Establishing an evidence-based Trauma Informed Care Pathway for Survivors of Modern Slavery

May 2022

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Executive Summary

Research aim

This research aims to explore how the concept of Trauma-Informed Care (TIC) approach can be adopted by SJOG services, in order to improve awareness of trauma as experienced by survivors[1] of Modern Slavery & Trafficking (MST), and to provide effective support. Notably, in this paper, we will also elaborate how the complex needs of MST survivors are related to their traumatic experiences, and the necessary steps and resources for implementing a MST TIC model.

Contextualisation

Modern Slavery is a serious crime and present everywhere in the UK. Often, the victims are unable to leave their situation of exploitation, being controlled by threats, punishment, violence, coercion and deception.

In the UK, this term encompasses both Slavery and Human Trafficking. The number of potential victims who were referred to the National Referral Mechanism (NRM) increased exponentially in the past decade, yet it is considered that it will grow even more in the years to come. According to the Human Trafficking Foundation, in 2010 there were fewer than 700 victims of Human Trafficking found in the United Kingdom; however, more than 12,000 people were referred to the NRM in 2021, seeing an increase of 20% compared to the previous year[2], while the police believe the real figure may be ten times that number.[3] This growth in reporting is also the direct result of the publicity around The UK Modern Slavery Act 2015 that helped to increase awareness of Modern Slavery.

Delivering services for survivors of modern slavery

Support in England and Wales is currently delivered by the Salvation Army and a number of subcontractors. With ten services, SJOG Hospitaller Services (SJOG) is currently the UK's largest provider of safe houses for people subject to Modern Slavery and Trafficking, supporting more than 700 people every year and providing specialist assistance to help people recover from their experiences, rehabilitate and rebuild their lives.

While services that offer accommodation and assistance to survivors seek to consider their complex needs and experiences in order to create personalised person-focused support, failure to acknowledge trauma in people's life and their consequent need for safety, mutuality, collaboration and empowerment may unintentionally retraumatise and further reinforce survivors' needs for harmful coping strategies.

Why consider trauma-informed care?

There are relatively few services in the UK that have a deep understanding about the survivors' and practitioners' views of how trauma impacts their daily life. Consequently, there is a strong need for

[1] The language of 'survivor' is generally preferred in the UK anti-slavery sector when referring to those who have experienced modern slavery and human trafficking.
[2] Amy Baxter for Home Office annual report, 3rd March 2022
[3] Human Trafficking Foundation Report, November 2020

developing services that are organised and delivered in ways that prevent retraumatisation and enable trauma survivors to engage safely with the right professionals at the right time, promoting healing through positive relationships. Such models, known as Trauma-Informed Approaches (TIAs), are widely used across many sectors in the US and elsewhere, and are gaining popularity in the UK.

Trauma-Informed Care is seen as crucial to the empowerment of survivors. It ensures that they are not retraumatised during legal proceedings or while receiving recovery services. It provides self-ownership over their recovery process and helps them to proceed towards safe and empowered futures. Yet, it remains a marginal implementation model by governments, law enforcement, judiciary, or care providers, who are frequently survivors' first point of contact in the recovery process.

Methodology

This paper is the result of a six months research project, focusing mainly on the development of a TIC approach for MST services delivered by SJOG. In order to understand better how to provide best practice and to adopt the concept, this study is based on a multi-disciplinary approach, encompassing both theoretical perspectives and co-production. By combining qualitative and quantitative research, and comparing different analysis of applied examples of TIC in the US and the UK, our study aims to gain important insights about the prevention and impact of trauma on survivors' life.

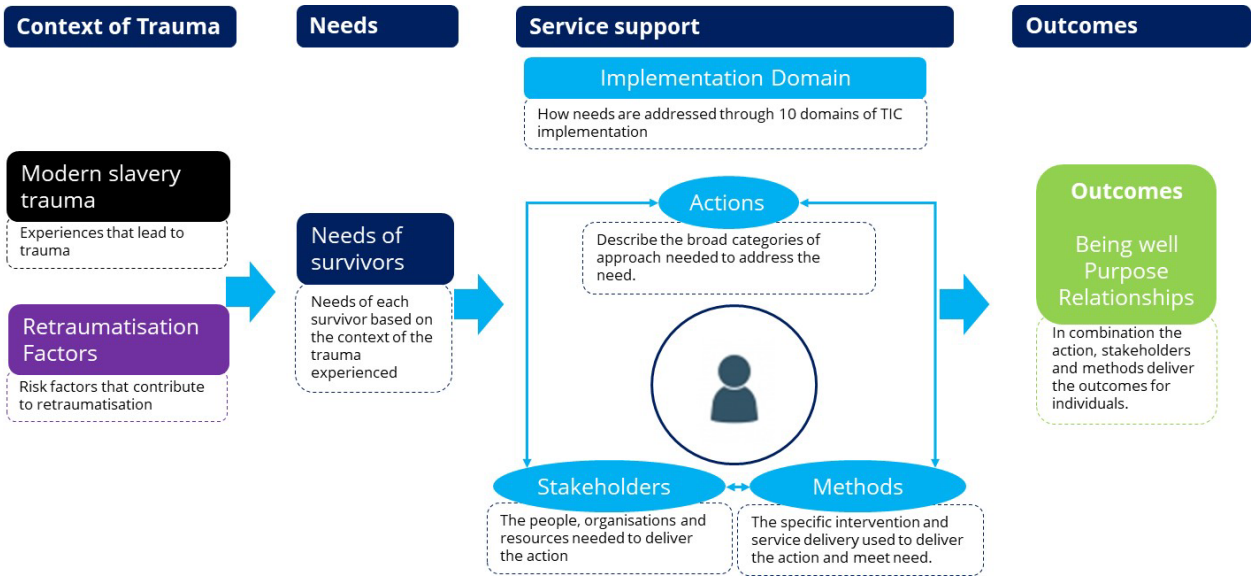
Notably, the articulation between a more general expertise on Trauma-Informed Care developed by other institutions operating in the field[4], and the SJOG delivery, based on the Salvation Army's Modern Slavery Victim Care and Coordination Contract (MSVCC) and the Care Quality Commission regulations, aims to identify on one side what are the complex needs of survivors derived from their traumatic experiences, and on the other side, how could MST services prevent retraumatisation.

Two in-depth interviews with survivors, who receive support from Olallo House in London, and a survey shared among all colleagues working with MST services completed the findings of the research with their personal experience and knowledge (see appendix 1 & 2 for details). The survey aimed to understand better the knowledge of colleagues working with survivors about trauma, and their view regarding the practice of self-care at work. The findings of the survey have been detailed in section 4 of this study, where we analysed the delivery of SJOG in terms of services and procedures. The interviews contributed to the examination of resources and gaps existing in the current system, and of survivors' perception of their present situation.

[4] such as SAMHSA (Substance Abuse and Mental Health Services Administration) US, the Right Lab from University of Nottingham, the Centre for the Study of Modern Slavery at St. Mary's University, London, the Trauma-Informed Practice Toolkit for Scotland and the City of Westminster strategy 2026 for Ending Modern Day Slavery, the Helen Bamber Foundation among others

Evidence-based trauma informed care pathway

The research process culminated in developing an evidence-based trauma informed care pathway to address the needs of survivors of modern slavery. In order to improve the wellbeing of survivors and support them to live a meaningful life, we established a pathway delivering three main outcomes belonging to the social determinants of health criteria[5]. The pathway covers key themes of the context of trauma, needs of individuals, service support and finally these combine to achieve outcomes: health and wellbeing, purpose, and relationships.



The model attempts to mobilise the best practice in the area and direct this into bite size service support elements for each individual. In the figure above service support is cyclical. This recognises that actions, stakeholders and methods are not static but dynamic. They are developed throughout service delivery responding to the needs of the communities that are being supported and the types of traumas being displayed. The model ensures support is aligned to positive and consistent outcomes.

[5] According to the government's Health website, the Social Determinants of Health represent "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks"[5]. Many can be considered as important aspects of health and wellbeing; however, they are divided in 5 main domains: Economic Stability, Education Access and Quality, Health Care Access, Neighborhood and Built Environment, Social and Community Context.

Acknowledgements

This research was funded by SJOG Hospitaller Services, UK.

We would like to thank our colleagues who contributed to this research and their expertise in developing this work.

Table of Contents

Section 1

What is Trauma?

"Trauma refers to single or multiple events that are experienced as harmful or life-threatening and that have lasting impacts on mental, physical, emotional, and/or social wellbeing well into adulthood".[6]

Even though there has been a general agreement around this definition of trauma, coined by SAMHSA in 2014, the notion has sparked debates and its perception changed radically over the years, across various disciplines. This because, a traumatic experience is not universal to all individuals, but is subjective to every person, its impact depending on the discrepancy between the threatening situational factors and the individual abilities of control, which is accompanied by feelings of helplessness and abandonment, leading to a lasting collapse of self-understanding and of the world[7].

Common examples of trauma include severe physical injuries, illness, domestic abuse, neglect or family separation. Less common examples are the ones resulting from community violence, such as bullying, gang culture, sexual assault, homicide and war. It can also include social trauma, such as inequality, marginalisation, racism and poverty, and cultural or historical trauma - which is the legacy of violence committed against entire groups, such are the cases of slavery, genocide, and the Holocaust.[8]

Traumatic reactions can include a variety of responses that impact an individual on a physical, psychological and cognitive level. Sometimes, the symptoms of psychological trauma may be increasingly severe. This could depend on the nature of the traumatic event, availability of emotional support, past and present life stressors, personality types, and available coping mechanisms. According to SAMHSA, some of the most common symptoms of psychological trauma may include the following[9]:

Thoughts

- Negative thoughts that are associated with fear or other emotions experienced during the trauma;
- Flashbacks and nightmares;
- Trouble concentrating;
- Dissociation (separation of normally related parts of awareness, such as thoughts, perceptions, memories, and identity);

[6] SAMHSA, 2014
[7] Vasile, 2018
[8] Sweeney and all, 2015
[9] SAMHSA, 2017

Physical Signs and Symptoms

- Feeling "on edge", very anxious and tense, or easily startled;
- Trouble falling or staying asleep;
- Significant changes in appetite and/or weight;
- Fatigue and lack of energy;
- Experiencing strong reactions to triggers (ex. fast breathing and heartbeat, sweating);

Behaviours

- Social withdrawal and isolation;
- Increasing intake of alcohol and other substances following an incident;
- Avoidance of people, places, and situations related to the traumatic event;

Emotions

- Intense feelings of guilt, anger, fear, anxiety, horror, sadness, shame, or despair;
- Intense distress in reaction to triggers, or circumstances you link to present or past trauma;
- Feeling distant from other people;
- Feeling unable to control your emotions, such as not being able to calm yourself down, a decreased sense of security and inability to feel love[10];

Some people may be affected by a series of traumatic events, known as complex trauma. This refers to the "simultaneous or sequential occurrences of maltreatment"[11] and could include a number of different experiences as mentioned above (emotional abuse, neglect, sexual assault, physical threat, etc.). What differentiates a complex trauma is the fact that the experiences are chronic (happening over and over) and usually begin in childhood or early adulthood. It is more persistent, diffuse, and complex than PTSD. It is also characterised by personality shifts most apparent in distortions of attachment and identity. Furthermore, complex trauma increases vulnerability to revictimisation, either through self-harm, or through further abuse from others.

Who experiences trauma?

Sweeney and her colleagues form King's College London highlight that many people in contact with mental health services have experienced physical or sexual trauma and that there is a strong link between childhood trauma and adult mental distress; additional experiences of marginalisation, poverty, racism and violence are correlated with poor mental health.[12] Consequently, individuals with a vulnerable social and cultural background are more likely to be affected by trauma and to experience mental health issues. Research evidences that traumatic events are more frequently experienced by people in low-socioeconomic groups and from minority ethnic communities. It has

[10] SAMSHA, 2017
[11] National Child Traumatic Stress Network, 2003
[12] Sweeney, 2016

also been argued that poverty is the most powerful predictor of mental distress because it can lead to so many other stressful situations[13].

Although the experiences may be multiple and various, Green listed 8 situational factors that mostly cause traumatic effects: threat to physical integrity and life; severe bodily injury; being exposed to intentional injury or damage; confrontation with deformed human bodies; the violent or sudden loss of a loved one; observing or informing a loved one about violence; being exposed to a harmful environmental stimulus; guilt over the death or severe injury of others[14].

In truth, according to contemporary psychologists and researchers, trauma may occur when fearful experiences overwhelm personal possibilities for self-regulation, causing vulnerability and a long-term deterioration of vitality, of identity and of coping mechanisms. These mechanisms, which can be physical or psychological, can provoke deregulations on various levels and can affect: the hormonal balance, the cardio-respiratory system, the digestive system, the capacity to regulate emotions, purpose and will, and the capacity of processing internal and environmental information[15].

We can, in fact, conclude that there is a strong connection between the experience of a stressful and fearful situation and individuals' capacity to manage these episodes, based on their background and the exposure to social, cultural and emotional precarious environments.

Summary

In this chapter we tried to understand better the definition of trauma and its impact on people's lives. Trauma can occur in case of physical injuries, abuse, family separation, war and life-threatening events, marginalisation and racism, poverty, etc. We can affirm that, in general, trauma refers to a single or multiple events that have been harmful for the person who experienced it, because it overwhelms personal abilities to cope, causing long-terms implications and negative effects, on a physical, emotional and cognitive level. These implications can in fact provoke deregulations on various levels and can affect: the hormonal balance, the cardio-respiratory system, the digestive system, the capacity to regulate emotions, purpose and will, and the capacity of processing internal and environmental information.

Different research demonstrated that traumatic events arise more frequently among people from low-socioeconomic environments, due to poverty, marginalisation, and childhood adverse experience. Consequently, individuals with a vulnerable social and cultural background are more likely to be affected by trauma and to experience mental health issues.

[13] Read, 2010
[14] Green, 1993 in Vasile, 2018
[15] Vasile, 2018

Section 2

What is Modern Slavery?

For general interpretation, slavery is the status or condition of a person over whom any or all of the powers attaching to the right of ownership are exercised. This includes every act of trade or transport in slaves[16]. At present, Modern Slavery is often a hidden crime, which makes it hard to identify and determine the scope of the issue. It is 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"[17].

Forced labour can be defined as work that is performed involuntarily and under coercion. It can take place in any industry, including in the informal economy. It includes men, women and children in situations of debt bondage, suffering slavery-like conditions or who have been trafficked[18].

Human Trafficking is a form of Modern Slavery that involves the movement of people internally within countries, or externally across borders. The UN Trafficking Protocol defines human trafficking as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the 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. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs".[19]

According to official statistics from Home Office, in 2021, 12,727 potential victims of modern slavery referred to the NRM, compared to 10,000 in the past three years. Based on the report, 90% of the referrals received reasonable grounds[20] for entering into the NRM programme, and 91% of the conclusive grounds decisions[21] were positive, which determined that individuals were indeed "victims of modern slavery" by the Competent Authority. Adult referrals accounted for 50% (6,411) of all referrals in 2021, seeing an increase in child referrals. Overall, the majority (58%) of potential victims claimed exploitation in the UK and 31% overseas, the most common type of exploitation reported for child potential victims was criminal exploitation, whilst labor exploitation was most common for adult potential victims (32% in total)[22]. Furthermore, the most common nationalities referred last year were UK, Albanian and Vietnamese.

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[16] antislaverycommission.co.uk

[17] As defined by the Slavery Convention, 1926 and the Supplementary Slavery Convention, 1956 https://www.antislaverycommissioner.co.uk/about-modern-slavery/

[18] As per the ILO Forced Labour Convention, 1930, in Helen Bamber Foundation, 2015

[19] Definition coined by The Palermo Protocol; United Nations, 2000 in Helen Bamber Foundation, 2015

[20] the decision from the Competent Authority that someone is a potential victim of modern slavery;

[21] the decision from the Competent Authority that someone is definitely a victim of modern slavery;

[22]https://www.gov.uk/government/publications/2021-uk-annual-report-on-modern-slavery/2021-uk-annual-report-on-modern-slavery-accessibleversion

Trauma and Modern Slavery

Due to distressing episodes endured before the referral, most survivors experienced trauma-inducing events at least once in their life.

Survivors of Modern Slavery and human trafficking experienced complex trauma and can face long-term consequences that amplify the state of vulnerability in which they find themselves. Sadly, many of them went through traumatic events on different occasions and developed further complex needs. It is important, therefore, to understand that they might have experienced traumatic events on different levels: before, during or even after the Modern Slavery episode.

As we can see below, the intersectionality of contexts that lead to traumatic events within Modern Slavery can have long-term consequences:

Before: Traffickers typically target people who are vulnerable in some way, whether that is due to poverty, lack of access to education, lack of resources and opportunities, chronic unemployment, discrimination, displacement or unstable living conditions, youth or naïveté, history of trauma exposure, lack of a supportive care giving system, responsibility for dependents, and limited awareness of the crime of Human Trafficking.[23]

During: Survivors may be subject to poor or unsafe living and working conditions, may have been trafficked in stressful circumstances or have been exposed to previous health-damaging trauma such as war, torture, persecution and separation from family. Survivors of sexual exploitation are also at high risk of sexually transmitted infections and suffer multiple traumas including violence and criminalisation. As exploiters deny people access to the fundamental determinants of good health, there is a high burden of multimorbidities among this group.[24]

After: Researchers and organisations that advocate for survivors' voices to be included in policy-making, highlight that incidents of poor interviewing skills for the purposes of establishing evidence of trafficking were commonplace; in some cases, the experience was highly traumatising for the victims[25]. Additionally, survivors may continue feeling threatened by their traffickers, or being exposed to further insecurity. Furthermore, once the referral to NRM is made, the survivors are confronted with new, distressing situations, that could contribute to retraumatisation and/or exacerbate trauma. Some of these factors can imply the loss of a stable shelter, of family connections and accustomed social roles and routines, and the long waiting time for a "status". In her recent research, Murphy demonstrates how this aspect entails a "politics of domination" that adds to the multidimensional impact on survivors' wellbeing.

Firstly, the lack of legal status as a citizen of a country compromises the sense of belonging and ability to integrate. Many survivors who are not British citizens could be entitled to apply for asylum, as they might have been trafficked overseas without papers. Regrettably, Britain is one of the most

[23] Wright, 2020
[24] Such, 2020
[25] Murphy, 2020

challenging destinations for asylum seekers in Western Europe, and the process is complex and requires multiple trespassing interviews with the Home Office. This represents an additional level of uncertainty, as the request for obtaining a leave to remain is often rejected, but the process also generates a sense of "otherness" and "alienation", financial instability, lack of access to health and social care services and restriction of daily activities.[26]

Secondly, as Khosravi points out, undocumented migrants experience the waiting as a sense of powerless due to the fact they constantly depend on the decision and assistance coming from others. The reliance on other entities such as the state, NGOS, religious groups and legal firms for support results in feelings of inadequacy and shame.

As we can see in this chapter, people with a vulnerable background are more likely to become victims of Modern Slavery and Trafficking and to experience different levels of traumatisation**.** This hypothesis has been also approached by recent studies on people experiencing homelessness, suggesting that they are also more likely to be victims of violence (including physical and sexual assaults) and to develop depression and posttraumatic stress disorder[27].

These studies are important for two reasons:

a) **To understand how trauma affects vulnerable people**: how addictions and other unhealthy behaviours are a way of coping with painful memories and life-events, how they can have difficulties in trusting people and services, and how they can feel powerless and helpless in front of choices[28]. For those with pre-existing conditions, uncertainty and stress factors may erode a person's coping mechanisms and lead to retraumatisation[29]. For example, they could more likely experience overwhelming emotions, have difficulties controlling fear and anger, and may have other mental health needs such as depression and anxiety. They could be more likely to have feelings of shame and lack of trust in others, therefore they may have problems sustaining stable relationships and receiving the necessary support.

b) **The knowledge would allow professionals to be aware of past events of trauma** among survivors and to develop relationships that give the client power and build trust, thus enhancing safety[30].

Taking into consideration the experiences of MST survivors may help to reduce distress, therefore to avoid retraumatisation once they have been identified as victims and offered support. By contextualising the factors that contribute to trauma for MST survivors, we can deliver a better understanding on how to implement a sustainable Trauma-Informed Practice that will take into account these aspects.

[26] Murphy, 2020
[27] Gulliver 2015
[28] Gulliver, 2015, SAMHSA 2012, The National Alliance to End Homelessness, 2012
[29] The Innovation and Good Practice Team in Briefing for Homelessness Services, 2017
[30] SAMHSA, 2012

Identifying needs of survivors

As explained in the previous chapters, there have been various studies that monitored the traumatic events experienced by different survivors and the impact on their life. According to Changing Lives Organisation, in a report completed in 2018, women who were victims of domestic abuse required support on different levels as they developed complex needs deriving from trauma: anxiety, abusive behaviours, substance misuse, and depression, lack of motivation, fear, social isolation, etc.[31]

In the case of MST survivors, many stress factors are due to their current social environment, such as the lack of progress with their status, lack of trust in support services or lack of familiarity with the host country. Prior to defining the necessary steps for implementing a TIC for MST services, trauma is inherently related to the identification of the complex needs derived from it.

According to Wright and colleagues, in a study about *"Supporting needs of survivors of Modern Slavery worldwide and the UK"* from 2020[32], several factors should be considered for meeting the requirement of survivors and avoiding retraumatisation. These depend on how urgent a request is, the length of stay and the environment in which they were placed after being under NRM.

In the following lines, we can see better what needs to be addressed are:

Immediate needs (0-9 months):

- **Safety:** there is evidence that the accommodation of survivors might trigger trauma; for example, those who have escaped sexual slavery are often placed in domestic violence refuges, causing conflict where women escaping abusive partners have expressed concern that their location will be revealed by the presence of survivors who might be traced by their traffickers.

- **Length of stay:** FreeForGood reports that a minimum of 12 months of support is necessary for survivors to have a stable foundation for recovery. In fact, it can take significant time for victims to feel safe enough to process their traumatic experiences through counseling or to engage with police investigations. They also need time to gain skills, experience and confidence that will enable them to live a full and integrated life in society, but also to be able to establish connections with legal representatives that will help them with their case.[33]

- **Eligibility:** The Human Trafficking Foundation noted in their study that 26% of survivors did not enter safehouses because they didn´t meet the eligibility criteria, declined support, or because contact was lost due to severe mental disorder, violent behavior, and/or severe addictions. The solution for ensuring sustainable support would be: longer stays in accommodation, building trust, providing one-to-one case management at risk periods in their journey.

[31] Changing lives, 2018
[32] Wright, 2020
[33] https://www.freeforgood.org.uk/

Mid-long term needs (9 months onwards):

- **Adaptation:** For those that have been trafficked from abroad, language is a barrier to integration, especially where there is little understanding of legal and practical systems and processes in the UK. Moreover, after years of being controlled and having no possessions, survivors have to decide everything. It is important for service providers to understand that even small decisions such as what to wear, when to eat, and when to sleep can become overwhelming. For them, day-to-day decisions can bring challenges; additionally, survivors also have to learn how to trust those trying to assist them and to navigate the support available to them. In other words, there is a need to adjust to the new environment first, before they can start to cope with their trauma.

- **Incomplete path – evacuation:** Another aspect to consider is the decision ground after being referred to NRM. Those that fail to be identified are suddenly faced with a lack of income, no secure permanent accommodation, and little emotional or practical support. This is also relevant for those with No Recourse to Public Funds (NRPF) who receive a conclusive ground and have no access to benefits, or other kind of support after NRM, being left vulnerable to face homelessness, deportation and/re-trafficking[34]. Although a person's nationality or immigration status should not prevent a local authority from providing the necessary support, failure to ensure a post-NRM sustainable pathway, will bring additional challenges and vulnerabilities to survivors who are not entirely independent.

Services that support survivors of modern slavery

While SJOG services are committed to address immediate needs of survivors through a series of procedures and values that we will elaborate later in this study, the long-term ones however, referring to adaptation and long waiting times, are less evident and more difficult to articulate in daily-life.

For example, for those awaiting a decision, periods of up to nine years have been recorded sometimes. Although, according to Rotter, "waiting is not an empty interlude between events but an intentional and agential process"[35] where some persons may be affective, active and productive, for many MST survivors the lack of status, of personal power, often mirrors their trafficking. For Murphy, the waiting also generates a financial cost to the state[36], as people who are supported by the NRM programme are financially supported through subsistence services: such as food, accommodation, weekly allowance and various expenses. On the other hand, a new cost-benefit analysis from the Rights Lab experts at the University of Nottingham has found that the benefits and savings of providing longer-term support to survivors of Modern Slavery considerably outweigh the initial costs. According to their report, an extended support period would save money in the future by preventing more costly interventions at a later stage, and would also mean additional support for prosecutions

[34] https://www.local.gov.uk/publications/supporting-modern-slavery-victims-guidance-and-good-practice-council-homelessness
[35] Rotter, 2016 in Murphy, 2020
[36] Murphy, 2020

of traffickers[37]. Such intervention is even more necessary for providing a sustainable programme for survivors, as the government invested substantial funds in prevention-focused campaigns, which resulted in an increased number of people referred to NRM[38]. During the year 2016/2017, it is estimated that the cost of the Victim Care Contract for England and Wales was £14 million. As we can see in the table below, the costs associated with the emotional care of a survivor are superior to the physical implications resulting from Modern Slavery experiences.

Table 1 – Estimated cost of healthcare associated to MST type - taken from Murphy[30].

Modern Slavery Type	Emotional (£)	Physical (£)	Total (£)
Labour exploitation	3,310	250	3,560
Sexual exploitation	2,710	9,120	11,830
Domestic exploitation	2,620	380	3,000

There is little information about the percentage of people that fully recover and (re)become active social and economic participants; however, investing in a service that adopts a multilateral approach for tackling the effects of Modern Slavery on individuals will help reducing the state's intervention costs in terms of healthcare and prevention campaigns.

The need for trauma-informed services

If we look at these questions through the lens of Trauma-Informed Care (TIC), the elements of vulnerability and distress need to be taken into consideration to avoid re-traumatisation. In practical terms, the service would ideally address the current mental health and wellbeing of survivors by offering a multi-dimensional support that encompass the complex needs of people who experienced multiple disadvantages: better understanding of trauma and its expressions (both for staff and survivors), addressing ongoing social issues: health, addiction, homelessness, immigration status, etc. and enhancing cultural fulfillment: being part of a community, feeling accepted for one's own differences (ethnic, gendered, religious), practicing and sharing heritage.

The process of understanding trauma and addressing present issues is not without challenge, thus: the lack of tools that allow providers to communicate appropriately with survivors, to report and escalate traumatic situations may contribute to lack of clarity that surrenders them, while exposed to a series of intrusive questions. As matter of fact, variation in responses from statutory agencies, first responders and support workers have an impact on survivors. The need to provide clear guidance

[37] https://www.nottingham.ac.uk/news/rights-lab-cost-benefit-analysis -*report unavailable to download

[38] Reed and all, 2018: a Home Office report claiming that during 2016/17, £905,000 of the fund was used for targeted projects to tackle modern slavery in source countries and reduce the number of people being trafficked to the UK. The funding was predominantly used to deliver a communications campaign to raise awareness of slavery in England and Wales, aiming to educate the public and small- and medium-sized businesses on different types of slavery and to increase their propensity to report suspicious activity.

and informed-understanding about TIC principles is of critical importance in smoothing the journey for survivors, ensuring that survivors are supported adequately.

It would be necessary that all parts involved above in the psychological assessment of MST survivors learn how use an appropriate language during discussions and interviews. Additionally, it would be useful if these parts would engage in a collaborative way and would adopt Trauma-Informed evaluation methods that include rapport-building and informed consent, safety assessment, needs assessment and goal-setting. Knowing the history and vulnerability factors, the trafficking narrative (including elements of force, fraud, and coercion) and trauma exposure would also favor the assessment of psychological symptoms, and the identification of strengths and coping techniques[39].

Finally, it is important to take into account the health and safety of survivors who have often experienced extreme violence and psychological abuse. Addressing the mental health needs of this population is part of anti-trafficking policies in the UK, such as the Modern Slavery Act, as well as internationally, for example, in the Palermo Protocols. Nevertheless, as we will see in the following chapter, the provision of evidence-based mental health support for this population is one of the largest gaps in both the national and global antislavery response.

The National Referral Programme (NRM)

The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of Modern Slavery and ensuring they receive the appropriate support. Adults in England and Wales who are recognised as a potential victim of Modern Slavery through the NRM have access to specialist tailored support for a period of at least 45 days while their case is considered, which include: access to relevant legal advice, accommodation, protection, and independent emotional and practical help [40].

Support in England and Wales is currently delivered by the Salvation Army and a number of subcontractors. With 10 services, SJOG Hospitaller Services is currently the UK's largest provider of safe houses for people subject to Modern Slavery & Trafficking, and provides specialist support to help people recover from their experiences, to rehabilitate and rebuild their lives.

Public health services

Modern Slavery presents a significant public health concern, and disproportionately affects vulnerable individuals, such as young people, women, migrants and those living in poverty. Survivors might have been subject to poor or unsafe living and working conditions, may have been trafficked in stressful circumstances or may have been exposed to previous health-damaging trauma such as war, torture, persecution and separation from family. As a result, there is a high burden of multimorbidities among this group.

[39] Wright, 2020

[40] https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales#Section-6

On a psychological level, according to Wright and colleagues, high prevalence rates of depression, anxiety, PTSD and suicidal ideation have been identified among vulnerable groups, 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[41]. Significant physical health symptoms have been uncovered as well, such as headaches, stomach pain and back pain and sexually transmitted infections[42].

In the UK however, there is still limited evidence regarding the initiatives that concentrate on the health-related needs of survivors. Additionally, relatively few services have been based on trauma survivors' and often, mental health support is not offered at all, nor are the types of therapy proposed always appropriate for addressing trauma. This can leave survivors without the necessary support and retraumatised. The reason for this lack is multiple:

Firstly, modern slavery has been addressed primarily as a criminal justice process, focusing on the detection and prosecution of criminal perpetrators. Although human rights and ethical rationale committees recognised the centrality of law enforcement in dealing with Modern Slavery, it was also noted a need to engage more proactively in victim-centred and preventative measures, therefore to involve the public health in this operation. Health implications depend on the nature, duration and severity of abuse, and require multiple interventions; however, studies suggested mistrust in these services by people experiencing MST because of stigma, fear of law enforcement and experiences of discrimination[43].

Secondly, this might be due also to the fact that if persons affected by MST are not referred by a third party such as private or public institutions, NHS staff may have contact with a patient that was trafficked or abused and be unaware of this fact or unable to support them further. In truth, one in eight NHS practitioners has been in contact with someone they knew or suspected were trafficked but lacked of opportunities during their interaction to identify and offer assistance. In these conditions, services such as SJOG that are working closely both with people affected by exploitation and public institutions, could cover this lack of access to healthcare, by referring, rising awareness and offering informed-knowledge about someone's background[44].

Thirdly, NHS and third sector services are operating in the context of long-term underfunding amidst a global pandemic. In the NHS, services are typically short-staffed with long waiting lists, with some services rationed to those who are most in need and/or most likely to benefit as a way of managing demand. While discussing with other mental health practitioners, notably with one of the providers for SJOG services, they confirmed the fact that only some cases are eligible for support, based on the gravity of their symptoms. Because some of them are under threat of evacuation, long waiting times

[41] Wright, 2020
[42] Such, 2020
[43] Such, 2020
[44] Such, 2020

for receiving health support based on the degree of vulnerability can also impact on the help provided to a survivor[45].

Finally, the concept of trauma itself represents an obstacle in the implementation of best-practice methods for people with lived-experience. UK public services face continuous change and upheaval, and the introduction of new conceptualisations of care can be challenging. Moreover, although some services are already acting on a trauma-informed basis, most centers are following the NHS Best Practice Guidelines for Mental Health.

Summary

Modern slavery is an umbrella term that encompasses several criminal offences: human trafficking, slavery, servitude and forced or compulsory labour, criminal, and sexual exploitation. Survivors of MST might have been subject to multiple traumatic experiences, both before and during slavery, but even after, due to a series of vulnerabilities they have been subject to during their life. Additionally, the lack of legal status as a citizen of a country compromises the sense of belonging and ability to integrate, while long waiting times generates financial instability, lack of access to social and healthcare services and restriction of daily activities that bring to isolation and otherness. Incomplete pathways and lack of post-NRM support would further exacerbate this state, since benefits and employment are not available for people with NRPF and no right to work, and these include most non-EU, non-British nationals.

In order to address their complex needs and to ensure a sustainable “move on plan”, services must act as an integral, multidimensional intervention, where all aspects mentioned above are considered for avoiding further retraumatisation and enhance empowerment. It is important, in fact, for all services that are involved in the support of MST survivors to adopt a TIC approach, notable within the public health and the NRM programme.

By adopting Trauma-Informed evaluation methods, based on rapport-building and informed consent, safety assessment, needs assessment and goal-setting, practitioners could have access to the history and vulnerability factors, trafficking narrative (including elements of force, fraud, and coercion) and trauma exposure, which would ensure better assessment of psychological symptoms, and determine strengths and coping mechanisms.

[45] Sweeney, 2016

Section 3

Understanding Trauma-Informed Care (TIC) Approach

A history of TIC

A Trauma-Informed approach (TIA) was first introduced in the United States as a response to growing awareness that health services were not designed to recognise the impact of trauma in children, young people and adults[46]. At that time, what developed as a necessity to understand and treat the physical and mental traumas experienced by Vietnam War survivors, has expanded in other care areas such as childhood trauma, homelessness, sexual and/or domestic abuse.

It is applicable across all sectors of public service, including social care, physical health, housing, education, and the criminal justice system and it has been described as:

> *"a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development"*[47]

Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. Trauma-informed services assume all people have had traumatic experiences, and as a result may find it difficult to feel safe within services and to develop trusting relationships with service providers[48].

The hope is that TIAs would minimise the risk that people presenting to services have their symptoms disconnected from the context of their lives. These models are based on the understanding that most people in contact with human services have experienced trauma, and this understanding needs to permeate service relationships and delivery.[49]

Trauma-Informed Practice is multidimensional and is informed by neuroscience, psychology and social sciences, as well as attachment and trauma theories, giving a central role to the complex impact of trauma in people's lives. It is applicable across all sectors of public service, including social care, physical health, housing, education, and the criminal justice system.

In the past years, various models of Trauma-Informed Approaches have been developed in order to better address the complex needs of different survivors; however, the three most prominent are the Sanctuary Model, the ARC Model, and the CARE Model [50]:

- **Addictions and Trauma Recovery Integration Model (ATRIUM)** for survivors of sexual and physical abuse who exhibit substance abuse and other addictive behaviours;

[46] Harris and Fallot, 2001
[47] Paterson, 2014
[48] Homes and all, 2021
[49] Harris and Fallot, 2001
[50] SAMHSA, 2015

- **Seeking Safety Model** is designed to attend to both PTSD and substance use disorders;
- **Trauma Recovery and Empowerment Model (TREM)** that supports women trauma survivors;
- **The Sanctuary Model** to create organisational cultural change and is structured on universal training of all staff in the organisation to define problems in a trauma-informed way, understand toxic stress, working together and creating non-violent, therapeutic communities.
- **The Attachment, Regulation and Competency (ARC)** Model is focused on supporting children, adolescents, and foster caregivers.

Understanding Retraumatisation

Most survivors of a traumatic event are able to work through their traumatic experiences, return to their regular activities, and enjoy their lives. Some people, however, experience retraumatisation and could benefit from recognising trauma symptoms, learning how to manage them, and seeking additional help as needed. As we mentioned earlier, trauma is a subjective experience and it refers more to the way the traumatic event is experienced by the person, rather than to the event itself. Recognising the risk factors for retraumatisation, may help practitioners to avoid and address potential signs and symptoms of distress. As per example:

- Having a high frequency of life trauma, such as abuse or neglect;
- Being emotionally disconnected from or not feeling love and support from others, such as family members, peers, colleagues, friends, or other loved ones;
- Living or working in unsafe situations, such as combat zones or other dangerous environments;[51]

When people experience retraumatisation, the symptoms may be recognised due to: flashbacks, distress after exposure to traumatic reminders, avoidance of trauma related stimuli, and negative thoughts or feelings that began or worsened after the trauma. Changes may occur in physical arousal or reactivity, leading to very low energy or conversely intense emotional arousal and related reactions that don't seem to match the situation. Survivors may react secondarily to these conditions through lowered self-esteem or self-confidence based on high levels of anxiety and/or shame, potentially seeing themselves as fundamentally flawed or inadequate.[52]

Several researches highlighted the importance of Trauma-Informed interventions, as a way of reducing re-traumatisation and promoting positive engagement, as per below:

- to increase engagement for "hard-to-reach" populations with treatment, reduce substance misuse, and reduce trauma related symptoms;
- to reduce the time to discharge for youth in secure care;

[51] SAMSHA, 2017
[52] Hernandez and all, 2020

- to increase offender responsivity to evidence based cognitive behavioural programmes that reduce criminal risk factors;
- to reduce restraints and seclusions for youth in secure psychiatric care[53];
- to reduce defensive behaviour, such as aggression, by considering what trauma-related triggers, including their own behaviour, might be contributing to the current situation;
- responding to defensive behaviour openly and calmly, rather than mirroring the behaviour, can potentially diffuse the level of arousal through a process of co-regulation;
- to understand triggers driving extreme behaviours as results of adaptation to past traumas rather than symptom of a mental illness[54];

Developing a Trauma-Informed Care Service for Survivors of Modern Slavery

Understanding and practicing trauma and resiliency informed care begins with recognising that trauma is common, therefore taking it into account when exploring client responses, designing service environments, and developing program activities. In fact, it is necessary to consider the possibility that traumatic stress reactions may be embedded into an individual's behavior, coping strategies, and responses in order to achieve effective outcomes related to housing and wellbeing.[55]

Trauma-informed care principles for MST

In this paper we tried to explore what are the traumatic experiences related to Modern Slavery, what are the complex needs for survivors derived from these experiences, and how to recognise signs of trauma and re-traumatisation. Based on this understanding, the implementation of a Trauma-informed Approach for MST should not only align with the six key principles of TIAs, but should also reflect the specific challenges that occur in this specific context.

Hence, for a better response to the necessities of the service, we tried to articulate the principles coined by SAMHSA[56] with the Code of Conducts for MST developed by Helen Bamber Foundation[57], as per below:

- ✓ **Establishing a safe environment:** a TIC service working with survivors should provide a calm, consistent, welcoming environment and prioritise emotional safety;
- ✓ **Developing trustworthiness and transparency:** establishing a mutual, open relationship based on trust, task clarity, consistency and interpersonal boundaries;
- ✓ **Offering systems of peer support:** survivors and practitioners should experience respect, belonging and have a support network around them; remaining safe and well during work, avoiding secondary traumatisation and professional "burnout"; additionally, mutual aid paired with shared experiences is one of the strongest means of developing self-efficacy, which is a key component to the healing process;

53 Homes and all, 2021
54 Sweeney, 2018
55 Hernandez and all, 2020
56 SAMSHA, 2015
57 Witkin and Robjant for Helen Bamber Foundation, 2018

- ✓ **Promoting collaboration**: relationships between staff members and survivors are mutual and power dynamics are shared equally between the two parts;
- ✓ **Supporting empowerment, voice and choice:** helping survivors to set realistic goals and objectives; offering informed options and discussing future plans; fostering co-production and strengths-based approach; supporting survivors to give a full account of their background as survivors of MST;
- ✓ **Attending to cultural, gender, and historical issues:** avoiding assumptions regarding their identity and choices. People can experience trauma on account of their social identity - for instance, women are more likely than men to experience serious and repeated violence in domestic settings, whilst people who identify as LGBTQ+ may be at risk of attacks from strangers. Moreover, people who do not identify as white, straight and middle-class face stereotyping and discrimination[58]; practitioners should have the knowledge and skills to work with each individual's culture and understand how one's own cultural perspectives may influence the client.

In fact, TIC services understand that when someone has been traumatised, regaining control over the environment should be the main priority, so they emphasise safety, choice, trustworthiness, collaboration, and empowerment. Ideally, services support resilience, self-care, and self-healing. As violence and healing both occur in a cultural context, trauma-informed programs also respect and include culturally specific healing modalities.

Furthermore, a Trauma-Informed Practice represents the implementation of a framework of support; it has shown to be effective with persons who have been trafficked because it recognises the impact of violence and victimisation on an individual's development and their capacity to develop coping strategies. According to SAMHSA, organisations, based on the knowledge and understanding of trauma and its implications, should adopt a Trauma-Informed Approach for supporting survivors as following[59]:

- ✓ **Realise** the widespread impact of trauma and how people might recover (realise that behaviours and attitudes often mask trauma)
- ✓ **Recognise** the signs and symptoms of trauma in those involved in the system (understanding of trauma expression)
- ✓ **Respond** by using the knowledge of trauma to improve and change practice (how to address complex needs)
- ✓ **Actively avoid and prevent** retraumatisation (ensure a safe and supportive environment)

[58] Sweeney, 2021
[59] SAMSHA, 2015; Changing lives, 2018

Review of Services Based on a Trauma-Informed Approach

In 2018, Wright and her colleagues[60] already tried to identify the main national providers that offer best practice for MST survivors, as per bellow:

Currently, the Helen Bamber Foundation (HBF) appears to be the "only clinical organisation treating survivors of Human Trafficking in the UK". Furthermore, HBF and partners resulted as one of the very few service providers devoted to designing and testing a mental healthcare support package, in cooperation with academia and other experts. Its "Model of Integrated Care" was developed specifically for "survivors of multiple trauma", including Human Trafficking and Modern Slavery. Such an integrated model entails both the provision of specialist therapeutic assistance and addresses medical, legal, housing, welfare and employment issues. Within its Trauma-Informed framework, HBF is approaching different mental health treatments for survivors, in particular looking into the Narrative Exposure Therapy, the Group Cognitive Behaviour Therapy, the Interpersonal Therapy, and a Companion Recovery Model (peer support).

The Snowdrop Project, based in Sheffield, can be seen as an organisation delivering services within a wider provision of care, often referred to as the Integral Assistance - holistic care package. The organisational structure of Snowdrop also uses a range of approaches in terms of mental healthcare: narrative exposure therapy, counselling for depression, cognitive behavioural therapy, transactional analysis, person-centred counselling.

City Hearts is also based in Sheffield and provides evidence-based services for survivors of Modern Slavery. Their Integration Support Programme provides long-term, open-ended support, post-NRM. City Hearts adopts a transparent approach, recognises the complexities surrounding Modern Slavery, such as those regarding terminological variation and the possibility of multiple sequelae in and between populations.

The City of Westminster in London also developed their strategy for ending Modern Slavery by 2026, highlighting the Ecological Model as a Trauma-Informed pathway, based on the collaboration and inter-dependency between the individual, the community, the professionals and the society[61].

What all the strategies have in common is the necessity to offer a holistic, person-centred approach, including culturally appropriate, trauma-based mental health therapies, post-NRM support and multi-agency assistance.

[60] Whright and all, 2018
[61] City of Westminster Report, 2021

Summary

Trauma-informed services assume that people have had traumatic experiences and as a result may find it difficult to feel safe within services and to develop trusting relationships with service providers. TIC models understand and address their needs, relationships and service delivery, with the aim of avoiding retraumatisation. In this section, we tried to understand what the symptoms of retraumatisation are and the core principles of trauma-informed approaches, but also how this could apply for MST services. Hence, for a better response to the necessities of the service, we tried to articulate the principles coined by SAMHSA with the Code of Conducts for MST developed by Helen Bamber Foundation.

Trauma informed services are able to recognise the impact of violence and victimisation on individuals' development and their capacity to develop coping strategies. Additionally, they would also: establish a safe environment, develop trustworthiness and transparency, offer systems of peer support, promote collaboration, support the empowerment, the voice and choice of survivor and would attend to cultural, gender and historical issues.

Some services around the country, such as the Helen Bamber Foundation, the Snowdrop Project, city Hearts or the City of Westminster already work on the provision of TIC approaches. Their models are principally adopting a person-centred approach, recognising the necessity of a multi-agency collaboration, of multiple mental health therapies, and post-NRM support.

Section 4

SJOG Delivery

SJOG approach for MST: policies and procedures

SJOG's Modern Slavery Services provide a holistic, person-centred approach, offering accommodation and outreach services to support victims of Trafficking or Modern Slavery. Safe-houses provide a safe space and a supportive environment with specialist support to help people rehabilitate and recover from their experiences. Working in partnership with The Salvation Army as part of the Government's Modern Slavery Victim Care Contract (MSVCC), teams across the country support people to reflect, recover and rebuild their lives. Additionally, a pilot project allowed SJOG services to be inspected by the Care Quality Commission, the independent regulator of health and social care in England to ensure they meet the necessary standards of quality and safety.

Being one of the main subcontractors of Salvation Army, SJOG supports more than 700 survivors every year under the NRM scheme. The protocols address many of the conditions established by TIAs. The principles rely on the practice of accessibility and non-discrimination, human rights-based, holistic approach, empowerment, freedom of thought, religion and beliefs, multi-agency collaboration, professional boundaries and safe-working.

In practical terms, SJOG addresses a series of policies and procedures[62] that aim to safeguard and protect the adults in their services. These include the Vulnerable Adults and Children safeguarding and the Anti-Social Behaviours and Conflict Management policies, designed to protect and to address signs of abuse. Advocacy and Empowerment Policy encourages survivors to support people to express their views, preferences and decisions, and the Information Security Management System policy ensures data protection along with information security, availability and integrity. General Data Protection Regulations (GDPR) policies and training secure the rights and freedoms of survivors, and protect their personal data, by ensuring that information is never processed without their knowledge and, when possible, their consent. This not only supports survivors in taking control over how their personal information is used and shared, and empowers them to understand and exercise their right to privacy, but it also contributes to the consolidation of trust towards support networks.

The Duty of Care requires that staff members need to assist the client with basic necessities with regards to: Accommodation, Financial subs and Support worker support. Staff also take due diligence in supporting the client to GP other facilities and raise suitable safeguarding alerts where applicable. Services work jointly with other appropriate agencies such as various healthcare professionals, local councils, legal advisors, etc.

Although at the moment there are no specific procedures that address the understanding of trauma and the derived complex needs of survivors, services have been already familiarised with the notion of Trauma-Informed Care though trainings (provided internally, and in some cases, by local mental

[62] www.sjogportal.uk

health professionals), allowing colleagues to acquire a basic understanding of trauma's impact on survivors' lives.

Training in Positive Behavior Support, Physiologically Informed Environments and Mental Health Recovery Model is also available to relevant services across SJOG. These models can be developed further and integrated into a Trauma-Informed Care model.

MST services viewed by SJOG colleagues

As we already mentioned, the goal of TIAs is to ensure a sense of security and autonomy for the survivor by preventing retraumatisation and promoting resilience. One challenge to this effort is that administrators, clinicians, and support staff often experience stressors related to providing care, as well as maintaining their personal wellbeing and safety. These stressors could manifest secondary traumatic stress, compassion fatigue, and PTSD. Experts such as Harris and Fallot emphasise that trauma and resiliency informed approaches must include awareness of all elements of TIC, while supporting both support workers and survivors[63].

The prevention and management of secondary traumatic stress should be taken into consideration if services aim to provide support for practitioners. In fact, training, feedback from managers and coaching improve professional knowledge and skills in trauma informed practice, increasing their sense of professional identity, while also improving their capacity for teamwork and communication. Similarly, strategies for the management of secondary traumatic stress, such as relaxation techniques, massages, yoga, exercise and music, and/or the possibility to dedicate time and resources to hobbies, will increase the ability to respond to stress in ways that are less damaging[64].

Support workers represent an essential resource and bring a multiple contribution to the service. For example, in managing a case of a trafficking victim, they will be the central point of contact to coordinate the survivors' access to medical appointments, financial support, housing, and legal services. As a central component support workers conduct needs assessments, identify and coordinate services, and initiate communication. In their role definitions, they play a crucial role in the emotional and psychological rehabilitation of the people they support, and often create a strong bond of attachment between them[65].

At SJOG, there are a range of support options available to staff members, including training, Lone working procedures, supervision and feedback.

However, as we mentioned at the beginning of this research, the aim of TIA is to acknowledge trauma in peoples' lives and to avoid further reinforcement of survivors' needs for harmful coping strategies[66]. Therefore, in order to understand to what extend colleagues who work directly with MST survivors understand and practice a TIC approach within services, we decided to introduce a 21-item survey

[63] Hernandez and all, 2020
[64] Ayre and Krishnamoorthy, University of Southern Queensland, 2021
[65] Enrile, De Castro, 2018
[66] Sweeney, 2016

tool, entitled "Knowledge, Attitudes, and Practices of Trauma-Informed Practice"[67] (See more appendix 1), adding three open questions. The assessment was based on the Likert scale, in which responders specify their level of agreement to a statement typically in five points: (1) Strongly disagree; (2) Disagree; (3) Neutral; (4) Agree; (5) Strongly agree.

This anonymous survey has been shared via email to all members of MST services, including support workers, volunteers, managers and other professionals. Finally, 22 colleagues out of 60 colleagues answered the call and completed the questionnaire.

The average results for each of the three sections were close to the maximum score, indicating a good understanding of most of the TIC principles. The knowledge section indicates that colleagues have a good awareness about trauma and its implications. The Attitude towards TIC section also revealed a general positive recognition of TIC principles, although more than half (55%) declared they lack a comprehensive understanding of the approach and believe that trauma is uncommon among the general public, but it might be common among people we support in terms of practice, there is a general agreement on the fact that practitioners comply with TIC practices in their daily interaction with survivors.

Asked how they cope with survivors who display disruptive emotional and physical symptoms, the majority revealed that additional training on trauma would be useful, as well as additional support and feedback from the team and from managers. Interestingly, most colleagues declared themselves neutral (27.3%) and/or positive (73.7%) regarding the practice of self-care at work. Some of the methods mentioned for experiencing soothing and wellbeing at work are: time management, using Personal Protective equipment (PPE) for safety and protection, good nutrition, mindfulness, positive interactions with other colleagues and regular breaks. Among the barriers acknowledged for overcoming the lack of access to self-care moments, the most common are: dedicating their time and energy for taking care of others, busy schedules, and/or shortage of staff.

Finally, another useful aspect that emerged from the survey is the fact that most colleagues (95% – 21 out of 22) claimed to have worked in the service for less than two years, and to have received at least one training session on TIC.

What we can conclude from the survey is that colleagues working with MST survivors at SJOG demonstrate a good understanding and practice of TIC principles. This suggests that the way in which the service is designed, its procedures and policies, notably, the provision social care regulated activities and the introduction of the CQC pilot scheme, correspond already with many of the Trauma-Informed principles. Additional training on trauma, stress coping techniques and a more relaxing environment would enhance the service offer for supporting both workers and survivors. SJOG selected a colleague in each region to undertake in-person TIC training in June 2022, and will extend the course to more colleagues working with survivors.

67 King S. and colleagues, 2019

SJOG Support Viewed by Survivors

For a better understanding and implementation of a Trauma-Informed Care model within SJOG services that is efficient for survivors of Modern Slavery and Human Trafficking, and for fostering co-production, we prepared a series of questions for people who are supported by our services.

Nevertheless, due to the terms required by the MDSV, we weren't able to interview directly survivors under NRM, hence, we tried to find alternative methods for obtaining the testimony of people who experienced traumatic events and have a history of vulnerability. We reached, therefore, one of SJOG's services in London, Olallo House, that offers additional support and accommodation to homeless people or at risk of homelessness, NRPF and asylum seekers, and who were eventually referred to NRM and waiting for decision. Finally, two interviews were conducted (see details in Appendix 2). The experiences narrated by survivors show that there are common elements of vulnerability both related to their background and to the present and future situation, and this increases their level of stress and retraumatisation.

Although both survivors admitted during the interviews that the conditions of living delivered by SJOG services are "nothing to complain about", and that support workers are like "family" that "looks after them", different issues regarding their immigration status/right to work were a visible concern. As first survivor was a migrant with NRPF and the second one was an EU national who did not receive a positive decision for his Pre-settlement application, they confessed experiencing current distress due to the lack working opportunities and preoccupation for their future. Moreover, the condition of their status affects both their sleeping patterns and relationships with their network. This because anxiety appears to impact their sleep quality, being unable to rest during the night, which makes them miss the chance to participate to different activities, to attend important appointments and to engage with their families and professionals during day-time. Sadly, the lack of sleep is not only associated with poor psychological conditions, but it also shadows other physical trauma symptoms such as: gastrointestinal heart disorders, blood pressure, headaches, etc.

As in both cases, the fear of "ending their stay" before solving all ongoing practices and becoming independent was a major factor of strain, a post-NRM recovery pathway would be essential for those who need additional support, for avoiding further exposure to trauma, such as risk of deportation, re-trafficking or homelessness.

Relationship issues were another element of concern that emerged from the interviews. On one side, the fact that they were not able to support their families back home was impacting their self-esteem, while the distrust and shame in disclosing their feelings with health-care professionals influenced their participation. They claimed, in fact, that sometimes "people don't care about them", that they felt "not taken on serious", or that their situation "won't change anyway". This not only indicates a feeling of helplessness, but also that the way of communicating with survivors and showing interest in what they are going through may help overcome distrust, shame and demotivation. Appropriate communication and understanding could play an important role also in the way triggers are addressed by colleagues and may decrease the frequency of incidents related to challenging behaviours.

Although the interviews took place in accordance to the principles of The Trauma-Informed Code of Conduct (TICC) developed by Helen Bamber Foundation, that ensured a safe, welcoming and private space for interaction, survivors showed a lack of trauma-awareness related to exposure to past trauma narratives, and avoided to disclosure many details about their background. Although the reason for this evasion was not clear, this highlights once again the importance of creating a trust relationship with survivors that enhances collaboration.

The challenge for services that work with survivors would be, in this context, to develop more inclusive and active forms of participation, to promote inclusion and multi-agency collaboration, and to create a safe space where survivors could feel empowered in their recovery process.

Summary

In this chapter, after reviewing the delivery of SJOG in terms of services and policies, we also intended to circulate a survey designed for colleagues working with survivors; the aim was to understand to what extend SJOG services reflect a trauma-informed environment. The policies, which are developed in order to meet Salvation Army's requirement of the Modern Slavery Victim Care and Coordination Contract's conditions, and to comply with the Care and Quality Commission standards, address many of the TIA requirements.

In addition to this, what we could conclude from the survey is that colleagues working with MST survivors at SJOG demonstrate already a good understanding and practice of TIC principles, due the procedures that are in place within services. Nevertheless, additional training on trauma, multi-agency collaboration, stress coping techniques and a more relaxing environment would further develop trauma practice for support workers and survivors.

Finally, in depth, face-to-face interviews with survivors allowed us to gain an even more comprehensive understanding about the experience of recovering from Modern Slavery. In fact, their narratives show that there are common elements of vulnerability both related to their background and to the present and future situation, and this increases their level of stress.

Section 5

The Implementation of Trauma-Informed Care at SJOG – Identifying Resources and Improvements

In the following section we better develop the necessary procedures for implementing a Trauma-Informed Care service, which takes into account the following ten implementation domains[68]. Each domain will be divided into resources available within SJOG and can be developed to improve TIC provision (please see table 2 at the end of the chapter for further reference):

Governance and leadership

This domain implies the recognition of needs and implements and invests in a sustainable trauma informed care approach.

This segment of the implementation phase of a TIC approach takes into consideration the existing commitment of the organization for providing a trauma-based services and support, in terms of procedures, policies and exposure to stakeholders. Based on the principles of TIC, a first step in this regard would be to understand the impact of trauma in survivors' life and why it is necessary to adopt trauma-informed practices.

Resources

SJOG recognises the importance of adopting this approach and therefore is committed to implementing it within its MST services. This research is an important decision in this process. The collaboration with community researchers that dedicated six months to studying and identifying the necessary resources for the implementation of TIC was part of a strategy that has long term impact.

Improvements

Trauma awareness campaigns

Educating and promoting trauma-related information and awareness among collaborators, staff members and survivors is essential for better practicing the TIC principles and understanding how to address better some complex needs deriving from trauma exposure.

Engaging existing and future stakeholders in this journey and exposing trauma-knowledge to a larger audience will represent another aspect in the consolidation of TIC principles around services that work directly with survivors in UK. One way of ensuring that partners who work closely with survivors are able to build a trustful, non retraumatising relationship with them, is to create a network of collaborators that are either trauma-informed, or willing to gain knowledge of this approach. SJOG could make use of social media, email and newsletters to raise awareness about TIC, and could organise and participate in periodic workshops related to this subject for all colleagues and to different external agencies that work with survivors. Awareness about the impact of trauma on survivors' lives would be beneficial both for partners as well as for the staff members, therefore the

[68] SAMHSA, 2015; Sweeney, 2016, Harris & Fallot, 2001; Changing Lives, 2018

circulation of information and the adaptation to TIC procedures and referral methods play an important role.

Policy

This domain makes reference to TIC protocols adopted for various service sectors, as an essential part of the organisational mission. At this stage, the charity reflects on what policies are in place and how they could include trauma support in their planning and evaluation.

Resources

Policies are developed in order to meet Salvation Army's requirement and MSVCC's conditions. As we elaborated in the previous chapter, many of the adopted procedures meet several TIC requirements, as per example:

The Anti-Social Behaviour policy covers expected standards of behavior, and the procedure to be taken when this is not followed. At the moment, this policy supports workers to respond in an adequate manner to conduct that may express signs of trauma. Survivors are also provided with License Agreement and House Rules at the moment of their placement within the service. In case of incidents such as abuse, harassment or conflicts, as per the contractual guidelines under the MSVCC, service providers would record any incidents pertaining to anti-social behavior.

Improvements

Peer support and trauma assessment are two of the elements to be taken into consideration to develop trauma informed practice further.

Physical environment

This refers to safety, collaboration, transparency and shared spaces. The physical environment of the organisation must be one that promotes safety and privacy. It must also protect against exposure to violent and sexual material that might be emotionally triggering. In fact, not only establishing a relationship of trust with survivors can be challenging even within the secure and private environment of an office, but it can be even more stressful if the context in which professionals and survivors meet and communicate does not appear safe.

Resources

A safe environment, based on trust, mutual collaboration and peer support, that aims to actively avoid retraumatisation, is another of the key principles of TIC for MST. Security, confidentiality and conflict management are some of the main priorities of SJOG services for a good practice.

For **SJOG colleagues** who are lone workers, panic alarms are connected through Solo-Protect, a deemed and effective way to connect with the emergency Services. When colleagues are working/ travelling alone, they are supported by on-call, direct contact with their line manager/service manager. Lone Workers undertake a competency assessment which must be signed by a manager and is reviewed annually, and are also required to complete Lone Working training, as well as a risk assessment. New staff members are required to have a valid DBS prior employment, and within the

first six months are inducted to all company's policies and trainings (complaints, behaviours that challenge, mental capacity, safeguarding, alcohol and substance misuse, self-harm, professional boundaries, health and safety, fire safety, anti-trafficking/anti-slavery support, etc.). Both practitioners and people supported in the service have the right to follow the complaints procedure in place and all colleagues have been trained in this procedure. Support workers are also informed about the Safeguarding team, and posters with their contact details are provided in all services. All complaints are centrally held and demonstrate the process undertaken to resolve matters and resolutions.

The Information Security Management System policy ensures data protection along with information security, availability and integrity. The CCTV allows staff members to monitor common spaces; bedrooms are private and individual, with locks at each door. There are also allocated spaces for meetings that ensure confidentiality of survivors' cases and conversations.

Psychologically informed environments are developed in our services. These aim to have the needs of each person supported taken into consideration. This ensures that there are shared and private spaces. These key physical environment features are part of our property appraisal process with adaptations made where needed.

Improvements

Survivors and staff members might benefit from further embedding Positive Behaviour Support and Physiologically Informed Environment policies, which will allow both to better reframe and to address certain behaviours, in a way that is not (re) traumatising. It is noted thus, that we currently run Psychologically Informed Environment training, but further development of the scope and breadth of training can be used to embed a PIE delivery further.

Psychologically informed environments (PIE)

Psychologically Informed Environments are services that are designed and delivered in a way that takes into account the emotional and psychological needs of the individuals. The concept of PIE has been convened by the Royal College of Psychiatry. It was recognised in fact, that high numbers of vulnerable people have needs around mental and psychological wellbeing[69].

The guidance set out a framework which can be used to redesign a service to become a PIE. The framework consists of:

- Developing a psychological framework allowing services to have a shared understanding of and response to the people they support;
- The physical environment and social spaces are adapted to improve the space available to engage and support people in the service;
- Staff training and support which enables workers to move away from crisis management and work in a more therapeutic and planned way;
- Managing relationships in order to help staff and clients self-manage their emotional and behavioural responses to triggering events;

[69] Homelessness Link, 2017

- Evaluation of outcomes to enable staff and clients to evaluate their effectiveness, for ongoing development, and to evidence service impact;[70]

Positive Behaviour Support

This model identifies the beliefs, values, and principles of care for supporting people who present behaviours that may challenge, but also seeks to encompass and drive positive practice in all areas of our work. The values, attitudes and practices of staff are central to the success of this policy and it is therefore extended to include the positive behaviour of our workforce. The procedure is intended to identify the proactive and positive strategies required to support people in their everyday lives and to enhance quality of life, personal growth, self-determination and opportunity. Although there is policy in place, developed for other services within SJOG, this approach could be explored for the MST ones as well. In addition to this, the policy includes a Positive Behaviour Support Plan that could be personalised for survivors.

Within this approach, the conditions surrounding the behaviours are changed to reduce or stop the undesirable behaviours and increase appropriate ones. By scrutinising the environment, looking for patterns and influences on the behaviour, its function or purpose can be determined, and behaviour interventions can be developed to match the function, and teach and reinforce new (replacement) behaviours[71]. Positive Behaviour support could also be a safe form of evaluating how people experience trauma and could incorporate strategies for improving the recovery process.

Post-NRM Pathway

Along with different studies about the uncertain future of survivors without status, under the support provision from the Victim Care Contract they are entitled to a further 45 days of support after receiving a Positive Ground Decision. This is unlikely to allow the necessary time for recovering and finalising a "move-on plan". An effective pathway supporting this move on plan should be developed.

Engagement and involvement

This part takes into consideration the involvement, voice, and meaningful experiences of MST survivors in all areas of organisational support plan (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support). Individuals who are in the initial phases of gaining support may not have immediate accessibility to these interpersonal skills, making the role of the case manager that much more significant. Having the case manager as a single point of contact is also a fundamental component in providing victims with essential resources[72].

[70] Homelessness Link, 2017
[71] Ayre and Krishnamoorthy, University of Southern Queensland, 2021
[72] Enrile, De Castro, 2018

Resources

Support plans

While daily support is provided, survivors are also allocated a keyworker with whom they can build a collaborative relationship and explore their needs more closely. SJOG ensures the presence of a multilingual staff member that can communicate clearly and is aware of cultural implications. Additionally, the support plan is reviewed monthly, where plans and objectives are discussed, agreed and scheduled in a careful process. As survivors should be supported to feel as confident as possible in making choices and asserting their needs, SJOG professionals attempt to always encourage individual preferences. The aim is not only to support survivors rebuilding their autonomy, but also to maintain trust and to avoid sudden changes of plans. These actions align with the principles of TIC and the Helen Bamber's Code of Conduct.[73]

Relationships

SJOG services allow survivors to visit friends/ relatives where the contact details of the person to visit is provided. Moreover, they are encouraged to engage in social activities and to build a support network based on their interests, beliefs and cultural background.

Advocacy and Empowerment Policy[74]

MST services support people in expressing their views, preferences and decisions on an equal footing, support their goals, and help them achieving their objectives, defend equal rights against discrimination and encourage the inclusion of the isolated and the excluded.

Satisfaction surveys are held annually across the services with the people we support. It is voluntary to respond but these insights help us shape delivery based on the needs and wants of the people we support. In the past these have led to changes such as providing more opportunities or culturally sensitive foods.

Improvements

Other useful recommendations include empowerment,[75] and strength-based activities[76]. Participation in meaningful activities would also increase the sense of belonging and purpose, while offering support for different coping strategies in times of distress would heighten empowerment and resilience.

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[73] Witkin and Robjant for Helen Bamber Foundation, 2018

[74] According to our policy, empowerment means enabling a person and supplying them with the means, information and confidence to make their wishes known and make an informed choice

[75] Working alongside people and services learning and testing different interventions to change the lives of people experiencing multiple disadvantages for the better – now and in the future; Fulfilling Lifes, 2021

76 A strengths-based framework focuses on the inherent strengths, talents, and assets of an individual and capitalizes of those strengths to propel them into a more successful outcome. In every aspect of treatment, the client's voice and choice is the driving force for services; Enrile, De Castro, 2018

Community resilience and co-production

Some of the questions that emerged during this study were related to the capacity of services to empower people during the waiting period: how could they facilitate the integration process and the adaptation to a new environment? How could they give equal value to the voices of both the decision makers and survivors for a better and efficient service delivery?

Co-production is when an individual or group of individuals influence the support they receive, in an environment that has equality and impact. Within a TIC context, co-production is considered to be (in part) a result of the design, administration, and dissemination of academic knowledge through collaboration among researchers, practitioners, and the survivors. True co-production is about creating a culture that challenges traditional hierarchical roles and take risks, openly acknowledging power imbalances, and distributing power equally, involving people as equals, and fully embedding this approach in the whole system[77].

Additionally, including survivors in the development and design of practices related to the needs of the service represents a good opportunity for building community resilience, increasing autonomy and addressing long-waiting times, through active participation. We have recently completed an innovation project where strategies are being developed and tested to humanise induction processes and develop visual tools for the people supported to understand where they are on their recovery journey.

Other important aspects that have been discussed in this paper take in consideration the need of initiatives aiming to facilitate belonging and inclusion, to address long waiting times, to promote advocacy and to give a public voice to marginal communities. Because of the difficulties that survivors must face during their integration process, such as obtaining a leave to remain, financial instability, the lack of access to social and healthcare services, the restriction of daily activities - their current social environment represent an additional stress.

Coping mechanisms and empowerment

Since prioritising the mental health needs of survivors is essential for sustained recovery from traumatic experiences and to increase their capacity to protect themselves from further harm, it is necessary to look for alternative ways of dealing with this without necessarily referring persons for mental health support through NHS or other public health programmes. As previously mentioned, mental health support is not always available and many of the symptoms can be addressed within a trauma-informed setting. In addition to mental health needs, there are also risks to a person's safety and protection which need to be understood and acted upon.

It has been stressed on different occasions that survivors have crucial insights into the harm caused by Modern Slavery and their own treatment needs, and they should be involved in the development of intervention models. Within this context, modern slavery survivors are seen as active participants in their care, with resources and strengths that can be used for mental health recovery. This can include factors within the individual, such as coping strategies, and also those external to them, for

[77] Fulfilling Lives Lambeth Southwark Lewisham, 2021

example their social networks. Just like trauma has been a subjective experience, recovery, in this context, is therefore, subjective and has been defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles" and as "a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness"[78].

Moreover, in the UK's mental health scene, the perspective of living well involves less emphasis on symptom amelioration, and a stronger focus on addressing psychological and social needs, supporting self-management and building individual and community resilience. This understanding is relevant to work with survivors of modern slavery, who may have mental health symptoms (ex. those related to trauma) and also a range of other psychological (ex. self-identity), social (ex. anticipated and experienced discrimination) and cultural challenges (ex. dislocation)[79]. In fact, mental health practitioners that work closely with SJOG services also expressed their preference in supporting workers to get trained in trauma management instead of assessing multiple referrals, as many symptoms of distress are related to social and psychological factors.

Peer support

People who have been exploited by a trafficker experienced isolation. Often persons who are trafficked do not know who to trust or have been put in situations where they are alone and the trafficker becomes a central figure to them. When they are coming out of trafficking, it is important to provide a range of support during this recovery process, including addressing social and emotional needs that can take place in crisis management and support groups. Peer support and self-help support are essential for creating a space where there is hope and rebuilding trust. They represent a visible recovery. Survivors can identify with others who have been trafficked and/or may have shared experiences, which can normalise what they are feeling as well as remove feelings of isolation and loneliness. Researchers that worked with survivors suggest that mutual aid paired with shared experiences is one of the strongest means of developing self-efficacy, which is a key component to the healing process[80].

Meditation and mindfulness

As the complexities of trauma are more widely understood, the integration and effectiveness of non-traditional interventions for survivors have been more widely accepted. The most commonly used are meditation and mindfulness. These practices help decrease anxiety-driven symptoms that many trafficking and trauma survivors suffer from. Through the multitude of techniques used in meditation, such as mantras, deep breathing, repetitive positive self-talk, acknowledgment and nonattachment to thoughts, an individual can enhance their cognitive flexibility and subsequently decrease their anxiety.[81]

The concept of Mindful-based intervention for practitioners is increasingly being integrated into contemporary clinical psychology and highlights the effects of mindfulness practice on coping with

[78] Wright, 2020
[79] Wright 2020
[80] Enrile, De Castro, 2018
[81] Enrile, De Castro, 2018

stress. A "mindful practitioner" would develop self-care and wellbeing through mindfulness, which will enhance a greater capacity for presence and compassion that positively benefits client care[82].

Strengths-based approach

A strengths-based assessment considers the survivor as a human being, with unique interests, concerns, assets, and goals, rather than as solely the victim of a traumatic experience. Within a trauma-informed care, it is important to recognise and develop an individual's coping skills and level of adaptation. In a trauma-informed lens, the development of adaptive coping skills can mitigate the symptoms of trauma. For example, agencies/organisations are encouraged to use "strengths inventories" as part of the assessment process. Using the strengths of survivors of trafficking helps boost their self-esteem and confidence. It will allow them to view what they are capable of.[83] Internal strengths include personality characteristics such as persistence and drive, social interest, conscientiousness, optimism, but also sources of meaning-making such as faith, connection to loved ones, or community.

External strengths include concrete resources such as having employment, financial security, stable housing, or a means of transportation. Other external strengths can be social, such as having close family relationships or a strong social support network that enables survivors to have access to professional resources and social services and engaging with the community[84.]

Locus of control (LOC)

As trauma typically involves a profound lack of control, anything that recreates powerlessness can cause harm. As we could see better in this study, the fact that survivors are often dependent on other services may contribute to this feeling and make them feel that they don't have control over their life. Trauma-informed assessments ensure that relationship-based practice is prioritised and that people feel a sense of control over what happens to them. Such collaborative, trauma-informed assessments can determine whether people have positive experiences that create safety, trust and connection, promoting agency and hope, or negative experiences that reinforce distress, distrust, powerlessness and hopelessness[85].

Locus of Control refers to the perceived control that an individual has on their life and gives further insight into the relationship that control has with the healing process. In fact, there are two types of LOC that can impact individuals[86]:

People with an internal LOC tend to believe that a person can influence the outcomes of their life and mostly have control over what happens to them.

In contrast, individuals with an external LOC believe they do not have control over the outcomes of their life and what happens to them is more up to fate, destiny, or luck. Individuals with an external

[82] Baverstock, 2020
[83] SAMHSA, 2014
[84] Wright, 2020
[85] Sweeney, 2021
[86] Zeligman and colleagues, 2017

LOC are further more likely to believe they cannot change their situation because an event (including trauma) was outside their control, and therefore may be less likely to seek ways to alleviate their emotional pain.

What is important to recollect from this approach is that those with an internal LOC have greater post-trauma outcomes, including less PTSD symptoms, and increased resilience, suggesting there may further be ties between LOC and resilience-building. In fact, those with an internal LOC are more likely to put effort into improved functioning and to try new coping mechanisms. Zhang and colleagues [86] also found that individuals with an internal LOC were protected from PTSD symptoms, suggesting that these individuals may have also had greater emotional health before experiencing trauma. Further, individuals with an internal LOC are generally more content with life, and are better at handling life's hardships[87]. Addressing survivors' Locus of Control may contribute to the creation of better resilience and autonomy.

Cross sector collaboration

Spreading awareness of what trafficking is, what it looks like in its different forms, and the powers of advocacy equip communities to become advocates for themselves. Thoughts have the power to influence one's behaviour, which is why it is important to focus on education awareness around trafficking and trauma.

Rehabilitation for this population involves participation of multiple systems. These systems are often difficult to understand and require advocacy skills to ensure that one's voice and best interests are heard and addressed. Building an effective team around any person who is currently vulnerable, wherever it is helpful and if permission is given, is an important step in the recovery process. It is important therefore to initiate contact for survivors with other known and supportive professionals who can offer additional assistance and protection.[88] When working with people who have suffered trauma, it is useful for all professionals to have a basic understanding of the effect of trauma on the brain.

Resources

Support plan review

In the referral process, interviews take place in order to determine whether a person has been subject to Modern Slavery or Trafficking, before being granted positive ground under the National Referral Mechanism. Nevertheless, little is known about their past experiences upon arrival at SJOG, therefore the process of understanding if there might be any trauma-related events is particularly long. Although services are prepared to ensure safety and support, as we explained in the previous stages, survivors are connected with different professionals after a first review and after identifying their needs.

[87] Zhang et al., 2014 in Zeligman and colleagues, 2017
[88] Witkin and Robjant for Helen Bamber Foundation, 2018

Multi-agency collaboration

Services at SJOG already have an established network of professionals with whom they collaborate on a regular basis, although sometimes very complex backgrounds require multiple interventions. In those cases, reaching out to a new agency is essential. The most common actions are: registration to a GP and addressing health related issues, application for NHS support and other benefits, contacting legal representatives, ensuring mental health and sexual health support, housing and employment, assistance with ID/passport applications, and connecting with drug and alcohol misuse or addiction programmes.

Improvements

Often, various public, voluntary and community services have their own referral procedures. This poses challenges in the continuity of support individual receive – their trauma is not known. Nevertheless, most referral agencies are specialists in working with vulnerable communities (either affected by homelessness or NRPF) therefore, some of them are already trauma-informed or have extensive knowledge in working with people with lived experiences. An important necessity that emerged from this study involves the collaboration of different mental health professionals that are specialised in working with people affected by trauma.

Mental health

Many survivors experience psychological distress as a result of traumatic experiences. Some may develop mental health problems, including Post-Traumatic Stress Disorder (PTSD), Complex PTSD, Anxiety and Depression. The Slavery and Human Trafficking Care Standards (2018) indicates that the presence or absence of mental health conditions should not be assumed: wherever possible, survivors should have access to a comprehensive mental health assessment and to a programme of specialist therapeutic care provided by an experienced mental health professional[89].

Helen Bamber Foundation also developed a report based on their experience in offering mental health support to MST survivors. According to them, some people with PTSD avoid or refuse exposure-based treatments (for ex. to therapies that involves repeated but controlled exposure to trauma-related thoughts, feelings, and situations) because of the distress that they anticipate, or because of other barriers including shame. They recommend, in such cases, longer-term individual therapy that does not address the trauma material, but instead focuses on establishing a trusting therapeutic relationship as a model for future relationships.[90]

Some of the most common and evaluated therapies for MST survivors are:

Cognitive Behavioural Therapy (CBT)

89 The Slavery and Human Trafficking Care Standards (HTF 2018 Op.Cit), Chapter 5, Access to Healthcare for Survivors & Annex 1: 3-Stage Therapy Model for Survivors, in Witkin and Robjant for Helen Bamber Foundation, 2018

[90] Helen Bamber, 2015

Cognitive Behavioural Therapy is considered to be evidence- based collaborative therapeutic approach that is usually short term. The therapy aims to change the way an individual feels by making positive changes to the way they think and behave; it is based on the assumption that thoughts, emotions, physical sensations and behaviour are all interlinked. The therapy tends to focus on current problems, but past experiences may be explored if they are related to current thoughts and feelings. CBT can also be offered in groups. CBT is a dominant psychological therapy in the western countries, but has been usefully adapted in a number of different cultural settings.[91]

Developmental Trauma Disorder Therapy (DTD)

Developmental trauma is a term which describes the origins and presentation of a significant number of adults (and children) and results from trauma experienced in a child's early development. Such trauma can arise from maltreatment, family violence, or a disruption in attachment to their primary caregiver(s). In general, treatments for developmental trauma disorder focus on establishing safety and competence. As an adult, survivors can learn how to move forward, reducing the pain they feel and improving their quality of life no matter how long it's been since the trauma occurred[92].

Posttraumatic Growth Therapy (PGT)

Posttraumatic Growth encompasses the psychological improvements and strengths a person develops following times of extreme stress or trauma. Further, experiencing PTG has associations with positive mental health outcomes, such as enhanced relationships, new views on life, and shifts in views of oneself. In fact, after a traumatic event, views of self and the world are often challenged and even destroyed. This can result in a search for meaning to reconcile the purpose of existence and new worldviews, which in turn can result in growth. Research on Auschwitz survivors found that when meaning can be found, growth and enhanced life satisfaction can result, transforming suffering. Trauma survivors have qualities and coping strategies that have helped them to survive tragic experiences[93].

Screening, assessment, treatment service

According to the Code of Conducts developed by Helen Bamber Foundation for MST survivors, all current safety risks should be assessed as quickly as possible for each person and then monitored on an ongoing basis.

One major exposure is the potential harm and reprisals from traffickers or networks against survivors or their family members. However, there are many other risks to consider, for example, to their physical health, mental health, safeguarding issues, immigration status, housing & welfare, and current relationships.[94]

Based on a project lead by the Trauma Centre at Justice Resource Institute, the assessment of trafficking survivors can be an essential first step in creating safety, meeting daily needs, identifying

[91] Helen Bamber, 2015
[92] Helen Bamber, 2015
[93] Zeligman and colleagues, 2019
[94] Witkin and Robjant for Helen Bamber Foundation, 2018

persons at-risk, making referrals for intervention, and paving a path for recovery. Whether a survivor chooses to pursue therapy or not, a Trauma-Informed assessment can afford an opportunity for them to gain information and to learn and practice emotional regulation tools through this form of brief intervention[95].

Trauma screening has been described in the literature as "a brief, focused inquiry to determine whether an individual has experienced specific traumatic events"[96].

Assessment is crucial. It advises practitioners to ensure their questions are thorough and open enough to provide a wide interpretation and to supply a variety of answers. However, understanding and addressing trauma is a complex, multidimensional approach; one of the obstacles that many services face in this process is indicated by the assessment phase and the evaluation of survivors' complex experiences[97]. In most case study areas, universal trauma screening was not considered applicable for most organisations. This is because addressing sensitive topics implies adopting an appropriate approach, and the development of the necessary instruments was time consuming and would have challenged the structure of the service.

The mental health problems of survivors are rarely immediately visible or obvious to others. People who have been trafficked and enslaved become used to minimising, concealing or denying their injuries and suffering in order to survive. Survivors may feel nervous, afraid and confused at the first assessment. As noted during our interviews, many experience feelings of shame and humiliation, which can prevent them from being able to express themselves and to assert their needs with others. Those who have post-traumatic stress disorder (PTSD) may go to great lengths to avoid speaking about traumatic aspects of their history because they fear that their symptoms become pronounced.

Resources

Needs and risks assessment plans

In order to offer support, we have a personal needs assessment so that individual steps towards recovery are planned. Survivors who are supported at SJOG are engaged in monthly risk assessment plans where any element that is considered harmful or worrying for the wellbeing and safety of the person is reported in the system. Based on this evidence, prevention and or/intervention actions are established by the team and the line manager to avoid further implications.

Handovers/ case reviews

It can be difficult for colleagues to recognise and report more subtle signs of trauma, both physical and psychological. Concerns and observations about sudden changes in survivors' behaviours and moods are reported during staff meetings and in the support plan system. This involves daily handovers between colleagues, writing about daily interactions with survivors and discussing weekly case reviews with line managers.

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[95] Wright 2020
96 Harris & Fallot, 2001
97 Sweeney, 2015

Improvements

Trauma-Informed psychological assessment

According to Wright and colleagues, an assessment process can be the first step in intervention; for this, a trauma-informed psychological assessment should be an empowering process for each survivor. The aim is to approach the person as a human being, with unique interests, concerns, strengths, and goals, rather than a survivor of human trafficking. This way, it would empower the person to view themselves as someone who is more than the sum of the difficult experiences in their life. However, active consent for participating in assessments can be a challenge because practitioners are often seen as authorities, and some survivors may feel the need to push back against recommendations in order to feel some sense of control. For this reason, time should be devoted to building rapport and offering information so they can make informed choices about their involvement in the process and with whom information can be shared[98].

The assessment process should balance between the identification of the psychological impact of trafficking experiences and the identification and development of resiliency in survivors.

Necessary steps for a successful assessment:

- **Building rapport**: by offering information and resources about how trauma assessment can promote health and empowerment.
- **Obtaining consent;** ensuring that consent is agreed and the individual is fully informed.
- **Safety assessment:** a safety assessment will include information about threats from the trafficker(s), history of physical assaults and harm, etc.
- **Needs assessment and goal setting:** assessment reviews a wide variety of current needs such as the need for shelter or housing, lack of basic necessities (clothing, food, and personal care items), medical or dental problems, communication barriers, transportation issues, immediate financial needs, etc.
- **History and vulnerability factor:** traffickers typically target people who are vulnerable in some way, whether that is due to poverty, lack of access to education, lack of resources and opportunities, chronic unemployment, discrimination, displacement or unstable living conditions, history of trauma exposure, lack of a supportive care giving system.
- **Trauma exposure:** the extent of information obtained about the trafficking experience should be tailored to the purpose of the evaluation; for physiological wellbeing, very limited information on the trauma exposure may be necessary.
- **Assessment of psychological symptoms:** struggles with emotional dysregulation, sleep disturbance, distressing memories, nightmares, depression, anxiety, stress, social isolation, and mistrust of other people.
- **Strengths:** identifying potential external and internal strengths can be used to develop a safety network of support).

[98] Wright, 2020

Training and workforce development

Within a TIC approach, practitioners recognise that behaviours and attitudes often mask trauma; their priority is not to retraumatise clients with repeated assessments or internal processes. Instead, they focus on engagement, using empathy, consistency and good boundaries to build strong, trusting relationships.

Resources

Training for SJOG colleagues

Training and understanding of survivors' trauma are offered in SJOG services, including a general overview on Psychologically Informed Environment. Some services have external access to trauma-informed workshops, supplied by local initiatives or mental health collaborators. Support workers at SJOG have been enrolled to numerous online courses designed to work with vulnerable persons and with people with complex needs. This covers Safeguarding, Health & Safety, Data Protection, Equality, Diversity and Inclusion, Person Centred Care, Mental Health.

Wellbeing

Additional supervisions, de-brief sessions (with an independent colleague who has not been involved in the incident), group supervisions and team meetings, allow colleagues to create a collaborative culture that ensures peer-support within the team. Colleagues also have access to Mental Health First Aiders throughout the charity, and to Bright Line which is a confidential telephone line managed by the mental health first aiders. Alongside this, support workers have access to the Employee Assistance Programme where they can receive counselling.

Improvements

Extensive training in trauma understanding should be available based on role (e.g. team leader, deputy or service manager), as well as procedures and benefits that help address colleagues' wellbeing and ability to cope with emotional stress.

Understanding and addressing signs of trauma

A better understanding of trauma symptoms is necessary to deal with situations where survivors appear distressed. Being able to identify and support the person in the moment would have a positive impact both on support workers and survivors.

Different techniques and methods for engaging with vulnerable persons, where practitioners recognise signs of trauma, would help prevent retraumatisation. For example, if survivors become distressed or overwhelmed at any time in the course of a meeting, a helpful technique is to quickly return their focus to the "here and now". It is also suggested to keep simple objects nearby, (such as plants, paintings, photographs, pebbles, beads). These techniques can shift the direction in a conversation because they provide a pleasant focus point for distraction and discussion.[99] Returning to discussion of current minor, practical issues and the planning of small actions that relate to

[99] Witkin and Robjant for Helen Bamber Foundation, 2018

survivors' current needs, is also helpful. This can be effective in helping them to regain the feeling that they are safe and in control.

Communication

It may be easier for survivors to answer questions such as 'how have you been sleeping', 'what is your energy level like' or 'how is your appetite', rather than a more ambiguous question such as 'how are you feeling'. Promotion of health behaviours can also be concrete, such as offering information on sleep hygiene, nutrition, and physical activity. As it is very rare for trauma survivors to spontaneously disclose their trauma experiences, health practitioners and support worker often fear asking people about their past or current experiences of trauma. Read and colleagues[100] report a range of reasons for this reluctance to ask, including:

- a need to focus on immediate concerns;
- fear of causing distress; fear of vicarious traumatisation;
- holding a biogenetic causal model of mental distress;
- lacking training;

They recommend instead:

- ask everyone about their experiences of trauma and abuse;
- ask at the initial assessment, but not during a crisis;
- ask in the context of the person's general psychosocial history;
- preface trauma questions with a brief normalising statement;
- use specific questions, with clear examples.[101]

In this context, where a person discloses trauma and abuse, support workers are recommended to respond in the following way: reassure the person that disclosure is a good thing/ to not try to ascertain the details of the trauma or abuse/ ask if anyone has been told previously and how that went/ offer trauma-specific support and know how to refer people to it/ ask whether the trauma is related to their current difficulties/ check their current safety (freedom from abuse)/ check the person's emotional state after the conversation/ get in touch to follow up with them;

Coping strategies

It is important to establish support with coping strategies as per The Trauma-Informed Code of Conduct[102]: This involves recognising signs of trauma, focusing on current and future safety (communicate clearly including, assess risks and needs and escalate issues, ensure safeguarding procedures, create personalised support plans, create support team), vetting other people who accompany survivors, working with interpreters (cultural sensitivity).

Often, extreme behaviours can best be understood as a survivor's attempt at coping, connecting and communicating their pain. A recognition that people adapt to trauma in order to keep themselves

[100] Read and, 2007 in Sweeney, 2018
[101] Read and all, 2007 in Sweeney, 2018
[102] Witkin and Robjant for Helen Bamber Foundation, 2018

safe (including abuse of substances, cutting, becoming aggressive, withdrawal or dissociating) could help service providers to work with clients to develop healthy substitutes**.** Therefore, support workers should also be aware of different techniques for helping survivors manage retraumatisation, such as the ones provided by SAMHSA[103]:

- Appreciate the impact of the original trauma. To not underestimate the experience, but also to recognise the strength and ability to recover;
- Understand how and why the event happened;
- Connect with people who understand and help through trigger events;
- Ensure that a support system is easily accessible and consists of people who know, accept, and care for the survivor;
- Develop effective coping skills (e.g., stress management, self-care, and social support, especially peer support);
- Have a self-care plan that includes strategies for building resilience (ex, get regular exercise, set aside quiet time for meditation or relaxation);
- Practice spiritual beliefs or reach out to a faith leader for support;
- Seek care from a trained, trauma-informed provider who can recognize retraumatisation symptoms and offer evidence-based treatment and guidance;

The access to coping strategies and stress management, should be taken in consideration both for survivors and practitioners. In fact, for this last category, training, feedback from managers and coaching would make them gain professional knowledge, and skills in trauma informed practice strategies for the management of secondary traumatic stress, such as relaxation techniques, regular breaks, massages, yoga, exercise and music, and/or the possibility to dedicate time and resources to hobbies, will increase the ability to respond to stress in ways that are less damaging.

Progress monitoring and quality assurance

This makes reference to the ongoing assessment and monitoring of trauma-informed principles approach that differentiates it from the usual approach.

Resources

Quality audit process

Offering support and accommodation to vulnerable persons and to survivors that are under NRM, SJOG services are visited every year by inspectors from Salvation Army and the Care Quality Commission pilot scheme to ensure procedures are followed correctly, as per latest legislations. This is in addition to monthly internal quality audits. During the visits, procedures, environment, documents and interactions with staff members and people supported are reviewed to establish compliance with health and care policies that provide people with safe, effective, compassionate, high-quality assistance.

[103] SAMSHA, 2017

Feedback from inspectors allows services to improve and to review their strategy for the coming year. Staff members and survivors also have the possibility to provide comments at any time through allocated feedback forms and through monthly supervisions and plan reviews.

Our internal monthly audits cover over 60 items across support provision, HR, information security, accommodation, property, health and safety. This allows any issues to be flagged effectively and mitigation plans put in place.

Improvements

The internal quality assurance framework can be adapted to cover the core principles of TIC. This will ensure colleagues internally and external partners of TIC practices being completed and a high standard of support being delivered.

Financing

Financing the implementation of a TIC approach within SJOG services plays an important role in the development of this model.

Resources

SJOG allocated a budget for a research study on Trauma-Informed Care for MST and is currently looking to funding support for ongoing training on trauma, leadership and staff development or for developing collaborations with peer specialists.

We are also able to refer colleagues to receive formal qualifications where bursary schemes are available.

Improvements

Investment in TIC can be built into service budgets to support continual improvement to offer the best support possible which has benefits for the wider public health sector.

Evaluation

This last stage in the implementation of a TIC approach refers to measures and evaluation used for assessing the effectiveness and embeddedness of Trauma Informed Practice within an organisation. This covers:

Resources

At this date, SJOG developed a series of questions addressed both to staff members and survivors for a better interpretation of their experiences and understanding of trauma. As explained previously in this study, an anonymous survey has been shared with practitioners and interviews with survivors took place. We also have confidential processes for individuals to raise concerns about the service and support.

Improvements

Evaluation of outcomes and internal process is to be embedded to ensure quality of support and adoption of the latest evidence based on best practice. This can take the form of an advisory council and co-production workshops.

Summary

Following the ten implementation domains of TIC, we tried to establish what the resources and procedures are already available at SJOG, and what improvements can be put in place to develop better practice (see Table 2).

Table 2 – Implementation of TIC at SJOG: Resources and Improvements

Implementation Domain	Current resources	Improvements
Governance and Leadership	Research, Policies, Models, Data	TIC Awareness and Advocacy, TIC Model
Policy	Policies regarding Safeguarding, Data protection, Empowerment, etc., Procedures (risk assessment), Conflict Management (complaint Policy, Anti-Social Behaviour)	TIC policies (adapt or renew existing policies, creating new ones)
Physical Environment	MSVCC contract, safe houses, Duty of Care, Data Protection, House Management, Private Spaces	Positive Support Plan Addressing anti-Social Behaviours timely manner, Post-NRM support (accommodation)
Engagement and Involvement	Advocacy & Empowerment Policy, Multilanguage staff, Case working, Individual support plans	Understanding of own trauma, Coping strategies, Strength-based approach, Motivation/Empowerment, Community building activities
Cross-Sector Collaboration	Immigration advice, Housing, Medical assistance, Addiction misuse support, Employment, Education	Trauma-based mental health therapies, In-house immigration service, TIC awareness among professionals, Personalised multi-agency support
Screening, Assessment, Treatment Service	Safety and Needs Assessment, Goals and Network, Identifying distress, mental and physical health assessment	Recognising assessment process as first step of intervention, Assessment of past experiences, trauma symptoms, Identifying internal and external strengths, resilience development, Emotions regulation tools
Training and Workforce Development	TIC presentation for colleagues	Providing tools for survivors and staff, Teaching techniques and appropriate language for addressing trauma

Progress Monitoring and Quality Assurance	Care Quality Commission, Modern Slavery Victim Care Contract, Feedback Forms, Plan and case reviews, Monthly supervisions	Monitoring TIC progress and procedures
Financing	Budget allocated for research	Looking for further funding opportunities for TIC implementation
Evaluation	Survey and interviews with colleagues and survivors	Evaluation of TIC procedures once implemented

What emerged from this analysis was that many of SJOG's policies meet several TIA requirements. These include procedures regarding safeguarding, safe environment, data protection and consent, empowerment, anti-social behaviours, person-centred support, and cross sector collaboration.

This foundation can be developed to offer improved TIC practice. Survivors would benefit from a fuller trauma understanding assessment, trauma-based mental therapies, peer support and strength-based approach, empowerment and civil/civic engagement for sustaining a purpose. Some of the proposed improvements are challenging due to the external socio-political environment such as post-NRM plans. Nevertheless, access to a range of coping strategies and stress management, together with a collaboration of multiple agencies around a support plan appear necessary for a more efficient and a faster recovery process.

Section 6

A Trauma Informed Pathway for MST

Avoiding retraumatisation

The need to address trauma across health-care organisations is increasingly viewed as an important component of effective support and the ability to cope with retraumatisation. This implies gathering evidence of the fragmented and often contradictory stories of survivors' and using their trauma-informed understanding for providing clear information for partners and collaborators. In fact, according to SAMHSA, organisations are encouraged to examine how a trauma-informed approach will benefit all stakeholders[104].

As we observed in the previous chapters, a TIC environment could successfully contribute to the engagement of "hard to reach" population and to the reduction of criminal risk factors, of substance misuse and symptoms of trauma, which include triggers and defensive behaviours.

Different aspects are to be considered for creating a safe space that avoids retraumatisation within MST services: the environment, policies and procedures, communication and training, external support, physical and psychological wellbeing, to name a few. At SJOG, the foundations for a TIC approach have been developed (see section 5). After identifying resources and improvements the aim was to develop a model of intervention that offers the best support to survivors in addressing current and further vulnerabilities. The model will be based on the findings we gathered in this research concerning the retraumatisation factors in survivors' lives, and their needs derived from these contexts.

This study highlighted how many stress factors are due to the survivors' current social environment, such as the lack of immigration status, lack of trust in support services, lack of familiarity with the host country, lack of a stable shelter and income, and even lack of purpose and demotivation due to long waiting times.

While many of these experiences are related to their status, additional pre-existing conditions due to a vulnerable social and cultural background, including the modern slavery experience, may erode a person's coping mechanisms and lead to retraumatisation[105]. In this context, survivors could show symptoms of trauma such as flashbacks, distress, overwhelming emotions, difficulties in controlling fear and anger, and may have other mental health needs such as depression and anxiety, or may struggle with substance misuse. They could be more likely to have feelings of shame and lack of trust in others, therefore they may have problems sustaining stable relationships and receiving the necessary support.

It is important, therefore, that the new integration model based on Trauma-Informed Principles, takes in account the factors that could contribute to retraumatisation, and deliver the necessary support

[104] SAMHSA, 2015

[105] The Innovation and Good Practice Team in Briefing for Homelessness Services, 2017

for survivors to have a stable foundation for recovery. This includes, for example, ensuring a minimum of 12 month of supported accommodation, and delivering a post-NRM programme where possible as it can take significant time for victims to feel safe enough to process their traumatic experiences through counselling or to engage with police investigations.

Providing the necessary strategies for the management of traumatic stress, such as relaxation techniques, coping mechanisms, and/or the possibility to dedicate time and resources to hobbies, will increase the ability to respond to stress in ways that are less damaging and would relieve pressure from NHS services who are typically short-staffed and have long waiting times for referrals. Access to different mental health therapies that are trauma oriented will support survivors in engaging with the right professionals at the right time.

MST survivors also need time to gain skills, experience and confidence that will enable them to live a full and integrated life in society, but also to be able to establish connections with legal representatives that will help them with their case. There is a need to create a safe, culturally responsive environment, where survivors can start coping with their trauma and to build trust with their support team.

An evidence-based pathway

In this paper we've carefully employed the term "survivor" for referring to someone who was subject to Modern Slavery, as we did not wish to consider them "victims", but as individuals with agency, who are rebuilding their life, a life worthwhile. Therefore, the outcomes of our pathway are defined by a research study carried out in 2019 by SJOG that explored what makes a life worthwhile[106]. In the study 112 people across 12 services participated. It revealed that relationships, meaningful activities (purpose), and health and wellbeing were the primary themes that contribute to a worthwhile life. Relationships were the main theme with 91.6% of people having reporting families as making their life better, followed by Meaningful activities for reinforcing purpose (46.7%) and Health and wellbeing (23%).

To achieve these outcomes for the people who are supported, our evidence-based Trauma Informed Care Pathway covers key themes of the context of trauma, needs of individuals, service support and finally these combine to achieve outcomes: health and wellbeing, purpose, and relationships. The pathway is outlined in figure 2 and presented in full in figure 3.

The model attempts to mobilise the best practice in the area and direct this into bite size service support elements for each individual. In figure 2 service support is cyclical. This recognises that actions, stakeholders and methods are not static but dynamic. They are developed throughout service delivery responding to the needs of the communities that are being supported and the types of traumas being displayed. What this does is to frame these within a defined structure so they are aligned to positive and consistent outcomes.

[106] Mackrill for SJOG, 2019

Figure 2 – SJOG Trauma Informed Care Pathway structures

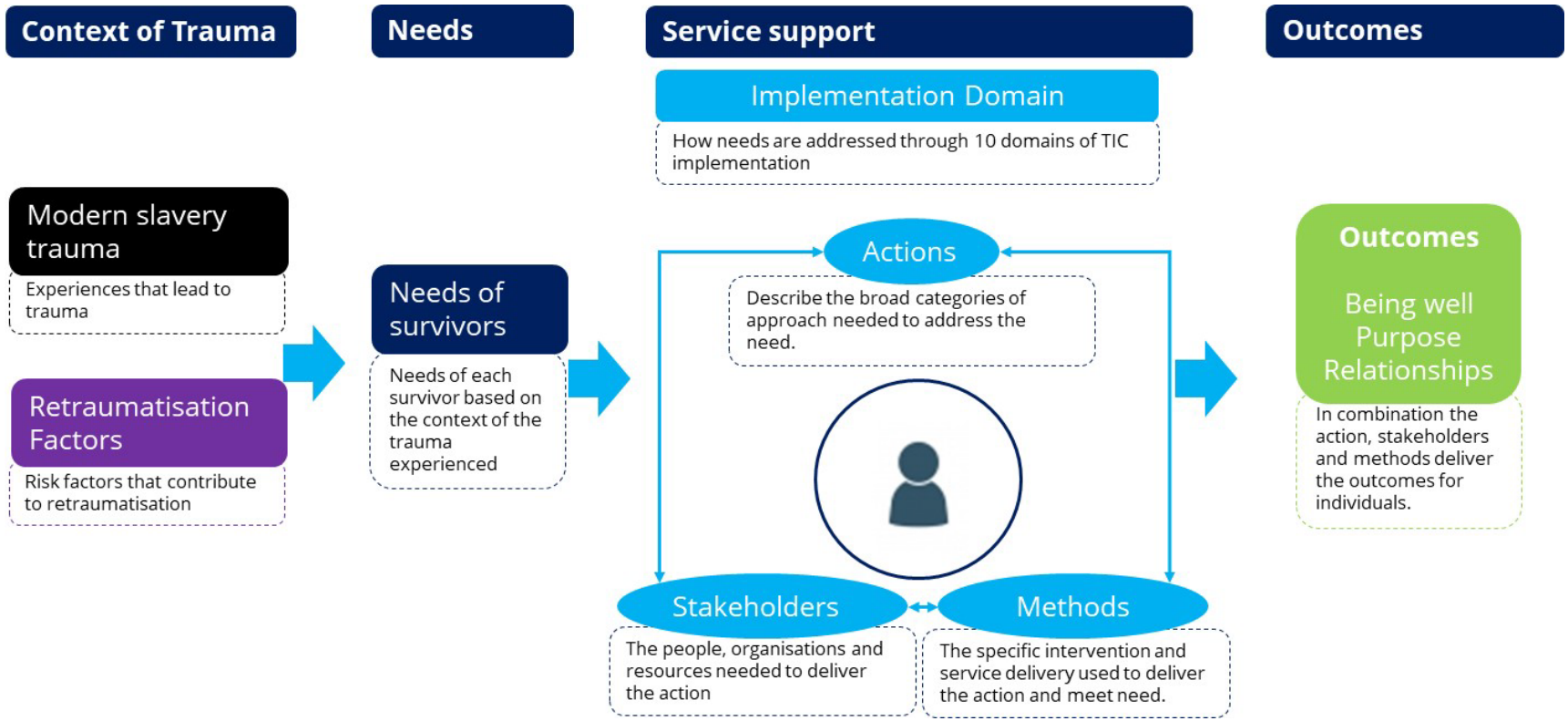
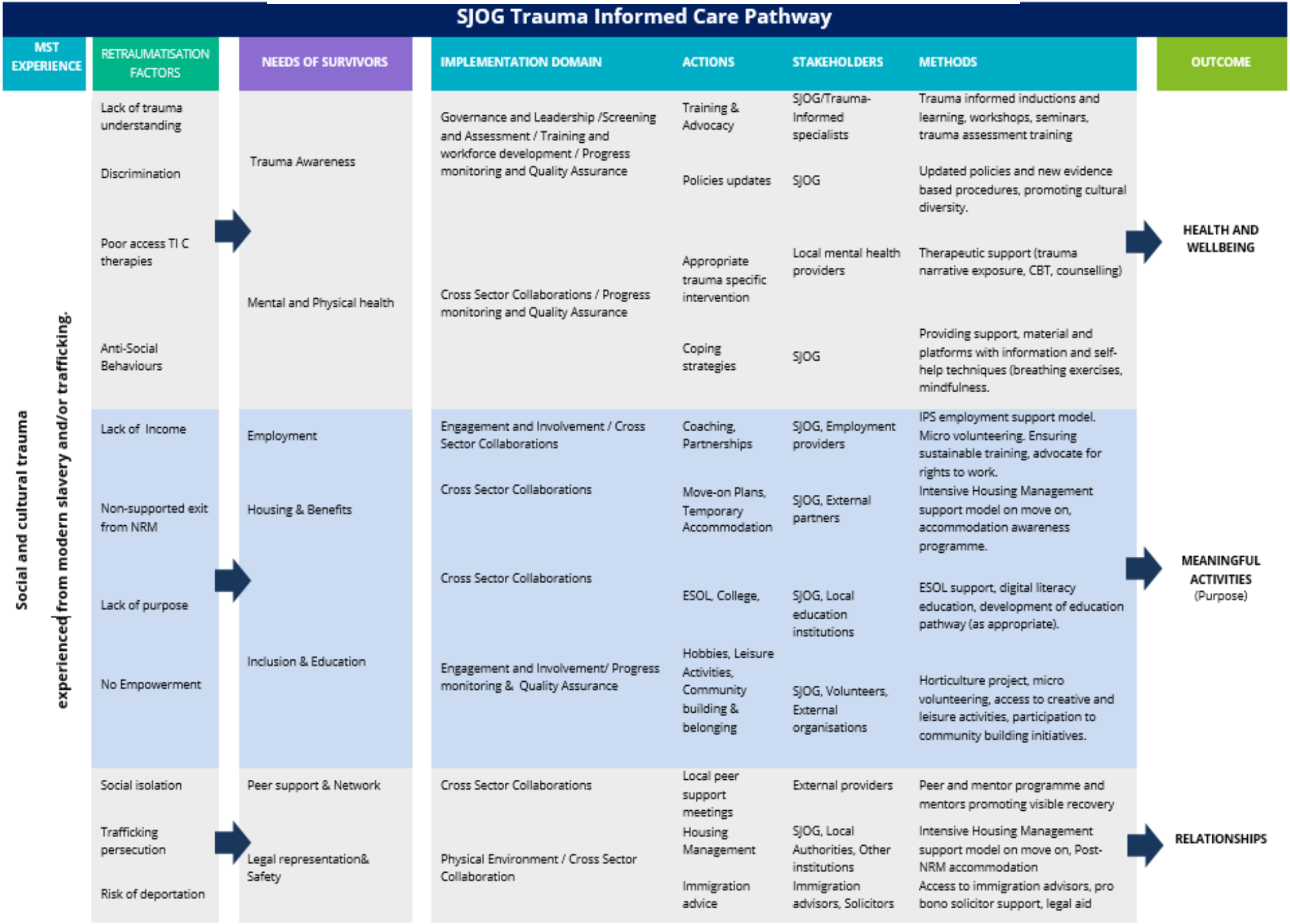


Figure 3 – SJOG Trauma-Informed Care Pathway



Summary

In this final chapter we aimed to articulate the MST experience, the retraumatisation factors and the resultant individual needs, to the TIC implementation domains, the necessary TIC actions, the stakeholders involved, and the specific delivery methods.

The pathway is underpinned by evidence from literature as presented in from previous sections regarding the need to adopt intervention methods such as: Psychologically Informed Environment that includes a Positive Behaviour Support plan for addressing symptoms of trauma, including addictions, trauma-assessment that incorporates strengths and coping strategies for a better healing process, different types of mental health intervention, peer support, social inclusion, trauma awareness and training and finally, a post-NRM support programme for avoiding further vulnerabilities.

The aim is to develop a Trauma-Informed Care pathway that will address all issues discussed previously. This is a survivor pathway recognising individuals with agency, who are rebuilding their life, a life worthwhile. Consequently, health and wellbeing, purpose and relationships are positioned as the main outcomes. Ambitious in the scope of the pathway, it requires a breadth of skills in house along with partnership work to offer employment and work initiatives along with embedded mental health support provision.

Conclusion

This report aimed to explore the concept of Trauma-Informed Care (TIC) and the development of a new model of intervention for SJOG's Modern Day Slavery (MST) services.

After examining the origins of trauma and its impact on people's lives, we could affirm that trauma occurs when harmful events happen, that erode individuals' capacity of coping with situations, and as a result, could induce lasting mental, physical, emotional and/or social consequences. Different researches demonstrated that traumatic events arise more frequently among people from low-socioeconomic environments, due to poverty, marginalisation, conflicts, and childhood adverse experiences. Consequently, individuals with a vulnerable social and cultural background are more likely to be affected by trauma and to experience mental health issues.

Through this research, we demonstrated how MST survivors experience trauma before, during and after the NRM referral, leading to a series of vulnerabilities and derived complex needs that could continue affecting their wellbeing. Subsequently, in section 2, we identified various retraumatisation factors to be addressed for a better practice and effective support: the lack of legal status as a citizen of a country, which compromises the sense of belonging and ability to integrate, long waiting times that generate financial instability, lack of access to social and healthcare services, poor physical and mental health, addictions that restrict daily activities and bring to isolation and otherness, incomplete recovery pathway, risk of homelessness, deportation or re-trafficking.

According to SAMHSA (Substance Abuse and Mental Health Services Administration), organisations that are based on Trauma-Informed approaches are able to recognise that trauma is common, therefore, to take it into account when exploring client responses, designing service environments, and developing program activities. As we aimed to understand how we could design a service that delivers best practice, in section 4, we articulated the SJOG's current procedures to the principles of TIC and the Code of Conducts for MST developed by Helen Bamber Foundation. Through this review SJOG's current policies for MST, which are developed in order to meet Salvation Army's requirement of the Modern Slavery Victim Care and Coordination Contract's conditions, and to comply with the Care and Quality Commission standards, address, in fact, many of the TIA requirements.

Finally, in the last two chapters we followed the ten implementation domains of TIC for establishing what are the resources and procedures already available at SJOG, and what improvements can be made. This culminated with the design of an evidence-based pathway for a trauma-informed intervention at SJOG, recognising that each person has individual agency to achieve outcomes across health and wellbeing, purpose and relationships.

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Appendix 1

Knowledge, Attitudes, and Practices of Trauma-Informed Practice Scale

A 36-item survey tool, "Knowledge, Attitudes, and Practices of Trauma-Informed Practice," was adopted and modified with permission from the author (Abdoh et al.) This 21 factor analysis scale is assessing the staff knowledge, attitude and practice related to TIC. The tool has been standardised by demonstrating the construct validity via Factor Analysis. The reliability was also shown as all the subscales demonstrated the p value above 0.7 which is desirable. In the final 21-item model, 7 items measure knowledge (5 items removed), 8 items measure attitude (2 items removed), and 6 items measure practice (0 items removed). Finally, 3 open questions have been added.

Reference: King S., Chen K-L D., Chokshi B., Becoming Trauma Informed: Validating a Tool to Assess Health Professional's Knowledge, Attitude, and Practice, in Pediatr Qual Saf., 4(5): e215, 2019 Sep-Oct;/ doi: 10.1097/pq9.0000000000000215

Below is the list of statements about feelings and thoughts. Please tick the box that best describes your overall experience regarding the understanding of trauma in your service:

TABLE 1

Age	20-25	26-30	31-35	36-40	41-50	50+
Role	Manager	Team Leader	Support Worker	Care Assistant	Other	
Years of experience in current role	<2	2-5	6-10	>10		
Participated in any trauma-informed practice/training	yes	no	I don't know	No response		

TABLE 2

Factors	Statements	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Knowledge	1. Exposure to trauma is common	1	2	3	4	5
	2. Trauma affects physical, emotional and mental wellbeing	1	2	3	4	5

	3. Substance use issues can be indicative of past traumatic experiences of ACEs	1	2	3	4	5
	4. There is a connection between mental health issues and past traumatic experiences	1	2	3	4	5
	5. Disruptive behaviours can be indicative of past traumatic experiences	1	2	3	4	5
	6. Retraumatisation can occur unintentionally	1	2	3	4	5
Attitude	7. Recovery from trauma is possible	1	2	3	4	5
	8. Paths to healing/recovery from trauma are different for everyone	1	2	3	4	5
	9. People are experts in their own healing/recovery from trauma	1	2	3	4	5
	10. Informed choice is essential in healing/recovery from trauma	1	2	3	4	5
	11. TIC is essential for working effectively with people we support	1	2	3	4	5
	12. I have a comprehensive understanding of TIP	1	2	3	4	5
	13. I believe in and support the principles of TIP	1	2	3	4	5
	14. I share my expertise and collaborate	1	2	3	4	5

	effectively with colleagues regarding the use of TIP					
	15. I would like to receive more training on TIP	1	2	3	4	5
Practice	16. I maintain transparency in all interactions with people I support	1	2	3	4	5
	17. I offer choices and respect opinions	1	2	3	4	5
	18. I help people I support to recognize their own strengths	1	2	3	4	5
	19. I inform people I support of my actions before I perform them	1	2	3	4	5
	20. My interaction with each person I support is unique and tailored to their specific needs	1	2	3	4	5
	21. I practice self-care (taking care of my own needs and wellbeing)	1	2	3	4	5

1. What does care and wellbeing mean to you? Do you feel that you can practice self-care at work?
2. How does being in close contact with people who experienced trauma impact you? Do you feel that disruptive behaviours/coping mechanisms due to trauma are addressed in a way that is supportive for staff and residents?
3. Do you have further comments/remarks?

Appendix 2

Interview with Survivors of Trauma - Homelessness

Doing qualitative or quantitative research is a necessary method in the implementation, evaluation and development of policies and processes within an organization and can be used to create or revise necessary institutional practices for a better intervention. This implies adopting a certain responsibility for ethical concerns when being in contact with actors involved in the subject of the study. Traditionally, the research integrity principles are based on respect for the person, honesty, transparency and accountability[107].

For a better understanding and implementation of a Trauma-Informed Care model within SJOG services that is efficient for survivors of Modern Slavery and Human Trafficking (MST), we prepared a series of questions for people who are supported at Olallo House, in London.

We interviewed individuals who experienced traumatic events and have a history of vulnerability, homeless people or at risk of homelessness, NRPF and asylum seekers and eventually referred to NRM and waiting for decision. Two interviews were conducted.

In order to follow the best ethical guidelines when asking sensitive questions to survivors, the interviews took place following the principles of The Trauma-Informed Code of Conduct (TICC) developed by Helen Bamber Foundation[108], designed to enable professionals in all fields of discipline to:

- establish and maintain a mutual relationship of trust with survivors in any working context or environment;
- impart a consistent sense of calm, security and safety throughout the course of the interview;
- increase the confidence of survivors and minimise the risks of causing distress and re-traumatisation;
- remain safe and well in the course of their work, avoiding secondary traumatisation and professional 'burnout';

In practical terms, this implied:

[107] Carpenter and colleagues, 2020
[108] Witkin and colleagues, 2018

- proceeding sensitively and simply observing each person's presentation and manner, providing them with appropriate physical space, and ensuring that they are as comfortable as possible;
- providing a simple explanation of the professional role of researcher before any interview commences; check if they understood the information and if they have any questions;
- providing the option of using an interpreter should always be offered if the language of the country they are now in is not their first language;
- keeping simple objects nearby (for example plants, paintings, photographs, pebbles, beads). These can assist a swift change in conversational direction in case of distress–refer to "here and now";
- maximising light and space in the meeting room or area. Ensuring that each person has the ability to move around as much as possible and to choose where they want to sit;
- avoiding a "formal interview" setting in which the researcher faces a survivor across a desk and therefore appears to be an authority figure. Sitting as equals in the room, at the same level and on similar chairs, will help to create a feeling of safety and openness which assists communication;
- making gentle eye contact can be reassuring, and prevent feelings of loneliness and isolation. If a survivor sees a kind and sensitive response upon obtaining eye contact with another person, they will feel less stressed, feelings of shame will lessen and their confidence will improve;
- always acknowledge any memory intrusions or symptoms that survivors appear to be experiencing.

Questions for interview:

1. How are you?
2. How have you been lately? How was your day?
3. How do you feel at Olallo House?
4. Do you know when do you end the treatment/ need to move out?
5. What are you working on currently with your keyworker?
6. How do you feel about leaving Olallo one day?
7. Where were you living before? When did you arrive in the UK?
8. Would you like to tell me a bit more about your past experiences?
9. In what circumstances did you arrive at Olallo?
10. Do you have any family connections in the UK? Or any friends?
11. Would you like to tell me more about your family?
12. What do you miss the most about your home or community?

13. Do you feel safe here?
14. Did you ever have moments in your life when you were feeling unsafe?
15. What do you think is your biggest need at this moment?
16. And your biggest fear?
17. How do you think this affects you? Any physical symptoms? Any struggles because of the current situation?
18. What do you think is the most difficult situation for you while living in the UK?
19. What is the best aspect of living at Olallo? What did you like the most?
20. And did you not like it instead?
21. Do you think that staff members have been helpful?
22. How about the other residents? What is your relationship with them?
23. Do you think that your voice was heard?
24. What would you like to do more or better while staying at Olallo?
25. Do you think that your stay at Olallo is helpful in some way? Did you notice any personal progress?
26. Finally, what do you wish for your future? What are your dreams and goals?


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