Modern day slavery and the responsibility of the dental team

Emma G. Walshaw[1] and **Kishan Patel**[1] introduce the concept of modern day slavery and present DCPs with potential indicators of slavery victims.

Abstract

This article introduces dental care professionals (DCPs) to the poorly understood notion of modern day slavery and what this may entail. Recent data from the government indicate that the number of modern day slaves in the UK is increasing. Therefore, there is a high likelihood that we come across such individuals on a more frequent basis than we think. As dentists, we are in the unique position to identify and intervene appropriately when suspecting an individual of being a modern day slave. This article discusses how to recognise a modern day slave and how best to refer them to onward services and provide support. We need to collaborate with other healthcare professionals through identification and appropriate referral of these patients, with the ultimate aim of eliminating modern day slavery in the UK.

Introduction

The Modern Slavery Act (2015) describes modern day slavery (MDS) as a crime that includes holding a person in a position of slavery, servitude, forced or compulsory labour, or facilitating their travel with the intention of exploiting them,[1] ie human trafficking. Victims of MDS may suffer its ill effects within their own country, however, human trafficking frequently involves the crossing of international borders. MDS violates many internationally agreed human rights – with particular relevance to dentistry, it undeniably violates the right to health.[2]

In 2013, it was predicted that there were 10,000–13,000 potential victims of MDS living in the United Kingdom,[3] with an annual cost to the national economy of £4.3 billion.[4] The Government estimates that it spent £61 million on the direct management of MDS in 2018/19, with the remainder being indirect costs to UK economy.[4] These numbers are increasing year on year with a 49% increase in recorded MDS crimes in England in March 2018 compared to 2017.[4] It is well established that many crimes and victims are not reported or identified so true figures could be significantly higher.

This national upward trend in the prevalence of MDS mirrors that of international figures. In 2016 it was estimated that up to 40 million people were victims of MDS globally – 25 million of whom were forced into labour and 15 million forced into a marriage to which they had not or could not consent to.[5]

The appropriate care of potential victims of MDS by the dental team is imperative and stipulated within the General Dental Council's *Standards for the dental team*; including 'put patients' interests first', 'work with colleagues in a way that is in patients' best interests' and 'raise concerns if patients are at risk'.[6]

Categories of modern day slavery

There are four broad categories of MDS (Table 1). The Home Office has further defined these categories into 17 distinct types which are included within these categories.[3]

Other types of MDS exploitation that have been reported are illegal adoptions, forced begging, organised theft and organ harvesting.

There are four types of theoretical dimensions that underpin the manifestation of MDS crimes. These are:

1. The methodology of victim recruitment
2. The motivational drive of financial profit for the abuser
3. The extent of crime organisation available to utilise
4. The control mechanisms of victims.

The broad diversity of motivation and opportunistic ability of MDS offenders demonstrates the hugely varying experiences that MDS victims can be exposed to, and why there is no 'one-size-fits-all' solution to

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Table 1 Shows four broad categories and subsections of abuse that can occur with modern day slavery and their prevalence relating to 2017 totals[3,4]

Type of abuse	
Labour exploitation • Victims exploited for multiple purposes in isolated environments. • Victims work for offenders. • Victims work for someone other than offenders.	**46% annual total** For example, poor working conditions, unacceptably low pay and an inability to leave freely.
Sexual exploitation • Child sexual exploitation (group or single exploiters). • Forced sex work in fixed or changing location. • Trafficking for personal gratification.	**34% annual total** Coerced into sex work, sexually abusive situations. Victims can be brought to the UK under the promise of a legitimate job, but are then forced into the sex trade. Females > males.
Domestic servitude • Exploited by partner. • Exploited by relatives. • Exploiters not related to victims.	**9% annual total** Victims work in private family homes, and are frequently ill-treated and have long working hours. Many may be paid very little or not at all.
Criminal exploitation • Forced gang-related criminality. • Forced labour in illegal activities. • Forced acquisitive crime. • Forced begging. • Trafficking for forced sham marriage. • Financial fraud (including benefit fraud).	Coerced into committing a crime for someone else's gain.

preventing MDS.[7] The complexity of these crimes was acknowledged in the international anti-trafficking legislation 'Palermo Protocol' published by the United Nations in 2000.[8]

Adult victims are thought to experience some aspects of coercion such as force, threats and deception. Children and vulnerable adults that are unable to give informed valid consent can be victims of MDS when they are exploited, even if there is no coercion.

The UK Government published their Modern Slavery Strategy in 2014 highlighting their four-pronged approach regarding how they aim to face these organised crimes. They are to Pursue, Prevent, Protect and Prepare.[9] So, what is our role as dental healthcare professionals and where do we fit in this approach to care of those who are currently involved in, or have a history of, MDS?

Social and health demographics

As dental professionals, we should be aware of the signs of possible abuse involving children and vulnerable adults, for example those with complex learning needs. But, do we know what we should be looking for in the cases of suspected MDS?

The truth is that the sociodemographic background of these victims is significantly diverse, and so immediate identification of these individuals can be difficult. In 2017, the most common countries of origin of potential adult victims who were referred to the National Referral Mechanism (an organisation which safeguards and manages those referred for human trafficking) were Albania, Vietnam, China, Nigeria and Romania.[4] In regards to children, their original countries of origin were United Kingdom, Vietnam, Albania, Sudan and Eritrea.[4] The majority of victims were female adults (55% of adults) and male children (62% of children)[4]. In international 2016 figures, 25% of MDS victims were children, ie under the age of 18-years-old.[5]

In 2017, a rapid evidence assessment was performed which found MDS to cause extreme health inequalities.[2] They found these health inequalities to disproportionately affect those already in vulnerable circumstances including children, undocumented migrants and those living in poverty.[2] MDS survivors also had very high unmet health needs and experienced poor access to healthcare services.[10,11] Dando *et al.* found the most commonly reported barriers to healthcare to be misconceptions around NHS eligibility and poor knowledge of MDS in the healthcare environment.[12]

Victims who are exposed to labour and sexual exploitation can have significant physical demands placed on their body, frequently leading to physical injury and exposure to infectious diseases. There is a raised prevalence of serious mental health problems[13] and suicide within modern day slavery victims, often resulting from significant post-traumatic stress.[14,15] Another form of physical and mental abuse is the possible effects of witchcraft. Witchcraft and the sequelae of 'juju' originate from the West African beliefs of a spirit world and previously were named as a means of silencing trafficked Nigerian civilians who were relocated in Europe.[16] Even following release from a trafficking crime, symptoms of post-traumatic stress can be seen as the spirit world inflicting retribution on a victim,[17] proving that witchcraft has very tangible effects on the health of its believers.

The Royal College of Nursing handbook published in 2017 highlighted common health issues that victims of MDS commonly suffer with, specifically mentioning dental pain.[18] It is therefore not unreasonable to deduce that dental professionals would come into contact with these individuals, at least in episodes of acute dental need. In the United States, 88% of female survivors stated contact with a medical/dental clinician during their trafficking period.[19]

Awareness and identification

Box 1 summarises some key indicators that could aid the identification of a patient involved in MDS or human trafficking. Those that could be particularly relevant to members of the dental team have been highlighted in italics. At this time the authors are not aware of any cases of MDS that have been primarily identified by a dental professional.

Financial concerns

In a primary care dental setting, where there is a monetary aspect to the delivery of dental services, it may be more apparent when an individual does not have complete autonomy over their own finances and could be under coercive control. Financial interactions may only be witnessed by a receptionist taking fees, hence the importance of the entire dental team requiring training and knowledge about MDS.

In 2017, 50% of MDS victims who were forced into labour had a debt bondage imposed, and thus they feel indebted to their abuser(s) and huge levels of guilt when imposing a cost directly linked to their health[5] – such as a dental fee.

In 2018, the Department of Health published their Overseas Visitor Charging Regulations which did not cover treatment provided by dentists.[20] Currently there is no guidance from the Business Standards Authority regarding how a dentist should/could charge someone they suspect may be a victim of MDS.

Language interpreters

Care should always be taken to use official

forms of language interpreters with any patient. This is particularly important when you suspect the patient may need safeguarding intervention. It has been found that the quality of medical care improves with the use of professional interpreters, in comparison with non-professional means.[21] The use of a family member or friend should be avoided if at all possible in these cases as it is known that they can jeopardise the patient's right to confidentiality and dissuade patients from disclosing information.[22] Phelan and Parkman (1995) suggest key principles regarding how health care professionals can efficiently work with professional interpreters, including debriefing the interpreter before and after the consultation and where possible to use the same interpreter for future consultations with the same patient.[23]

Understanding what to look out for, who to contact and where to declare your concerns is vital in our role as dental professionals. With the concerns and uncertainty regarding 'Brexit' and the UK's strategic exit from the European Union, the implications on MDS are unknown as the number suffering could dramatically increase. For this reason, now more than ever, it is vital that our profession has insight into these patients and how to manage this situation.

Education of healthcare professionals

The definition of safeguarding includes the 'protection of a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect'.[24] There are six principles of safeguarding: empowerment, prevention, proportionality, protection, partnership and accountability. The prevention element primarily focuses on mandatory staff training, raising awareness and making information accessible to those who require it.[25] This unequivocally reinforces the statutory duty that dental professionals carry to understand, be vigilant of and manage MDS suspicions.

The Department of Health's PROTECT (Provider Responses, Treatment and Care for Trafficked People) project looked into the relationship between healthcare and MDS. Their cross sectional UK survey found 87% of 782 NHS professionals lacked the necessary knowledge to identify victims of MDS and 71% were not confident to make the required referrals for additional victim support.[26] Since the release of this information, the Department of Health has developed an e-Learning tool[27] and the Royal College of Nursing developed a 'pocket guide'.[18]

NHS England has created an anti-slavery programme, which supports NHS staff to understand and respond to MDS and human trafficking. The programme hopes to ensure that all NHS staff have access to training in MDS and includes developing real-life skills to support these patients.[28]

Of the 34 medical schools within the UK, nine reported that they provide teaching on modern day slavery within their syllabus,[29] unfortunately there is no such information from dental schools. Consideration should be had regarding the possibility and need for inclusion of this vital topic into the dental undergraduate and postgraduate curriculum.

The authors of this article believe that MDS awareness and support training should be incorporated into current safeguarding continuing professional development (CPD) to encourage the entire dental team to be vigilant in their approach to this sensitive topic.

Box 1 Indicators of potential modern day slavery victims*

Distrust of authorities + reluctance to engage

- Expression of fear or anxiety
- *Person acts as if instructed by another*
- Evidence of control over movement that is, journeys arranged by another party
- *Physical injuries (old, new or serious)*
- Lack of access to medical and dental care
- *Doesn't know home or work address*
- *No free access to their own finances*
- No or limited bathroom or hygiene facilities
- *Struggles to speak English, or only knows 'sexual' words in the local language*
- *No official identification documentation*
- *Tattoos or other marks indicating 'ownership' by their abuser*
- *Frequent changing of geographical location and lack of knowledge of current location*
- *Altered behaviour in relation to peers*
- *Concealment from local authority care services*
- *Incoherent/changing account of events*
- *Unexplained eagerness to leave a safe space*
- Sexually transmitted diseases
- *Missing episodes – 'was not brought' events*
- *Language barriers and mistrust in their interpreter*
- Fear of repercussions
- *Always accompanied by their perpetrator*
- Stockholm Syndrome
- Substance addiction
- *Unsuitable clothing for weather, for example, flip-flops in winter, or limited amount of clothing with a large proportion being 'sexual' in nature*
- *Undernourishment and failure to thrive*

*Highlighted in italics are those indicators that may be easily noted by a dental professional[3,18]

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Management in a dental setting

As with any patient who you believe requires safeguarding support, you should follow your local safeguarding policy and receive input from your local safeguarding lead. It is prudent that dental professionals consider that some of these people may be unaware they are a victim and that there is help available. They may feel as though they are better off in their current situation than their home country or historic living scenario. As such, approaching a conversation regarding their social situation could be difficult and intimidating to broach.

Discussion with the patient

To obtain a clearer picture of a patient's background and support any safeguarding referrals that members of the dental team make,

Box 2 Modified SAFE questions that can be utilised when asking potential MDS victims about their social circumstances

Stress/safety

Do you feel safe at home?

What stresses do you experience day to day?

Afraid/abused

Have there been situations where you feel afraid at home?

Have you been physically hurt or threatened?

Have you been forced to engage in sexual activities that you didn't want?

Friends/family

Are your friends and family aware of where you are and who you live with?

Emergency

Do you have a safe place to go in an emergency?

Are you allowed to leave if you feel unsafe?

Questions derived from reference:[30]

Table 2 Shows specific guidance focused towards modern day slavery within healthcare[5,18,32,33,34,35]

Resource	
Royal College of Nursing 2017	Free online booklet
Modern Slavery Helpline (if not at immediate risk of harm)	08000 121 700 https://www.modernslaveryhelpline.org
Home Office 2014	Identification guidance and awareness leaflet
Unseen	Info.mshelpine@unseenuk.org
HEAL Trafficking toolkit	Free online toolkit info@healtrafficking.org
Adult Human Trafficking Screening Tool and Guide	Free online screening tool
Emergency services (if patient is at immediate risk of harm)	999

it is vital that we ask relevant social history questions. These may include:

- Where do you live and who else lives with you?
- Do you have any family or friends who live locally? Or in the UK?
- What do you do to earn a living? How many days/hours a week do you work?

Ashur devised systematic SAFE questions in 1993, which primarily related to asking about the possibility of domestic violence.[30] These questions, if modified slightly, can provide a sound framework in asking about MDS suspicions, a modified version is included in Box 2.

Treatment of dental disease

From a purely clinical perspective, one may suspect that these MDS individuals or immediately-liberated survivors would have a neglected dentition. They should be seen as high risk individuals for developing oral diseases, and therefore an evidence based approach to their care should be implemented in accordance with *Delivering better oral health* guidance.[31]

The treatment of these patients may be complicated by anxiety, panic disorders, post-traumatic stress disorder (PTSD) and mistrust of authority. Coordinating frequent acclimatisation appointments with these individuals to build rapport and gain trust will hopefully allow them to feel comfortable enough to confide their social situation with you and request support.

The feasibility of providing multiple visits for these patients may not be possible in a primary care setting. Clinicians should seek local guidance as to whether these patients would qualify for specialist care, such as the community dental service.

Liaison with the patient's general medical practitioner (GMP) could also allow pharmacological interventions such as oral sedation, to be prescribed which could aid treatment acceptance in a primary care setting. It is within the remit of a dental care professional to highlight an underlying panic disorder to the GMP who was otherwise unaware; they may then be able to support the patient in seeking mental health support such as cognitive behavioural therapy.

Specific guidance

Table 2 includes specific sources of guidance regarding how to identify and support a patient who could be a victim of MDS, which could perhaps be an addendum or amendment that may be necessary in your own local safeguarding policy. If there is as suspicion that your patient is under the age of 18, you must assume and act as if they are under 18,[18] despite any protestations otherwise.

The Care Act (2014) states that healthcare services and local authorities have a statutory responsibility to integrate the overall care and support of vulnerable adults.[25] Direct safeguarding referrals can be made to the National Referral Mechanism regarding both adult and child suspected victims of MDS.[36]

If you have raised concerns through the appropriate networks, and feel as though they have not been appropriately acted on, then you should be 'whistle-blowing' these concerns. Whistle-blowers are given protection under the Public Interest Disclosure Act (1998).[37]

Conclusion

MDS is not a frequently discussed clinical situation, but it could be much more prevalent in our practice and society than we know. Being aware of signs to look for and how to identify a potential victim could enable healthcare professionals to make a great positive impact on our patients. As a dental professional, we frequently have a unique insight into the nuances of our patients' lives that could highlight areas of concern.

This article highlights the importance of safeguarding training for both undergraduate and postgraduate dental care professionals, and the significance of collaboration between healthcare, social services and public services.

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