Working Paper on Interventions against Trafficking for Sexual Exploitation in England and Wales[1]

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Part 1: The Intervention Sequence and the Response to Core Questions

1 Empirical data and case story

This working paper is based on two multi-agency workshops in which the intervention responses to trafficking for sexual exploitation were explored (see background paper). Each workshop comprised two half-day sessions, and a focus group methodology was used. Participants were given a case story in three sequences to discuss. Six 'core questions' were introduced during the discussions. The stories were agreed across the four countries, but adapted to fit the national context when necessary.

Participants in the workshops from two different cities were: 1 police, 1 prosecutor, 1 refugee/asylum worker, 2 health worker2 (1 sexual health), 5 non-governmental organisation (NGO) workers (including faith-based and feminist NGOs), 3 representatives of the United Kingdom Immigration and Visa service, 3 lawyer and 1 Local Authority/Asylum worker.

The trafficking the story was as follows:

1st PHASE OF THE STORY

Maria came from Africa on a 6 month visa expecting that she would be able to work in a hotel and send money home. She is in debt for the costs of her travel and her family also took a loan to help with the costs so they are in debt as well. On her arrival she was taken to a brothel. She speaks only a little of the language and the brothel manager has her papers. Seeing no alternative, she agrees to work in the brothel for a limited period until the debts have been paid off. She has been in the country for 4 months and the visa is due to expire in 2 months. During one of her shifts Maria collapses. The receptionist at the brothel has one of the other women take her to a local health centre where her physical and mental health are assessed as poor and she is found to have a sexually transmitted infection. The doctor indicates the need to inform Maria's sexual partners but Maria responds that this will not be possible. The doctor prescribes Maria antibiotics and hands her a card with details of a helpline.

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2nd PHASE OF THE STORY

Maria did not dare to call the helpline, and saw no option but to return to the brothel. She has been there for 7 months. She is exhausted and very unhappy and has been looking for a way out of her situation, but has been told that her visa has expired and that she can be prosecuted as a criminal if she is found by police, and also if she goes to any other public office or agency. She has received practically no money and is now even more in debt as she had to take time off to recover but was still required to pay for the antibiotics and the brothel house fees to cover her shifts. Now she is very much afraid: afraid of the managers of the brothel, afraid of being sent to prison and afraid of being deported to stand empty handed in front of her family. In desperation she calls the helpline and tells them about her situation and names the brothel. The helpline gives her information about other sources of support.

3rd PHASE OF THE STORY

Early one morning immigration officers attend premises to carry out a check on the occupants. They find Maria and a number of other women as well as two men. The men produce valid identity documents. Maria is unable to produce any identity documents and is taken into custody. The officers suspect she may be a victim of trafficking but she is reluctant to talk to them. She believes the helpline gave her away. She is fearful of the authorities and unwilling to make a formal statement but says she is afraid for her family back home and is likely to be in danger herself if sent back. She appears unstable and there are concerns for her mental health. It is also apparent that she has no money and says she owes a great deal of money.

2 Intervention pathways from the perspective of professionals

The two workshops in England and Wales were held in different parts of the country. The following sections discuss participant responses to the above narrative with respect to the ways in which a potential victim of trafficking might enter the intervention system, any influence she has on interventions, the sequence of intervention and the roles of different professionals within the intervention process.

2.1 Routes of entry

In one workshop there was an assumption among participants that any agency coming into contact with a potential victim of trafficking would bring in other agencies, regardless of whether the first point of contact was in the health sector, the police or a non-governmental organisation (NGO). The emphasis was on process – described as a 'victim pathway' – and referral into the national referral mechanism (NRM). This process was the same with respect to European Union (EU) nationals once a victim was in contact with professionals, although some participants expressed doubts that the agencies an EU national was more likely to come into first contact with would have the requisite knowledge to spot any trafficking indicators.

In the other workshop there was more uncertainty that Maria would be identified as a potential victim of trafficking. The routes of entry were deemed to be through the health sector, the police, immigration or direct contact with an NGO. With respect to health workers, in the first instance, participants considered that it would depend on the sector a potential victim first approached, with sexual health services being most likely to ask relevant questions. First contact with police would again depend on all the circumstances. If, for example, Maria had been found in a brothel during the

course of a raid[2], police would not necessarily be looking for victims of trafficking and may fail to identify Maria at this early stage, more so where she is an EU citizen. Contact with immigration services was deemed to be the most likely route into intervention for non-EU women. Unlike the other group, few points of intersection emerged, except between a faith-based NGO and the police.

2.2 Victim's influences on courses of action

In one group, practitioners saw themselves as in charge of all courses of action, save with respect to referral into the National Referral Mechanism (NRM; see section 2). Generally, however, if the potential victim of trafficking failed to consent to a particular course of action deemed appropriate or necessary by an agency to ensure a woman's safety or the safety of other potential victims of trafficking, her wishes would be overruled. This was also the case with respect to a faith-based NGO, but contrasted sharply with the position a feminist NGO where a participant confirmed that no action would be taken without a victim's express agreement. Similarly, lawyers acting for individual clients in both workshops confirmed they were duty bound to act only on instructions and with their clients' express consent.

2.3 Sequences of Intervention and Professional Roles

Once identified as a potential victim of trafficking, in one workshop the sequence of intervention followed a clear path. Where an agency other than the police came into first contact, and the individual was perceived as being at immediate risk of harm, it would be reported to police. They would contact Social Services and the lead anti-trafficking NGO in the area to arrange a place of safety. If police were notified out of working hours, they would make a referral to the Emergency 24 hour Homelessness Service to find a temporary (overnight) place of safety. It would then be referred to the lead NGO first thing in the morning. This would also be the case where police were the first point of contact. The lead NGO would complete an individual assessment, coordinate the multi-agency response and ascertain NRM status. If the woman consented, a referral into the NRM would be made. The same NGO would then set up a Multi-Agency Risk Assessment Conference (MARAC) within 7 days involving key agencies - at a minimum police and social services. If deemed appropriate other agencies would be involved. This may comprise workers from the health sector, housing and other NGOs (for example, those dealing with refugee and asylum issues). In acute situations, an emergency MARAC would be convened and all relevant statutory (police and local authorities) and third sector support agencies would be involved. The purpose of the MARAC was to undertake a risk assessment and formulate a plan of action with three possible outcomes: to do nothing, to monitor or to act, that is, to further intervene. This may involve, for example, enforcement action against the suspected traffickers and engagement with the criminal justice process, the engagement of immigration lawyers and liaison with the Competent Authority– United Kingdom Visa and Immigration (UKVI) service in the case of third country nationals, and the UK Human Trafficking Centre (UKHTC) in the case of European Union (EU) nationals.

Potential victims of trafficking are granted a 45 day recovery and reflection period which runs from receipt of a positive reasonable grounds decision from a Competent Authority. The victim is then entitled to continue to receive assistance and support until a conclusive grounds decision is reached which may, in fact, be a long time after expiry of the 45 day period. Where a victim does not consent

[2] In the UK, while prostitution itself is not illegal, certain associated activities are, including keeping and managing a brothel. Often police are aware of the existence of brothels in their areas but may only act to raid and close it, for example, on receipt of complaints from the public, local residents, and the like.

to referral into the NRM or where a negative conclusive grounds decision is made, the lead NGO is obliged to have her leave their service with short notice. At this point, the victim has few options. If from a third country, she may be advised to seek asylum (EU nationals can also follow this route although participants thought it would be unlikely to succeed) and she may, during this process, find some temporary support through other agencies. This includes another NGO which can provide short-term support to trafficked women, irrespective of NRM status, but – in their region – only to those who do not require accommodation; alternatively, she may be detained and held pending a final decision with respect to any asylum claim, or pending deportation or trial on charges, for example, of breach of immigration rules or other criminal activity. Faced with such circumstances, participants indicated it was not entirely unusual for a woman to return to her trafficker. The only remaining option is where a victim has cooperated with police and the Crown Prosecution Service (CPS), *and* her testimony is required by the prosecution, *and* she is assessed as in need of witness protection for the duration of proceedings. Witness protection is arranged and paid for the by the police service and includes accommodation in a safe place. This is also available to an EU national although, if there is cooperation between police here and police in her country of origin, it is more likely she will be repatriated and brought back only for the trial. An EU national may also remain in the UK if she can demonstrate she is exercising Treaty Rights[3] of residence and work.

In the area of the other workshop, there was no central referral agency equivalent to the lead NGO mentioned above, and no process involving a MARAC. Consequently, there was no format for a multi-agency response. If a potential victim of trafficking came into contact with a first responder from the specialist NGO sector, among the participants taking part, the sequence of intervention depended on whether or not the NGO was faith-based or feminist. In the former case, the police would be contacted and requested to intervene to remove the woman (and possibly other potential victims) to a place of safety. There she would be assigned a caseworker to provide accommodation and access to medical, legal, and counselling services, and to assist and advise her with respect to referral into the NRM. If the woman consented to referral into the NRM, support and assistance would continue until a conclusive grounds decision was made, either confirming her status as a victim of trafficking, or refusing it. The decision resides with the appropriate Competent Authority. They would conduct a trafficking interview and undertake further investigations into her status, including enquiries of other agencies with which the potential victim of trafficking had had contact, such as police, health and NGOs. In the event that a woman did not consent to referral into the NRM, or a negative conclusive grounds decision was issued, she may continue to receive assistance for a short while, but there are again limited options. Where the woman is a third country national she may be detained pending deportation or trial on criminal charges, or pending a final decision with respect to any asylum claim if she has been able to access legal advice and representation. An EU national who is unable to demonstrate she is exercising Treaty Rights will be in a similar situation. As above, if the case is referred to CPS, a prosecutor will review the evidence to decide on charges against the woman or against her trafficker. A decision to prosecute the trafficker is not conditional on referral of the victim into the NRM or on receipt of a positive conclusive grounds decision, although a negative conclusive grounds decision may influence whether the prosecution proceeds, that is, whether it is assessed as more probable than not that a conviction will ensue. If the prosecution is to proceed and the woman's testimony is deemed necessary, a decision will be made as to whether any special measures are required and/or whether to place the victim in witness protection.

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[3] Directive 2004/38/EC on the rights of EU citizens and their family to move and reside in Member States but in the UK to stay for longer than three months, EU migrants must show that they are in work or actively seeking work with a genuine chance of being hired, or that they have sufficient funds not to be a burden on public services.

Where a potential victim came into contact with a feminist NGO in this area, no action would be taken without the woman's express consent, including where she may be at risk, for example, where she is being held against her will. Instead, she would be informed that the police can remove her to a place of safety and that she may then be offered advice and support from the feminist NGO. If the woman consented to police intervention, or succeeded in escaping from her trafficker and contacted the feminist NGO again, or was referred back to them, a caseworker would be assigned and a trafficking assessment made. This would include obtaining information from all other agencies which had contact with the woman, such as health, local authorities and other NGOs, provided the woman consented. Again, with the victim's consent, the feminist NGO may also refer her into the NRM. The primary difference between the feminist NGO and the faith-based NGO was that the former would provide accommodation and assistance to any women they assessed as a victim of trafficking irrespective of her NRM status. There were some practical constraints in that the number of beds they now have available has been reduced by more than 80 per cent.

In all cases, the involvement of lawyers - other than CPS – was most likely when immigration issues had arisen. Although instructed on behalf of individual women, the referral to the lawyer tended to come from NGOs assisting potential victims. Means-tested legal aid is available for immigration and asylum-related matters or, for example, for judicial review proceedings with respect to a negative conclusive grounds decisions issued by either Competent Authority. As such, UKVI also appeared to be a frequent first responder, usually after a person had been detained. Their involvement tended to arise during an immigration interview which, if certain facts were disclosed suggesting the individual may have been trafficked, led to a trafficking interview.

2.4 Participants' responses to core questions

(1) As a professional what might lead you to try and discover whether this might be a trafficking situation or, on the other hand, what might keep you from getting involved?

The narrative provided to participants in the workshops identified a potential point of entry via the health service into trying to discover whether this might be a case of trafficking for sexual exploitation (TSE). Here there was considerable consensus in both workshops that key to discovery was to ask 'trigger questions' and to try and build trust.

> *How do you feel now, what about when you go back? Scale it 1-10. Has she got support networks, can she complete her antibiotics, why can't she discuss it* [the STI] *with ex-partners?* (Refugee/Asylum).
>
> *Ask questions. Who did she come in with? How is she dressed? Try and build up a wider picture, and build trust* (*Lawyer*).

There was acknowledgement that many women might not disclose their concerns or personal circumstances. These trigger questions might be improvised or follow a standard form and national guidelines (for health service staff).

> *In our pro forma we ask trigger questions. There are resources and there are national guidelines but you need to build trust. If a consultant agrees she could be admitted overnight, then you can see her next day and say, ok, can we have a chat. Sometimes the person doesn't want to disclose and sometimes they open up* (Health).

For the faith-based NGO it was a matter of knowledge and experience.

> *You pick up who's controlled and who's fine. We give out mascara with phone numbers, meet for coffee, build relationships. A lot of girls are scared by police and authorities. There's a lot of gut stuff, whole mannerisms, open or quiet and hesitant* (Faith-based NGO).

In one workshop, there was some discussion as to how the matter might come to the attention of agencies other than health. The police indicated the response would vary according to the source of the referral, namely whether or not the victim made direct contact with police or whether the referral came from a support organisation. In either case, however, it was confirmed that Maria's protection and safety would be the first priority.

> *We're guided by source, how we were informed. If the victim came forward, it would be dealt with one way; if it was referred to us by a support agency, it would be dealt with differently but the first concern is her safety, protection and well-being* (Police).

The UKVI representative suggested that an immediate referral would be made to the NRM in order to conduct a trafficking interview. The purpose of this would be to establish, initially, whether there were reasonable grounds to suspect Maria to be a victim of trafficking.

> *If this is all we have, I would make an NRM referral and conduct a trafficking interview. I'd unpackage all the parts to her documents. It does not matter how it comes to us, we have to do it* (UKVI).

This was also the initial response of the UKVI participant in this group, who took the view that if there are suspicions a woman might be a victim of trafficking, a referral into the NRM must be made. By contrast, some of the other participants in this same workshop, notably two of the lawyers, were a little more circumspect. There was doubt whether there was sufficient information at this stage for the matter to be brought to the attention of other agencies, or that all health workers would be sufficiently knowledgeable, or even think, to ask further questions. It was pointed out that the story at this point did not specify that Maria had visited a sexual health clinic where staff might be better trained and have more awareness. An interesting debate also took place about Maria's immigration status and whether she would be charged for the consultation and treatment.

> *So it depends on what Centre you walk into, what training they've* [staff] *had* (Lawyer1).
>
> *If she's walked in to a regular health centre – instead of a sexual health centre – she'd be asked about her immigration status because they'd have to say we have to charge* (Lawyer2).

This latter comment, in particular, also gave rise to an interesting discussion highlighting possible dilemmas and conflicting mandates, discussed below.

(2) How might it come about that your institution or profession is the place to which Maria turns for advice, intervention or support? Or how else might it happen that someone in your position would become involved?

As above, there were also some differences here between the two workshop discussions. In one, NGO participants discussed possible routes of referral but were unequivocal that they would contact and bring in the police, as a single agency, or to trigger a multi-agency response. The participant from the lead NGO confirmed she would call an emergency MARAC which would have the effect of bringing a range of professionals in. MARACs were developed in their area to respond to domestic violence. They operate on a closed basis to address issues of trafficking, based on a MARAC developed to deal with cases of women in prostitution. Hence, there was an assumption by most participants that processes were in place to ensure their involvement.

> *Someone would phone me* (Police).
>
> *I would bring in the coppers. I'd sent the information to the police. As a single agency, they might just go in or, if more linked, they can go multi-agency and build up a wider picture* (NGO2).
>
> *I'd call an emergency MARAC, then it's like a domino* (NGO1).

One participant, however, disagreed.

> *You ask her, if she's saying she needs to get out, you ask what has changed? Find out what her concerns are and how she wants help. You need to find out what she wants before acting* (Health).

In the other workshop, on the other hand, there were no assumptions that the matter might come to the attention of any agency at this point in the narrative. An immigration lawyer was clear that at this stage the matter would never come to her attention; instead, she stated that this might happen only after Maria had been through a range of other agencies some of which, such as social services or local authorities, she deemed likely to be lacking in knowledge.

> *She'd only come to an immigration solicitor after she'd been lots of other places. I think she'd be reluctant to come forward because immigration status is used as a method of control so it's usually only available after the NRM. There are softer ways into discovery but the problem is that social services, local authorities or the Home Office, they're not informed at all as to what their duties might be. There doesn't seem to be much knowledge about the duty of a first responder, so with health there's more space for things to develop and emerge and there's confidentiality. In the social services situation that can't be guaranteed because social workers feel a duty to report. Where there's confidentiality you understand about consent and an opportunity to build trust* (Lawyer2).

Another lawyer stated in her view that it would depend on how Maria presented to the helpline as to what, if any, further action might be taken. The tenor of the discussion here was broadly in line with earlier discussions in the workshop, indicating doubts as to whether other agencies, so-called first responders, would have taken steps to identify whether Maria was a victim of trafficking. Only the representative of a faith-based NGO was unequivocal that he would immediately refer the matter to police, that is, there was an immediate shift to an intervention which was justified by reference to a duty of care and an obligation to rescue Maria.

> *I would see it as quite black and white. My duty of care is to remove her from that situation and get her safe* (Faith-based NGO).

This is contrasted with the different approach of a feminist NGO where the participant indicated that most referrals come to them from other agencies.

> *We would first see what she was seeking in terms of services, what she needed, what her main concerns were, and explain that if we're going to accept her into our service, we'd have to do an assessment which is usually a three hour interview in which she'd have to talk about her experiences. Then, based on that, we would decide whether we could provide her with the services she needs, so it would be very much laying it out in front of her and her deciding if this is something she would want to go through but we wouldn't do anything without her consent* (Feminist NGO).

This was followed by an interesting discussion on the duty of care and consent (see below).

(3) Would you consider asking Maria directly about being trafficked, or what reasons might there be not to do so? How important do you think this is?

In response to this question, participants in both workshops indicated they would ask less direct questions or trigger questions and seek to build trust and some rapport.

On the face of it, this seems to stand in tension with assumptions, prevalent in one group, that there would be an immediate intervention if a woman was suspected of being a victim of trafficking. The likelihood, however, is that if the trigger questions confirmed their suspicions or risk was identified to the woman and/or others, intervention would follow (see below).

(4) When might you pass on information to relevant authorities or institutions without the consent of the victim? Or, on the other hand, what might keep you from doing so?

The issue of consent generated some discussion in both workshops. In one, it was stated that an emergency MARAC can proceed without the consent of the victim, although all those attending would be bound by a memorandum of confidentiality referred to as an Accord on the Sharing of Personal Information (the accord). Some participants expressed a little doubt about sharing information without consent but this was invariably subsequently justified.

> *It's confusing, making decisions is a human right but if you call a MARAC you don't need consent. The police can keep an eye on the premises* (NGO1).
>
> *With a MARAC there's an obligation to sign (the accord)* (UKVI).

In this group it was taken for granted that a range of professionals would be working together, that this was in a victim's interests and that consent could and should be overridden when a victim was deemed at risk or where there were risks to other potential victims or the public.

> *It would be ok if there is a risk to others. I'd ask why, what their fears are and try to allay them* (NGO2).
>
> *If they're still reluctant, I'd explain the duty of care to others* (Refugee/Asylum).
>
> *The whole consent issue is massive, I think it's a non-issue and agencies have hidden behind it in the past to do nothing. How many others are there who need safeguarding? For the MARAC process, it's a victim pathway and inter-agency involvement is good* (Police).

For a lawyer participant there was an acknowledgement that her professional code of conduct did not permit her to act without her client's consent but she stated that it was also her role to advise and, in doing so, to use influencing skills without necessarily directing her client. There was additionally an expression of a shared mandate among most participants with an emphasis on process – 'a victim pathway' – which assumed collaboration among practitioners, although an NGO and a health participant initially indicated potential disadvantages of the involvement of so many agencies as this might lead to a passing of responsibility. It was, however, also pointed out that, in the case of a MARAC, there would always be a lead agency in the form of the lead NGO.

In the other workshop. discussions centred on a duty of care with clear differences in mandates emerging. The lawyers had the clearest mandate derived from their professional code of conduct to only act on behalf of their individual client, that is, to act in her best interests and with her consent. A CPS lawyer, on the other hand, had a similar duty in the sense that her 'client' was the state and, hence, the victim's consent was not a prerequisite to sharing information and, indeed, the rules on disclosure of information in legal proceedings precluded any confidentiality to a victim.

> *It depends on your profession. I have a duty to my lay client, it's in my professional code of practice. The duty of care is a legal principle. My duty is to act in the best interests of my client and very rarely is there any reason to go outside of that. Child protection issues are the only time and then they're usually my clients anyway but it's really rare. So even if she* [Maria] *said there were other women in the brothel, I could not share that information unless she consented* (Lawyer1).
>
> *There's no such thing as confidentiality if there's a prosecution because of the rules around disclosure of information. I don't know if victims know that* (Prosecutor).

Likewise, UKVI saw their primary duty as reporting crime, a view that was shared by the faith-based NGO although for different reasons. In the former case, it was seen as an obligation of the role, while in the latter case, although also deemed part of the role, the obligation was protect victims and potential victims.

> *I have previously worked as a social worker, and in that capacity I would have had a duty of care to her* [Maria]. *Now I'm at UKVI. If this situation arose now, I'd have a clear duty to report the crime* (UKVI).
>
> *I think issues about confidentiality cover well-trodden ground. The issue is about exceptions because there are always exceptions. There are always things that are exempt from that* [confidentiality] *and you need to explain that but if someone says there's an organised crime group bringing women into brothels, you can't promise them confidentiality because you have a duty of care to those other women* (Faith-based NGO).

By contrast, the participant from a feminist NGO was unequivocal that information would not be shared without a woman's consent while in health it emerged as conditional. Confidentiality could not be preserved in all circumstances and there might therefore be instances where health workers would be required to disclose information to other agencies, for example, if someone is underage or there is risk of self-harm.

> *Women have already been denied any voice or control so to deny them choice again would be replicating their experiences of trafficking. The first thing we do is have women sign a consent form and put on it any agencies they don't want us to contact. In most cases, referral comes from another agency so we get all we can from them as long as that organisation has the woman's consent to refer to us so we'll work very closely with other agencies, solicitors, etc. so there's quite open information sharing in my experience* (Feminist NGO).
>
> *So we have these rules, if someone is under the age of 15, we have to report it to the Council, to the police or social services. It's very difficult for us because people come to us confidentially but we build the trust and explain to the patient that these are the rules and we will have to report it - or if they might harm themselves - we might have to breach the confidentiality* (health).

(5) When could it be right/appropriate to initiate measures of protection from further violence, even against Maria's wishes? What concerns might prevent you from doing this or cause you to hesitate?

Discussions here proceeded along similar lines to those above. In one workshop, initial doubts expressed by the lead NGO gave way to a consensus that intervention without consent was justified where there was a risk to the victim, to other potential victims or where issues of public protection[4]/safeguarding arise. There was also reliance on systems and processes.

> *If there's a risk of further violence, nothing would stop me going against consent*. *You have to risk assess her vulnerability. Professional judgement should override forms and guidelines. They're better for us because we're crossing all the 'Ts' but it's about saving lives* (NGO2).
>
> *It's about public protection, threat, risk and harm. I'd rather get it wrong than fail. There are strong systems, victim pathways, that put them at the heart of the process* (Police).
>
> *As soon as they enter that pathway, they're in it until the case is resolved. It's a safeguarding route and if she doesn't enter the NRM, she can be in a care pathway* (UKVI).

[4] Where a woman is believed to be a victim of trafficking, this means there will be one of more potential traffickers, or perpetrators of sexual and violent crime which may pose a threat to other individuals or the public at large. Police have a duty to investigate, assess and manage this risk as part of a wider 'public protection' mandate.

Consent was, however, deemed relevant once the victim was in a safe place and it was accepted that consent was required to refer a woman into the NRM but this was qualified by the lead NGO in stating that women had little other choice but to cooperate in the process as they would otherwise have no access to support, including accommodation. For a health sector participant, key here was to return control to the victims.

> *Where's she going to go anyway, she's likely to engage* (NGO1).
>
> *It gives them control, it's a rebuilding process that they take it back. We need to treat them as adults, not children* (Housing).

The situation differed somewhat in the other workshop, as both feminist and faith-based NGOs indicated they could take women who were not in the NRM, although the faith-based NGO was more equivocal. For the feminist NGO, the issue was simply a practical one in that their funded bed spaces had been significantly reduced. As previously, the feminist NGO also confirmed that no action would be taken without the victim's express consent, even if she were deemed at risk. This was in contrast to the faith-based NGO for whom risk/duty was the trigger for intervention, including risk to other potential victims who might be in need of rescue. There was some discussion of why a victim's permission was required to intervene with respect to a crime and a prosecutor again confirmed that a victim's consent was not a prerequisite to prosecution or even that a referral had made to the NRM.

> *It's strange that you need the victim's permission. It's not the same with other crimes. It's like DV 30 years ago* (Faith-based NGO).
>
> *You don't need the victim's permission to prosecute and we can prosecute even without a NRM decision or their consent to referral* (Prosecutor).

For another participant, the question of referral into the NRM was inextricably tied to immigration decisions and to recording information.

> *Even if people don't want to be referred, we would still send the information to UKHTC. So, yes, there are human rights but it's also a decision that's tied up with leave to remain. And the process is also* about *recording that information and passing it to the police if it's relevant to them...so it should be that someone's considered to be a victim via the NRM but you can't make an asylum decision unless it's accepted that they're trafficked and you have to go to the COMPETENT AUTHORITYfor this* (UKVI).

(6) Imagine that Maria is an EU citizen. What difference might this make? Would your strategies of intervention differ in any way from what you have described in the first part of our workshop?

This section addresses the transition from Maria as a third country national to an EU national.

Here, responses from participants in both workshops emerged with greater similarities. In one, the early response was that there would be no difference in the identification and subsequent intervention processes. The health worker stated that Maria would be screened in the same way, that later in the narrative there were sufficient trafficking indicators, such as working in a brothel and having no documents, to trigger the same courses of action and that only the immigration advice would be different.

> *We'd screen her in exactly the same way* (Health).
>
> *There would be no difference at this point. She still has no documents and little language. The only difference would be when she identifies herself as EU. Then the immigration advice would be different* (Lawyer).

It was at this point that some doubts began to emerge with a discussion as to whether a woman in such circumstances may be able to assert EU Treaty rights and the risk that Maria might be deported without the benefit of an immigration/trafficking interview.

> *There's a drive now to also deport EU citizens who do not comply with Treaty Rights. What is the process before removal here? And even if there's an interview, they might not consider trafficking* (LA/Asylum).

This in turn led to speculation that EU citizens might be less likely to come to the attention of practitioners or that they might be more likely to be prosecuted, for example, for benefit fraud as Job Centre[5] staff are less likely to have sufficient, if any, training to spot trafficking indicators.

> *EU migrants, they may be less likely to be identified even though the figures are higher* (LA/Asylum).
>
> *Might EU migrants be more likely to go to job centres? Then it will depend on whether they* [staff] *have any awareness of trafficking indicators* (UKVI).

In one workshop, immigration was very quickly picked up as a gateway, particularly with respect to identification.

> *If someone doesn't present as having an immigration issue, how are they identified? I think an immigration issue is one of the gateways and a way to start thinking about whether there are trafficking indicators* (*Lawyer1*).
>
> *There are lots of opportunities to miss trafficking of EU nationals. First responders are often the police and they can eventually refer a case to us when an immigration issue arises, then in the interview it comes out the women is trafficked, but she's been through a lot of other people before then* (UKVI).

As in the other group, this led to a discussion of Treaty rights for EU workers although it was pointed out that EU citizens can and do also claim asylum. In particular, concerns were expressed that social services and local authorities do not know what the NRM is or what their powers of referral are. This lack of knowledge on the part of some first responders was stated to be another reason why EU nationals may fail to be identified as victims of trafficking and assisted.

> *An EU citizen doesn't automatically have more rights to benefits or resources than a non-EU citizen. You have rights as a worker, or as a dependent of a worker, but not as a citizen. There are no such things really as citizens' rights. In the EU there are only workers' rights* (Lawyer2).
>
> *I think it's ok for UKVI, they know they're first responders. A lot of people in social services and local authorities do not so how can you expect people to refer into the NRM when they don't even know what it is or that they have that power. So I think that's why they're being missed at the early stages and why EU nationals are being missed because they're not coming into contact with those first responders that actually have some knowledge* (Feminist NGO).

One significant difference emerged with respect to the legal process insofar as EU women were most likely to be repatriated pending trial while African women, in particular, remained in the UK.

> *I'm generalising but in a lot of cases, if they're from Europe, in a lot of cases they will go home. In relation to third countries, I'm not so sure but with victims from Africa, we've always had them in court, now that I think about it, and that's quite a big difference* (Prosecutor).

[5] This is where people go to register for work and to claim benefits.

Part 2: Framing of the Problem and the Intervention

3 Framing trafficking and intervention

3.1 Key frames in legal and institutional documents

This section discusses how trafficking for sexual exploitation is framed in law and policy and some of the implications, tensions and contradictions which are revealed.

3.1.1 Trafficking as a criminal offence

Trafficking for sexual exploitation is first and foremost framed as a criminal offence as defined in the Sexual Offences Act (SOA) 2003. In keeping with most criminal law, references to victims and perpetrators are gender neutral. On the one hand, this is important in acknowledging that women can be, and are, involved in the trafficking of other women, while men can be, and are, among the victims of trafficking for sexual exploitation. On the other hand, as in most cases, gender neutrality serves to obscure differences between women and men in routes into criminality, as well as the fact that women, as a group, are disproportionately victimised and, more specifically, that women facing multiple or intersectional discrimination are among the most the most vulnerable.

The consequences of trafficking – framed as a gender neutral crime – are that law enforcement activity and prosecution are deemed to be the primary interventions, while efforts to combat the underlying causes – gender inequality and intersectional discrimination – remain, by comparison, under-resourced and secondary. This is also reflected in current policy in the Human Trafficking Strategy 2011, published by the Home Office, with an emphasis on 'disrupting trafficking networks before they reach the UK; smarter multi-agency action at the border; improved coordination of law enforcement in the UK, and strengthening intelligence gathering and sharing'. Further, while government policy is also to 'improve care arrangements for victims', the secondary and subordinate status of these interventions is again revealed in cuts to the funding of specialist women's support services which have taken place over the last several years under the banner of 'austerity measures'.

3.1.2 Trafficking as Organised Immigration Crime

While awareness in the UK of internal trafficking is growing, both of UK nationals and of women from abroad (after they have been trafficked into the country), the emphasis remains on the cross-border elements. This creates and reinforces a strong association between immigration and trafficking such that trafficking is also prominently framed as 'organised immigration crime'. This framing is similarly gender neutral and, again, obscures the differential access to legal means of migration available to women and men. In terms of the EU, however, and specifically the expansion of the EU over the last decade, rules on freedom of movement and residency rights in the exercise of Treaty Rights challenge the function of border controls in efforts to combat trafficking, and have led to a shift in focus to so-called (welfare) 'benefit fraudsters' and 'NHS tourists'. This may adversely impact women from within the EU who are unable to demonstrate that they are exercising Treaty Rights and who consequently may be at risk of deportation (and re-trafficking), while women from third countries may fail to access vital medical services or face large financial liabilities if they do. This had the further effect of creating conflicts in mandates whose first duty is to treat and care for patients but who also now have an obligation to establish their immigration status.

3.1.3 Official identification of victims

In addition to ratifying international law (the Palermo Protocol), the UK has also ratified the Council of Europe Convention on Action Against Trafficking in Human Beings (CoE Trafficking Convention). In accordance with its provisions, government has established a process for the identification of victims,

namely, the National Referral Mechanism (NRM). The terms of the NRM provide that frontline, or first responders, such as police, local authorities, health and social care services, as well as a number of NGOs, refer suspected victims of trafficking to the competent authority to investigate and determine their status. There are two competent authorities, the United Kingdom Human Trafficking Centre UKHTC) and the United Kingdom Visa and Immigration service (UKVI) which deals with referrals from third country nationals. In the case of adults, the referral can only be made with the written consent of the victim but in all cases it is a two-stage process: initially it is made on the basis that there are reasonable grounds to suspect an individual is the victim of trafficking. The Competent Authority then undertakes investigations with a view to confirming or rejecting victim status. Pending that decision, and within a 45 day reflection period, a woman is entitled to be accommodated and to receive a range of support services. If her status as a TSE victim is confirmed, she will be entitled to continued support. If it is not confirmed, support services may be withdrawn, and she may also face prosecution, for example, for immigration-related offences and/or be deported if she is from a third country. In the case of EU women, they may also be deported unless they can demonstrate they are exercising Treaty Rights.

3.2 Key frames from the perspective of intervention professionals

The main themes or frames to emerge from workshop discussion were public protection/duty of care, risk, multi-agency co-operation and information sharing, and immigration/asylum.

(1) Public Protection/Duty of Care

Public protection was prominent in one of the workshops but the "duty of care" frame featured strongly in both, albeit with differences in perspective. In one, the focus was on public protection in which the duty of care was understood as a formal, quasi-legal duty to intervene where women, other than just the victim, were potentially at risk. There was a sense that the duty of care was something external to, and imposed on, participants and that it could and, indeed, should be invoked to justify actions even against the wishes of Maria.

> *There is a duty of confidentiality to them* [individual victims] *but not if there are issues of public protection. You still want to protect them and will do intelligence gathering first, but public interest means public protection and safeguarding* (Police).

A participant from the lead NGO initially expressed some doubts about overriding the wishes of an individual woman, but fell silent when another participant asserted:

> *There is some legislation about the duty of care* (Refugee/Asylum).

This assertion was unchallenged suggesting a more or less common understanding that there was some overarching legislative framework which was invoked to justify actions and interventions even against the wishes of Maria.

By contrast, public protection was not a dominant frame in the other workshop, and the duty of care was invoked by only one participant to justify non-consensual interventions where others may be at risk and in need of rescue.

> *I'd have no hesitation in 'phoning the police and asking them to visit that address* (the brothel) *and this would almost certainly happen. I have a duty of care to send officers to the address. There is prima facie evidence of a crime, there will be more than one woman in the brothel so I have a duty of care to potentially more victims, to potentially rescue sometime, potentially rescue others. If there is a threat, I have a duty of care* (Faith-based NGO).

There was consensus, however, that the duty of care emanated, not from some overarching legal framework, but from participants' respective professions or organisations.

> *If there's a crime I have a duty to tell the authorities. If you're working as a social worker, you have a duty to her* (the individual woman) (UKVI).
>
> *You're limited by the money the government gives you so when that stops, the duty of care stops. The duty of care ends. It's* the *same for all of us. It depends on the relationship you have with the organisation that pays your salary and pays for the work you do* (Lawyer2).

As the above quote suggests, a duty of care is a frame shared by all although the recipient of the duty varies from profession to profession and agency to agency. It was not perceived as having any ethical foundation but was instead embedded in a professional code of conduct (lawyers) or emanated from the organisation professionals were engaged by/the role they were required to perform. This was most clearly articulated by an UKVI participant. In this sense, the duty of care was expressed as coming more from within professionals' organisational or organisational roles. One clear difference emerged, however, between a faith-based and a feminist NGO. The latter participant did not express her work in terms of a duty but instead focused on issues of women's empowerment and self-determination. The participant from the faith-based NGO, on the other hand, was strongly wedded to a duty of care which was embedded in a rescue discourse.

Subframe (1a) Trafficking as a crime

A subordinate frame here was trafficking as a crime, in line with the official frame defining trafficking as a criminal offence. Other than the prosecutor, this was particularly the case for the UKVI participant and for the participant from a faith-based NGO who also invoked this frame to justify non-consensual interventions and compared it to other crimes for which a victim's permission (to act) was not required.

> *It's complex, the whole thing about a victim. You don't need consent to investigate a crime, like an NRM decision. It's not the case with any other crime that you have to go before a panel to decide if you're a victim* (Faith-based NGO).

CPS also confirmed that no permission was needed to prosecute a trafficking offence but identified the victim's cooperation as helpful.

> *You don't need the victim's permission to treat it* (trafficking) *as a crime...*
>
> *It's very difficult. In DV the policy has changed and if the victim doesn't cooperate we still try to build a case because we are sending out a signal that it's not acceptable. We can do that with trafficking as well. I've prosecuted cases based on flight schedules, bank information, text messages and the like, but if you have the cooperation of the victim, life is much easier* (Prosecutor).

In the other group, by contrast, participants did not explicitly invoke this frame. It was, however, nonetheless implicit in references to public protection. This was most clearly articulated by police but it was also shared by other participants.

(2) Risk

Risk discourse was exclusive to one of the workshops, perhaps because of the greater focus on public protection but also because of the formal victim pathway which has been developed in that area, geared to ensuring a victim's immediate safety, and the trafficking MARAC.

> *You have to risk assess her vulnerability. There are several options through the pathway and an emergency MARAC. If you see a risk you call social services and ring 999 (the national emergency number)…If she's saying she's in a brothel, that she's in fear of persecution, then she's at risk and you have to act* (NGO2).

This was also endorsed by other participants, including the police who added that:

Failure would mean a serious case review[6] (Police).

Here, risk is built into the approach with the corresponding interventions – risk assessment, removal to a place of safety, action – being inherent to the process as well as a means of professional and organisational protection, in which the victim's wishes, at this point are not paramount or even irrelevant.

This stood in sharp contrast to the approach taken in the second workshop in which no risk discourse was present, although one participant did engage in a rescue discourse based on risk to the victim and other potential victims (see above). This again was in the context of a duty of care, in this case, to intervene to remove all potential victims but was challenged by another participant.

> *The duty is first to do no harm. The first duty is that intervention will do no harm. In that situation, if you mention the police, unless you've explained a lot of other things like the reflection period, a safe place, all those reassurances, you're as likely to do harm than good – to do more harm than good, especially if there's no consent* (Lawyer2).

As indicated above, the dominance of a risk discourse in the above workshop is explained through the processes and procedures which operate in their area and which determine professional responses and interventions. There is a subordinate frame of 'rescue' expressed through phrases such as 'referral', 'removal' and 'entering the pathway'. A rescue discourse was also articulated by the faith-based NGO in the second workshop but, as previously indicated, this was not shared by other participants there.

(3) Multi-Agency Co-operation and Information Sharing

This frame was more prominent the workshop with a risk discourse. On the face of it, the two aspects might be regarded as separate frames but, in practice, they were inextricably inter-connected. This is largely a consequence of the process which has been established in that area, the 'victim pathway', for responding to potential victims of trafficking. It was taken for granted that agencies would share information and cooperate with one another, with or without a victim's consent, with issues of confidentiality being deemed adequately protected by all those attending a MARAC signing an accord (see above). One participant did point to possible strains in the system.

> *If she* [the victim] *comes to a refuge, you get a health assessment and engage a solicitor, but if someone is found and then comes in via other referrals, you can get a mess of referrals in one day* (NGO1).

Multi-agency work was, however, accepted and endorsed as an essential part of the process of response and intervention with the sharing of information deemed not only central to that process but also central to the task of public protection and the basis of trust between agencies.

> *Public protection is the main issue and we need agencies to share information with the police so we can gather intelligence. And it's about trust. Trust is an issue between a client and an agency and between agencies* (Police).

In the other workshop, inter-agency cooperation and information were less evident and considerably more limited. This approach was most likely to occur between agencies with shared mandates – in broad terms – such as among referring agencies and support services, or between police and CPS.

> *In lots of cases I've been involved with, the police have received intelligence about a trafficking operation so they've commenced observation of various brothels and followed suspects and*

[6] This is a process involving close scrutiny of non-/responses to an incident with a view to accountability.

> *they will come to us before any raids or arrests are made so we can have a strategy and plan of action. So when the police do go in, one of us can be on standby to advise straightaway, to advise on what to do and what they're looking for* (Prosecutor).

The same participant also stressed that during the pre-trial legal process, rules of disclosure obligated her to make available any information to the defense which was relevant or potentially of assistance to them; further, that CPS had a duty to obtain that information from all other parties, including support agencies. These agencies, in turn, were obliged to release the information to CPS unless it was covered by legal privilege.

Another participant, however, commented on the reluctance of other agencies to release information to her agency and the potential negative consequences for victims.

> *I understand why other organisations feel they have to retain information but that can affect an asylum decision because we don't have the full picture* (UKVI).

(4) Immigration/Asylum

This frame featured in both workshops but was more prominent in one of them. In the other, it is best described as a subordinate frame, as it only came to the fore following the transition in the narrative to Maria as an EU national. There participants speculated that in the absence of an immigration issue a victim of trafficking may be less likely to be identified although there was an unchallenged suggestion by one participant that they are also more vulnerable.

> *There's more work with asylum seekers than with EU migrants, so they may be less likely to be identified even though the figures are higher* (LA/Asylum).

> *The EUs are a lot more vulnerable as they also have drug and alcohol issues. They have access anyway but then they're more vulnerable, they've grown up in care and have family issues* (NGO1).

In one workshop, participants also queried whether EU nationals might be less likely to be identified.

> *Look at scenario C* [in the narrative], *I can't imagine the police response would be the same with an EU national because that immigration issue wouldn't be flagged up. I think immigration issues are quite an alarm bell for trafficking* (Lawyers).

However, immigration also emerged early on as an issue in the discussions in this group. Initially it arose in the context of the NHS now having to charge foreign nationals for medical advice and treatment. While the NHS participant pointed out that this was not the case in sexual health clinics, she was reminded that the narrative did not specify that Maria had attended a sexual health clinic and participants went on discuss the impact questions about immigration status might have on a potential victim.

> *Well they have to ask because they then have to say that we will charge you if you don't have immigration status, so that's a pretty scary question* (Lawyer2).

> *Even if she's not aware of her immigration status or how long she has left on her visa, it's just quite scary* (Lawyer1).

One participant felt it was less of an issue.

> *There's no problem with that. If someone's from Africa, they expect to pay, their concept is quite different from ours* (Faith-based NGO).

Subframe (4a) Austerity measures limit women's choices

A subordinate frame here is the issue of austerity and cuts to funding of services. This was mentioned explicitly in relation to health services, as indicated above, but it also emerged in relation to limitations on the availability of legal aid and the 'no recourse to public funds' rule, and with respect to a sharp drop in the availability of accommodation for the victims of trafficking seeking support from the specialist NGO. This meant that lawyers at times had to bend the rules a little in order to be able to advise and represent their clients, but it was also acknowledged to potentially limit women's choices in other respects, particularly with regard to entry into the NRM. Women's consent is required for this process, but it was regarded by most participants as a gateway to support services. Only a feminist NGO was able to offer their services to women who were not in the NRM. In one area, however, this excluded accommodation while in the area of the other workshop it was limited by the severely reduced availability of beds. In circumstances, therefore, where women do not wish to enter the NRM, their choices are very limited. This issue is discussed further below; however, it is illustrative of the ways in which government policies ('improved care to victims' and austerity measures) are in tension, with the effect of undermining women's self-determination and restricting the services which aim to empower women.

3.3 Frames and Interventions

In one workshop, the dominance of the public protection frame gave rise to a perceived duty of care which mandated intervention without a victim's consent, or even against her wishes. Combined with a strong risk discourse, participants agreed they could, should and would act to protect the victim, other potential victims and/or the public. The intervention itself was determined by a 'victim pathway' which further necessitated multi-agency co-operation and information sharing, most typically in the form of a MARAC. This, again, could be convened without the consent of a victim and decisions were taken by professionals about the most appropriate course of action without the active participation of the woman. With respect to referral into the NRM, the requirement to obtain consent was acknowledged and endorsed by participants and seen as 'giving her back control', while in reality it was conceded that women in fact had little choice. If consent was not forthcoming, only very time-limited support and few services were available, while a negative conclusive grounds decision meant a woman would have to leave the support services, including accommodation, with short notice. This process- and procedure-driven approach accounted for a sense of a shared mandate and created a sense that a victim's individual rights were subordinate to the rights and freedoms of others, and could be overridden in the interests of protecting others.

This approach was shared by only one participant from a faith-based NGO, where a rescue discourse – and trafficking as crime - was invoked to justify the action. By contrast, a feminist NGO stood outside both the public protection and the duty of care frame, insofar as interventions were based exclusively on women's own decisions within an ethos of self-determination and empowerment. With respect to other participants, there was greater emphasis on a duty of care as inherent to professional rules or organisational roles. Hence, there was no overriding mandate of public protection. Instead, interventions were shaped by individual constraints which determined what could, would and should be done in the discharge of that duty. For the lawyers this was to act only in the interests of their clients and with their express consent, but the duty ended when all possible legal remedies had been exhausted and/or funding ceased to be available. The prosecutor's duty was to act in the public interest (as opposed to public protection)[7] and in accordance with the

[7] 'Public interest' is part of a two-stage test employed by prosecutors in deciding whether to prosecute a given case. The first stage is the evidentiary test, whether a prosecution is more likely than not to result in a conviction, and the second stage is the public interest test. The prosecution of offences such as trafficking is

professional rules applicable to the conduct of criminal proceedings. She had no duty to any individual victim and would, for example, only seek special (protective) measures if this was necessary to 'achieve best evidence'. For UKVI, the duty of care was to the organisation while for health workers it was to the patient. Here, potential tensions arose between that duty and a requirement to ascertain the immigration status of service users with a view to seeking payment where necessary. However, the participant from the NHS came from the sexual health sector where consultation and treatment is free of charge, hence, this could not be further productively pursued.

There was, therefore, no sense of a shared mandate among participants in the second workshop which was also reflected in low levels of multi-agency cooperation and information sharing. Similarly, although trafficking framed as an immigration issue was a strong theme here, interventions were shaped by participants' individual professional roles. This was deemed problematic by UKVI in circumstances where support organisations, in particular, were reluctant to disclose information. Only the participant from a feminist NGO indicated routine information sharing (although not multi-agency work) with other agencies but, again, only with a woman's express consent and in accordance with their approach of self-determination and empowerment. Here, however, financial constraints severely limited the numbers of women accessing the services.

The approaches taken by the two workshops stand in sharp contrast and raise a number of issues. In one, interventions intended to assist and protect women might in fact serve to undermine women's autonomy, rights and freedoms. The requirement to remove a victim to a place of safety overrode the wishes of the individual, while the need to protect other victims and/or the public rendered her rights subordinate to the rights and freedoms of others. Far from considering this problematic or debatable, however, these actions were justified as not only possible, but as necessary and fully mandated by process and procedure.

In the other, however, the absence of a formal process raised doubts, in the first instance, that women would be identified because of a lack of knowledge on the part of first responders or other agencies with which women might come into contact. Even once past the entry point, there was a sense that interventions were more fragmented, or contingent, for example, on the availability of legal aid or bed spaces. This raises questions as to the identification of victims, with many women possibly falling through the net. Thereafter, the extent to which women are able to exercise their rights appears to depend on which support services are accessed and whether they consent to referral into the NRM, a process identified as potentially problematic. This is further discussed in Part 3 below.

4 Framing of culture and difference

There was very little reference to culture in either workshop. In one group an unchallenged reference was made by one participant to EU (and internally trafficked) women being more vulnerable because of drug, alcohol and family problems rather than 'just' poverty. Another participant, in describing the post-MARAC process, asserted that in some cultures women may be unaware that they have been trafficked.

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usually deemed to be in the public interest or good, and is assessed by reference to factors such as the seriousness of the offence, the level of culpability of the suspect, the circumstances of and the harm caused to the victim, and the impact of the offence on the community.

> *There's an action plan that sets out who brought the issues, what the issues are and who will act and by when but one of the issues is that, in some African and Asian cultures, they are not aware they've been trafficked and think it's in their best interests* (LA/Asylum).

This assertion also went unchallenged and poses an interesting juxtaposition with perceptions of EU women, particularly when placed in the context of earlier discussions on choice and consent or, more specifically, decisions to override consent. While public protection dominated, these assertions also seem to be infused with a rescue discourse. On the one hand, interventions are justified with respect to EU (read Eastern European) women because they are 'more' vulnerable. On the other hand, interventions are justified in relation to African and Asian women because they do not know what has happened to them or what is good or bad for them. In this sense, practitioners appear to be culturalising the experiences of minority women.

Another participant referred in particular to Indian women and asserted that, once in the support system, they are not only more demanding of services but that they are also better able to manipulate them.

> *That's like the Indian women I work with. They won't let me go. They ring again and again and they're clever at playing agencies off against one another* (NGO).

Again, this points to the ways in which culture shapes perceptions, in this instance, of Indian women who were seen as demanding and manipulative rather than vulnerable and needy. This statement was, however, subsequently challenged.

> *No, it's an individual matter. There's no pattern* (Lawyer).
>
> *People who have lived in the UK know the system. It's not cultural as such* (Health).

These exchanges are indicative of the ways in which culture becomes associated with racism, particularly when generalisations are made, and the need to resist this.

Racism also briefly emerged as an issue in the other workshop in the context of the NRM process in which, statistically, EU citizens are more likely than third country nationals to get a positive conclusive grounds decision.

> *I don't rule out racism or an obsession with immigration but no-one has really dug in there and actually looked at why that difference exists* (Faith-based NGO).

In fact, this assertion is not correct as research on the NRM process has been undertaken with the conclusion that there are potentially discriminatory practices by decision-makers.

There was no discussion of a majority culture; nor did class emerge as an issue in either workshop save as implicit through reference to poverty but, as it was linked to migrants, it was not understood as class. Given the absence of detailed discussions, however, it is difficult to draw conclusions about different experiences of minority groups or different intervention routes and patterns. In part, this is undoubtedly because trafficking differs from domestic violence or child maltreatment in that practitioners, with the exception of those dealing with internally trafficked UK citizens, are invariably dealing with 'foreign' women who are, by definition, minorities in the UK, and processes and practices have developed around this.

Part 3: Ethical Issus and Dilemmas

5 Ethical issues in the workshops

5.1 Consent

In the workshop with a strong focus on public protection, this laid the foundation for a duty of care in which ethics equated to a formal, quasi-legal responsibility, and which all but precluded ethical dilemmas from arising in the early stages. Subsequently, the dominant multi-agency cooperation and information sharing frame fore-grounded risk assessment processes to determine and justify interventions, if need be without, or even against, a victim's wishes. A woman's consent was relevant but only after she had been moved to a place of safety. As noted above, initial doubts raised by one participant who mused that *it is a human right to make your own decisions* (NGO1) were overridden. With respect to referral into the NRM, for which consent is needed, non-consent was considered to pose challenges but, interestingly, women were then also perceived as autonomous.

> *You make short term interventions, then it's up to them how they live their lives. These are challenges for everyone* (UKVI).

This same participant, however, also believed that there was an alternative care pathway for women outside the NRM process but this was quickly corrected.

> *Unfortunately we can only support those who are in the NRM. We'd meet her and discuss why she's fearful of identification. Sometimes we can take in women in an emergency but only for a very short period and only to meet her basic needs…We cannot guarantee the safety of non-EU women. They thought they were safe and then they end up sleeping in a bus shelter* (NGO1).

This latter reference concerns circumstances in which a conclusive negative grounds decision is issued, allowing a woman just a few days to leave her safe accommodation and access to support services. On the one hand, the damaging effect of this decision on the woman concerned is clearly acknowledged – '*she thought she was safe'* – together with some sense of a breach of trust. On the other hand, this is mitigated by an inability to '*guarantee safety'* (NGO1). Here, the systems and processes intended to protect women have now turned against them, but there is sense that they have been set up in such a way as to almost design out the potential for dilemmas.

These issues also give rise to additional questions. Given the dominance of the public protection/duty of care and risk frames in one of the workshops, there appears to be little questioning of the consequences of the fairly sudden withdrawal of support. Is public protection and risk no longer at issue? Has the duty of care ended? Participants did not explore these questions and their implications for the processes and procedures they accept, rely on and endorse. In this sense, there was an absence of acknowledgement of any 'deficit' on their part, or a querying of the privilege they enjoy through their professional mandates.

5.2 First Responders as Gatekeepers

This theme was absent in one workshop, notably because of adherence to a formal process and having a central referral point. In the other, it emerged during the course of discussions triggered by one participant's comment that a review of the NRM was currently underway to consider who should be included in the 'list' of first responders, whilst bemoaning that, once on the list, there was no standardised training or criteria for removing 'bad' first responders. In response to a question from another participant as to what makes a good or bad first responder, he replied:

> *Knowledge, experience, objectivity. I have dilemmas. Every fortnight or so, I get a call from a solicitor who says 'I've got a trafficking case, will you refer it for me', and how do I make that*

> *decision? Do I just refer it, or do I send someone from my office to make an assessment?* (Faith-based NGO).

This triggered a series of further responses.

> *We get referrals from port officers. Sometimes they're ridiculous but it's better to err on the side of caution and make the trafficking assessment even if there's only one indicator. And, for example, there have been referrals from social services via schools or a GP's receptionist* (UKVI).

> *That's the point, that the school or the receptionist might have had genuine concerns but what if they're not shared by the first responder?* (Lawyer1).

That's the problem, there are guidelines and things but no-one has told me what my duties are as a first responder. To have anyone be a first responder sounds good but there are conflicts of interest. I can remember when CPS was *a first responder but then there were conflicts between that and prosecuting* (Faith-based NGO).

Another participant pointed out that it was a requirement that *first responders take all the answers and get consent* (Lawyer1), however, the original questioner remained dissatisfied.

> *It terrifies me that there's a gatekeeper in the way that I might refer someone to them only for them to say, no, I don't think they are* [trafficked]…*The point is whether the first responder is a referral agency or a decision-maker and that's the clarification that needs to be made. Why do they need objectivity if they're not making a decision? And why not self-refer? An asylum seeker can make a claim, why not a victim of trafficking?* (Lawyer2).

This exploration of the power of the first responder as a gateway into the NRM reflects concerns with the ways in which an established process or procedure, mandated by law and policy, may conflict with professional assessment of a concrete situation and give rise to conflicts between the 'correct' course of action as perceived by different professionals/practitioners. It also underlines the absence of the multi-agency cooperation and information-sharing frame so prominent in the other workshop.

5.3 Culture of Disbelief and NRM Decision-Makers

This is a theme which arose in different contexts during discussions in one workshop but mostly focused on referrals into the NRM process. It was related in particular to UKVI as a decision-maker regarding NRM status and was identified as a source of potential tension by some practitioners, particularly lawyers, who were outside of that decision-making process.

> *There is a huge culture of disbelief. It's very hard to say to someone that you might have formed a relationship of trust with, to essentially refer them into a process where they may well not be believed* (Lawyer1).

> *In the course of advising a client, we've had to test the evidence…I can say none of my clients have lied. Some don't always disclose everything or they've been given a story by their trafficker but it's a very severely tested process to go through asylum or any other application* (Lawyer2).

These quotes illustrate the difficulties legal professionals experience in providing advice to clients on the question of consent to referral into the NRM. This is essential if they are to receive support, and it will also assist with any application for leave to remain in the UK. Indeed, a positive conclusive grounds decision will often be the basis for granting an application. There is an added dilemma in that the prior rigorous testing of the evidence is not sufficiently regarded and that a contrary decision may also have the effect of undermining the judgment of the professionals concerned.

This was to some extent acknowledged.

> *Credibility is always an issue. In my office we have tried but with the trafficking assessment, there's a focus on trusting the experts, like* [one NGO] *or* [another NGO]. *But there do come issues and we have a conflict in information and there's this issue, the culture of belief versus the culture of disbelief, so UKVI don't believe anything and* [the NGO] *believe everyone's been trafficked. So I think there's an issue with each other's process. Sometimes we have information which conflicts with the information provided by the applicant, for example, you say 'you've been trafficked', but then we find you had a visa, and another visa, and that undermines your story. We have a saying in our office, the 'bull-crap-sandwich', you get the truth, then a lie, then the truth, and I think in the culture that I work in, in immigration, it can encourage people to exaggerate. It is very difficult for a decision-maker to separate that* (UKVI).

In this context, some conflicting views also emerged with respect to the labeling of individuals as 'victims of trafficking'. One participant considered this might be a benefit of obtaining victim status, a kind of 'emotional justice', while another highlighted that the label might be problematic.

> *I've had lots of clients recognised as refugees which is important even if they've already been given humanitarian protection and access to support services. I haven't come across it but I can imagine it might be just as important to trafficking victims, it's a kind of emotional justice* (Lawyer1).

> *I've also had clients that have wanted the opposite, who don't want to be stamped as a victim. They say, 'this is going to follow me, the government will always know this horrible thing has happened to me', and they're afraid of that* (Feminist NGO).

Associated with these discussions was also a critique of the NRM and asylum processes.

> *The problem arises when a person with authority to give leave is also the person who decides if someone is trafficked. In other countries it's often first responders who make that decision and a person is then assessed separately for asylum* (Lawyer1).

These frank discussions reveal tensions and contradictions in the intervention system and the differing mandates of various professionals. They underline the strong immigration/asylum frame so prominent in one of the workshops. For those non-decision-makers providing advice with respect to consent to referral into the NRM, there is the uncertainty that this will prove to be in their clients' best interests, and the knowledge that a refusal is likely have serious repercussions for the women concerned. For lawyers, the dilemma is addressed through their professional code of conduct in providing advice based on the evidence with their clients' express consent, and in exhausting all legal channels or sources of funding. For a feminist NGO consent is also central to any course of action. However, the issue of how they would approach a situation in which they assessed a woman as trafficked but had no available bed spaces was not addressed.

On the other hand, UKVI is also obliged to test the evidence but, in doing so – often with input from the 'experts' – conflicting evidence is more likely to lead to negative conclusive grounds decision, that is, they are inclined to err on the side of a culture of disbelief, even while acknowledging that the situation women have been placed in may encourage them to 'exaggerate'. In this sense, professional or organisational mandates determine actions and outcomes.

6 Summary

As will be apparent from the foregoing, approaches to intervention differed significantly as between the two workshops.

In one workshop there was reliance on procedure and process – a 'victim pathway' – which mandated multi-agency cooperation and information sharing. It was underlined by a strong public protection/duty of care frame which was invoked to justify interventions without, or against the wishes or consent of individual women. While one participant did suggest that lack of consent had previously been used as an excuse for inaction, the absence of consent did not appear to cause participants concern. This reflected an assumption that the 'process' was correct and adequately safeguarded confidentiality, and that practitioners were best placed to determine what was in women's interests, where they identified risk to a victim or other potential victims. To some extent, this was at odds with a strategy to build trust in the early stages of the process. It also stood in stark contrast to the situation in which a negative conclusive grounds decision was issued and the 'process' ceased to mandate a duty of care or public protection.

There was little discussion of culture, although the experiences of minority women were culturalised by some practitioners in that their responses to trafficking or intervention were attributed to certain traits associated, in particular, with African and Asian cultures. With respect to EU women, there was acknowledgement that differential rights led to differences in how women's stories are heard or assessed, with an implication that they might be less likely to come to the attention of the authorities.

Overall, the strong reliance and endorsement of frameworks of interventions created a strong sense of a shared mandate, and appeared to preclude or marginalise tensions within and between agencies, with women's rights and freedoms being subordinate to, or conduits for the protection of, the rights and freedoms of others.

In the other workshop, by contrast, the duty of care was less associated with mandates of public protection. Instead, participants expressed the duty in more individual terms by reference to professional codes of conduct or organisational obligations inherent in their respective roles. Only one participant from a specialist feminist NGO stood outside a duty of care frame and instead focused on women's empowerment and self-determination. Multi-agency cooperation was not the norm and information-sharing was largely confined to agencies with similar mandates. Indeed, there were illustrations of the ways in which the reluctance of some agencies to share information with others could negatively impact the intervention process.

The strong immigration/asylum frame prevalent in this group also revealed a number of conflicting mandates and tensions, as well as some distrust of the intervention system. A lack of knowledge on the part of some first responders was indicated, while the role of others, potentially as gatekeepers, was challenged. Concerns were further raised with respect to the duality of the role of UKVI in simultaneously determining both victim and immigration status, particularly in the context of a perceived culture of disbelief of potential victims and asylum seekers.

There was no discussion in this group of culture. Instead, the focus remained on immigration status, Treaty Rights, with immigration issues in particular as an important point of entry into interventions.