiple elements across national, local, and service levels. There were six 'C's to national components: policy that was coherent, co-ordinated, consistent, comprehensive, co-operative and compliant with international law. Local components centred on effective local multiagency partnerships and service design and delivery focussed on trauma-informed, flexible, person-centred care.
Conclusions: A public health approach to modern slavery is a promising development in the antislavery field in the United Kingdom and globally. It was well supported by workshop participants and appeared to be operable. Barriers to its implementation exist, however, including the challenge of intersectoral working and an incongruent policy environment.

Introduction

A public health approach has been identified as an emergent and promising framework that could address the complex problem of modern slavery and human trafficking.[1–5] To date, a criminal justice and law enforcement approach has dominated the response to modern slavery in the United Kingdom[5] and elsewhere.[6,7] This approach is limited in its scope and carries some risks, particularly the criminalisation of victims. This paper pursues this promise by building a refined public health framework that could be applied to both policy and practice settings.

Modern slavery is an umbrella term used in the United Kingdom to describe a range of exploitative crimes, including human trafficking, sexual exploitation, forced labour, domestic servitude and forced criminal activity. Its meaning is debated widely in the literature, not least because it covers such a broad range of exploitation types.[8] Here, we use it as an umbrella term, as applied in the UK Modern Slavery Act 2015, which is inclusive of the international definition of human trafficking in the Palermo Protocol.[9]

Modern slavery causes considerable harm to individuals, families, communities and broader society. Harm occurs throughout the cycle of trafficking and/or exploitation bringing about elevated risks of physical injury, illness and mental health morbidities.[10] Modern slavery victimisation often builds on people's existing social hardships and inequalities, exacerbating health harms in a cumulative way.[10] Child victims face considerable developmental harms,[11] and survivors report very limited access to health care through the exploitation cycle.[12]

The harms generated by modern slavery is one part of the argument for addressing the problem as a public health challenge. Such et al. characterised a public health approach to modern slavery as:

- Understanding the problem at a population level
- Looking at what is driving or causing the problem and framing it as part of a complex, multilevel and interdependent system
- Collating data and evidence of what works/what happens
- Being prevention focussed

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- Protecting and promoting health and well-being
- Multiagency/partnership working
- Addressing inequalities, social justice and human rights[5]

Furthermore, they identified an emergent public health framework to address the problem (Fig. 1). It included upstream and downstream components at global, national, local and service levels. This emergent approach required some refinement and development.[5]

Public health approaches are characterised by thinking beyond the boundaries of the health sector. Such an approach is presented as a way of thinking and acting collectively to address a problem that can generate harms, including health harms. Importantly, public health organisations and/or practitioners both *lead* and are *led by* the work of other services, such as policing, social work and education who work towards similar goals.

This paper attempts to build on this framework by drawing from two participatory projects with people working across the UK antislavery sector. The first project was co-development research with people working across the modern slavery field. The second was a proof-of-concept exercise that sought to interrogate the applicability of the outputs from the first programme to real-world policy and practice settings.

The overall aim of these projects was to develop, refine and assess the usefulness of a public health framework to address modern slavery in the United Kingdom. Our objectives were:

1. To deliver a practicable public health framework to tackle modern slavery;
2. To create practical tools and guidance to support the adoption and implementation of public health framework for the anti-slavery sector;
3. To critically appraise the refined framework and the supporting tools developed through engagement with a regional anti-slavery partnership.

Methods

Both elements of this work made use of participatory principles (Bergold and Thomas 2012). On that basis, participants were both the producers and users of knowledge.

Project 1: Refining a public health approach to modern slavery

The research was designed as a series of participatory, deliberative events with people working across the antislavery policy and practice sector (Table 1). The research workshops were held online as social contact was constrained owing to social distancing policies at the time of the COVID-19 pandemic (February to March 2021).

Potential participants were recruited through partner channels, for example, email distribution lists through Public Health England

Table 1
Number of expressions of interest and final sample characteristics.

Sector	Expressions of interest	Final sample (*n*)
Statutory		
Law enforcement	11	7
Local government	19	7
Health	9	7
UK policy officials	5	4
Non-statutory (third) sector	25	19
Other (e.g. private individuals and business representatives)	4	3
Total	**73**	**47**

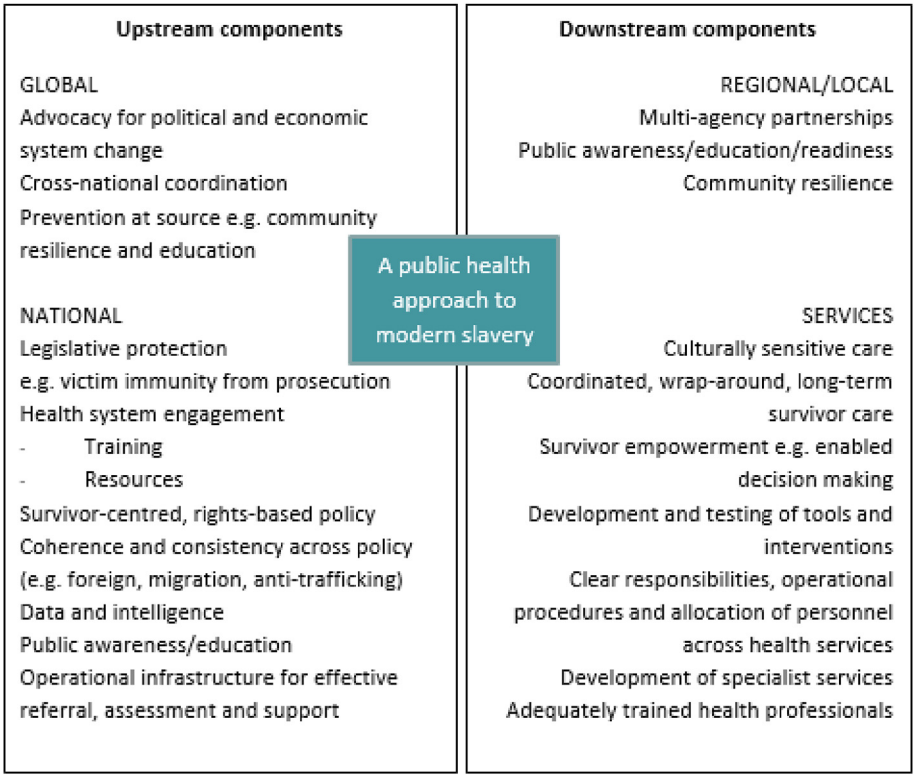

Fig. 1. The components of an emergent public health approach to addressing modern slavery. Source: Such et al., 2020[5], Fig. 2, reproduced with the permission of the publisher, License Number 5737540770523.

and the Office of the UK Independent Anti-Slavery Commissioner. The study included input from people working across the sector and included two participants who identified as survivors of modern slavery. This limited engagement is a weakness of the research. Further refinement work is required with people who have lived experience of exploitation and trafficking to enhance its credibility and legitimacy.

Research workshops were conducted in small groups (range: 3–9). There were seven workshops in total. Each was 2 h in duration, except one which was 90 min long. They were loosely structured (see Appendix A) and facilitated by two or three members of the research team. Participants discussed in detail the topics of a public health framework for modern slavery, its different components and prevention.

Research workshops were recorded on the software Blackboard Collaborate, anonymised, transcribed in detail and analysed thematically. NVivo 12 Pro was used to organise data. Drafts of project outputs were sent to a subgroup of workshop participants for comments and refinements. Ethical approval for the project was granted by the School of Health and Related Research Ethics Committee, University of Sheffield (reference 037607).

Project 2: Proof-of-concept exercise

This was designed as a follow-on project (July 2021) to examine if, how and why the public health framework developed was meaningful and useful for a regional antislavery partnership in England. A similar process of recruitment to the exercise was adopted to Project 1: an online expression of interest form was sent to relevant stakeholders connected to National Health Service (NHS) regional safeguarding leads, regional Public Health England colleagues and people linked to the lead antislavery third sector organisation, Unseen. The exercise recruited 18 contributors (see Table 2 for their affiliations).

Table 2
Proof-of-concept exercise contributors by sector.

Sector	Expressions of interest	Final group (*n*)
NHS/health sector	13	8
Police/law enforcement	6	6
Local government	11	2
Third sector	4	2
Total	34	18

Two online workshops were conducted. Each lasted 2 h. Recordings and detailed notes were taken in each workshop. The workshops were a blend of knowledge and information sharing, familiarising participants with the findings from Project 1 and discussing how they related to their local context. There was also structured discussion on prevention, and materials from the online guide, *A public health approach to modern slavery: A guide for policy, strategy and local partnerships*, were used to help illustrate key points and to encourage discussion.

Results

The thoughts, ideas and preferences of the 47 research participants and the 18 proof-of-concept contributors resulted in a codeveloped public health framework to address modern slavery (Fig. 2).

The case for a public health approach was reflective of the points made in earlier research (e.g. George et al., 2017; Such et al., 2020, 2022); that a criminal justice approach was limiting, that a public health approach helpfully focussed attention towards prevention and that the values and methods adopted in the public health field were more oriented towards supporting affected people and communities.

> *The word on the street is that the criminal justice system is not helpful. … There is a mistrust in the justice system. An advantage of a public health approach is the value system that comes with it, not just the tangible activity.* [Participant 1, Workshop 1]

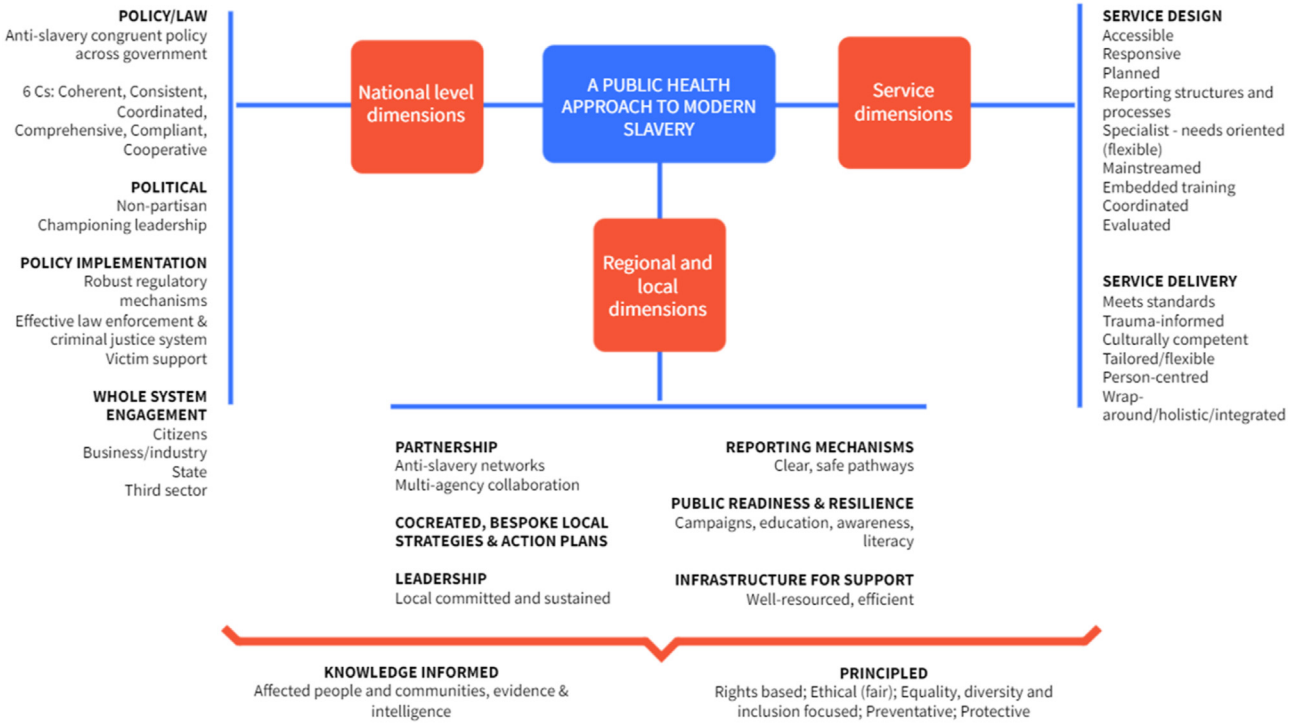

Fig. 2. A public health framework to address modern slavery and human trafficking.

Contributors to the proof-of-concept exercise revealed that some aspects of their work were congruent with a public health perspective. A '5C4P' approach to local policing, for example, had been adopted in one service where the 5Cs of public health (collaboration, coproduction, co-operation, counter-narrative, community consensus) had been combined with the 4Ps of traditional police responses to serious and organised crime (prevent, prepare, pursue, protect). Such an approach was not, however, system wide. Contributions highlighted that people working within different parts of the regional antislavery system had very different levels of knowledge and experience of public health perspectives. This underlined how important appropriately pitched system-wide information and knowledge sharing would be needed for the approach to be mobilised across a broad range of services, professions and local structures.

The components and dimensions of a public health framework to address modern slavery

Fig. 2 outlines the components and dimensions of a public health approach to modern slavery developed in the workshops. Overall, the framework has three levels: (1) national, (2) regional/local, and (3) service (design and delivery). These dimensions were referred to in the context of modern slavery as a cross-border, global problem.

National dimensions of a public health approach to modern slavery

The national components of a public health approach to modern slavery were considered critical to creating a preventative and humane antislavery environment. Participants' discussion of national legal and policy interventions could be summarised under six Cs. They identified that national policy needed to be:

1. **Coherent** across different policy areas, for example, antislavery, welfare, migration, health. This required policymakers *outside* of bespoke modern slavery policy to engage with an antislavery agenda.
2. **Consistent** with counter-slavery goals. Again, this applied across all policy areas.
3. **Co-ordinated** across government departments and between nations (England, Scotland, Wales and Northern Ireland. For an outline of the differences of national responses, see Anti Trafficking Monitoring Group, 2016).[13]
4. **Comprehensive** in terms of wrap-around legislative protection for victims and survivors.
5. **Compliant** with international law.
6. **Co-operative** with the antislavery sector, including co-operation with the third sector.

Reflecting on the first two of the above, one respondent noted: 'Coherence and consistency across policy is key. We work in silos and I think anti-trafficking policies need to be built into, and reflect across, all the other policy approaches at a national level' (Participant 2, Workshop 2).

There were perceived considerable gaps in achieving the six Cs. Brexit, overseas visa schemes and migration policy were all highlighted as areas of policy that were inconsistent with counter-slavery goals and were poorly co-ordinated. One workshop participant identified that this was: 'Setting ourselves up to fail in this preventative work' (Participant 3, Workshop 4).

The theme of co-ordination and co-operation was also reflected in a desire to see all sectors engage with the antislavery agenda. This 'whole system engagement' included citizens/the public, business/industry, and the statutory and non-statutory sectors. Such an approach is characteristic of the work of the public health field, particularly where problems are complex and require cross-sectoral partnership (e.g. violence prevention, homelessness, health inequalities).[14–16]

In addition to these system factors, participants noted the importance of high-level political commitment and leadership and robust policy implementation structures, processes and standards at a national level. This included ensuring regulatory compliance mechanisms were in place (e.g. inspection of care and labour standards) as well as appropriate law enforcement and criminal justice system responses (including effective perpetrator strategies). Victim support included a robust infrastructure for referral, assessment and care as well as protection and support for people affected by exploitation and trafficking *outside* of formal systems (e.g. victims not accessing the UK's National Referral Mechanism, the main state-provided system for identifying, referring and supporting victims).

Regional and local dimensions of a public health approach to modern slavery

Aligning with earlier work,[5,17] multiagency partnerships were seen as the primary mechanism through which regional and local exploitation and trafficking could be addressed. It was noted that effective antislavery partnerships at the regional/local level needed to be sustainably funded and resourced, required multidisciplinarity (including law enforcement, community safety, health professionals, social work and safeguarding specialisms, for example), cross-sectoralism and an action orientation. Strategic and action planning that was bespoke to the local context was endorsed. Similar to the national level, local partnerships needed dedicated, empowered and committed leadership. Sufficient power, authority and resources were all required to mobilise change.

At a local level, clear pathways to reporting suspected and experienced exploitation were required in a way that protected people, families and communities and minimised risk of harm. Law enforcement mechanisms needed to be supplemented with anonymous, third-party reporting options (e.g. the UK Modern Slavery Helpline) to ensure victim protection. Locally delivered, integrated, suitably resourced and safe pathways to exit exploitation and access protection were necessary.

Community resilience, readiness and literacy of modern slavery were identified as important for local resistance to modern slavery. Although awareness-raising campaigns were acknowledged, participants emphasised that deeper understanding at the local level was needed to ensure complexities were understood and to promote local ownership of solutions.

Service dimensions of a public health approach to modern slavery

Service factors were divided into two main considerations: Service design and service delivery. Service design refers to the specification, planning and arranging of resources, including infrastructure, people and the material components of a service. Service delivery relates to the ways in which services are managed and provided to the recipient. In practice, the two were interlinked and complementary. For example, safeguarding services required consistency across both design and delivery. Participants' contributions focussed on the characteristics of service design (see Fig. 2). Accessibility of services to victims, survivors and people at risk were a concern, with many noting well-documented distrust in services among marginalised populations, victims' fear of coming forward and the stigma experienced by people who have been harmed. One workshop participant commented:

Table 3
Service design principles and delivery components of a public health approach to modern slavery.

Component	Description
Service design principles	
Accessible	Services are designed to enable survivors to access entitlements during exploitation/trafficking whilst exiting exploitation and throughout recovery
Responsive	Rapid, early-stage response services are available for victims/survivors and people at risk that focus on (1) safety, (2) meeting survivors' immediate needs, (3) dignity and autonomy
Planned	Transparent service planning that identifies clear responsibilities, operational procedures and allocation of personnel across services, including social services police, border force, labour inspectorates and health services
Reported	Clear reporting structures and mechanisms with actionable outputs
Specialist	Development and adequate resourcing of services designed to meet specific needs, bearing in mind intersecting vulnerabilities and ability to access services, e.g. outreach services, free legal advice
Mainstreamed	Ensuring mainstream services are 'modern slavery aware' and responsive, e.g. 'Making Every Contact Count' approach
Skilled	Adequately skilled practitioners with training embedded in service design
Co-ordinated	Co-ordinated services for survivors between multidisciplinary professionals
Evaluated	In-built, robust development and testing of tools and interventions
Service delivery components	
Meets standards	Services meet specified standards, e.g. survivor care standards[18]
Trauma informed	All services adopt trauma-informed principles and operate them in practice
Culturally competent	Services are delivered in a way that meets the needs of people with diverse backgrounds, flexibly responding to the practices and beliefs of different communities, families and individuals. Psychological support, for example, should be responsive to diverse understandings of mental health and illness
Tailored/flexible	Service delivery should be flexible enough to be tailored to the needs of affected communities, families and individuals and should enable informed choice
Person centred	Affected people have services delivered in a way that meets their specific needs
Wrap around/holistic/integrated	Service delivery accounts for the needs of the person and people close to them as a whole, providing wrap-around support and care (e.g. through multiagency conferencing, service navigation, specialist support workers)

> *It's fear of immigration control if they come forward as victims of trafficking. Thinking about county lines and certain communities, there isn't a good relationship with the law.* [Participant 4, Workshop 4]

Table 3 describes the elements of service design and delivery highlighted in the workshops.

Cross-cutting elements of a public health approach to modern slavery

Cutting across the national, local and service dimensions of a public health approach to modern slavery were a series of universal principles. These included a commitment to all elements being knowledge informed. This included formal knowledge, such as scientific evidence and local data and intelligence. It also included the experiential knowledge of affected people and communities. The involvement of people with lived experience of exploitation and trafficking in the design of services was particularly endorsed. This connected to other core principles: that antislavery work should seek to empower affected people and communities; that all dimensions were rights-based and ethical (fair); and that responses were equality, diversity and inclusion focussed, preventative and protective. The groups discussed the value of a public health approach in its focus on primary, secondary and tertiary prevention in particular and saw and expressed the need in the field to focus more on preventing harm from happening in the first instance. These cross-cutting elements are evident in the quotes in Table 4.

Discussion

This research has built on earlier work that identified promise in a public health approach to modern slavery and human trafficking.[3,5,19] The renewed framework offers an evidence-derived opportunity to shape policy and practice in a way that is prevention focussed, multiagency and driven by data, evidence and experiential knowledge. Participants were enthusiastic about a public health approach and welcomed practical tools to support its growth and spread. The current project built a 'microsite' – a small, focussed website – to respond to such a need for local antislavery stakeholders to refer to 20. This guide includes antislavery partnership supporting materials.

There remain, however, challenges and risks to the adoption and implementation to a public health approach to modern slavery, which need consideration. These have been discussed in detail in other, sister publications[21,22] as well as noted in brief here. First, workshop participants were clear that local antislavery partnerships were important for adoption and application of the approach, having key co-ordination and oversight functions. However, there was significant variability in the resources available to the partnerships, as well as the processes, and structures which govern them. This reflects others' findings and represents a barrier to widespread adoption.[17,23,24] There is a strong argument here and in others' research for increased formalisation and improved resourcing at the local level.[24] Improved local governance would also assist the sharing of knowledge, best practice and data, all of which were highlighted by participants and in the literature as important considerations for the fulfilment public health approach.[15,25]

Second, and linked to this challenge is the risk that, in promoting a public health approach to modern slavery, the issue becomes somehow 'disowned' by law enforcement agencies.[21] It is incumbent on the antislavery sector to drive multiagency dialogue to ensure law enforcement engagement. Here, at least, there is precedent, with the UK's policing and public health bodies developing a consensus agreement on protecting and preventing harm to people living in vulnerable circumstances.[26] It is clear that in order for any benefits of a public health approach to be realised, there is a need to retain equivalent authority, resources and impetus.

Finally, at the heart of these national and local level challenges is the well-known problem of effective intersectoral working.[27–30] Contributors to the proof-of-concept exercise highlighted the everyday tension between meeting immediate service delivery demands and working in longer-term strategic ways with partners. Here, there are some important and helpful starting points for collaboration in the United Kingdom such as the new Integrated Care Systems that are explicitly intersectoral.[31] It is important

Table 4
Illustrated examples of cross-cutting elements of a public health approach.

Cross-cutting element	Example quotes
Knowledge informed/all types of knowledge	'The experts are those who've been through it and survived it. We need to do more to make sure their views are systematically included.' [Participant 2, Workshop 2] 'There's a question about how we use the information that we have to prevent [people] from being re-victimised. We hold this intelligence, we have a lot of information to start preventative work, but the collaborative approach doesn't feel integrated, it's separate tasks. We need to be more collaborative.' [Participant 4, Workshop 1]
Empowering affected people	'We're doing lots of studies and lots of local work, but are we learning from that? Why is this particular housing estate or area of one county more susceptible to county lines than others? We need to be proactive about using this learning to help. To be clear, it's not that 'We use this learning and solve the problem', it's that we use this learning to support and empower that community to sort the problem themselves.' [Participant 1, Workshop 4]
Preventative, especially preventing exploitation before it happens	'There needs to be more about capturing people before they are victims and survivors. Training usually focuses on people who are obviously victims, but what can we do before that point to effectively prevent it?' [Participant 3, Workshop 1] 'As well as the workers, we also look at the businesses. So, making the environment hostile to the exploiters, making it as difficult as possible for them to operate and continue to be able to commit offences and exploit individuals in that way. It's creating a hostile environment that prevents them from being able to operate, but also really focusing on empowering those that may be subject to that exploitation to help themselves prevent them falling into that situation.' [Participant 1, Workshop 2]

antislavery partners are well represented at these strategic windows of opportunity.[20]

Conclusions

This research and proof-of-concept work has devised a more mature, considered and coproduced public health approach to modern slavery. In sum, the framework can be characterised as an umbrella under which to guide policy, strategy and practice across antislavery systems in the United Kingdom. Its appeal lies in its coherence as an alternative to (albeit inclusive of) law enforcement concerns that offer a clearer narrative of prevention, multiagency working and victim/survivor centrality. It was apparent throughout discussion with these 65 stakeholders that the approach fitted well with existing practices and frameworks for addressing harm, for example, contextual safeguarding, multiagency working and could provide a long-term, yet flexible structure for thinking and doing antislavery work.

This is not to say, however, that implementation will be straightforward, with multiple barriers and challenges noted here and elsewhere.[21,22] Perhaps one of the most significant concerns since the conduct of this work has been the UK government's shift towards a considerably more punitive system for undocumented migration (cf. Nationality and Borders Act 2022 and the Illegal Migration Act 2023). In this context, it is important that local antislavery partners retain focus on locally led multiagency activity for harm reduction using public health principles.

Author statements

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Ethical approval

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Competing interests

The authors declare no competing interests.

Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.puhe.2024.04.004.

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