University of Nottingham
Rights Lab

St Mary's University Twickenham London
Bakhita Centre for Research on Slavery, Exploitation and Abuse
Applied Research, Education and Training

Pathways to Liberation

A policy report

JUSTRIGHT SCOTLAND

Hestia
LIFE BEYOND CRISIS

HOPE FOR JUSTICE

FLOURISH
a brighter future

migrant help

CAUSEWAY

Women's Aid
BELFAST & LISBURN

TARA
Trafficking Awareness Raising Alliance

Migrant Legal Action

SIFA fireside

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Executive Summary

Survivors[1] of modern slavery and human trafficking in the UK are entitled by law to support, currently provided through the National Referral Mechanism (NRM). Previous studies have identified concerns around inadequate survivor support and resulting long-term impacts on mental and physical health, poverty, destitution and risks of re-exploitation. This research critically examined how survivors experience life post-exploitation and support services in the UK, and undertook a comparative analysis of the effects of support available in England and Wales, Scotland and Northern Ireland. Its aim was to contribute new understandings shaped by a population currently absent from the analysis and measurement of survivor needs—those persons who have lived experience of extreme forms of human exploitation—to suggest models of support based on the research findings, and provide recommendations on the reform and improvement of existing support frameworks and pathways. The need for evidence-based scholarship to contribute to the development of the provision of UK support from a survivor-centric perspective is neccessary to drive a coherent and logical approach to policy and service provision for survivors.

This is an important study, the biggest of its kind in the UK context. The findings provide a comprehensive insight into the effectiveness of existing government-funded support systems for modern slavery survivors. They are based on analysis of data from 95 in depth interviews with survivors of modern slavery across all four UK nations, and five workshops with representatives, from survivors/lived experience consultants, to NGOs, law enforcement and government departments. The study highlights the variability in support based on location, availability of wrap-around services (such as counselling and psychologial support, medical and legal support, interactions with the criminal justice system), and the consequences for survivors mental and physical health, which frequently deteriorated over typically very lengthy periods of waiting. The report also identifies examples of good practice available in the different NRM systems, as well as areas for improvement. The report concludes by offering a ‘re-imagined NRM’, grounded in the findings of this important study.

[1] The research team recognise the problematics of the term survivor, but for brevity we use this term to define those who have been identified under the National Referral Mechanism as having been subjected to ‘modern slavery’ as defined by the Modern Slavery Act 2015.

Key Recommendations

Develop local or regional hubs for survivor services, involving local statutory services as well as statutory and NGO support providers, to help overcome fragmentation in the existing system and ensure that survivors are assessed consistently.

Re-house decision making and contract management within the department of Health and Social Care to prioritise care needs and prevent conflation with immigration policy objectives.

Commission NRM services within a framework that creates clearer lines of accountability to service users and government. Make details of performance against the contract available for public scrutiny and that of Parliament, for example through inclusion in the Independent Anti-Slavery Commissioner's annual report.

Provide mental health support within 30 days of entering the system of support

Develop a Charter of Rights for victims/survivors that commits to survivors being treated with dignity and respect.

Provide 12 months of automatic leave to remain on receipt of a positive Conclusive Grounds decision, which includes the right to engage in paid employment and access to education.

Improve decision making mechanisms (NRM) and asylum (UKVI) and instigate protocols for timely communication with applicants during the waiting period.

Implement a two-stage consent process, with initial consent re-visited after 30 days so that survivors have time to understand the implications of the NRM and the information they have received.

Investigate further how digital records and data-agreements can help professionals work across agencies to communicate details such as case histories without requiring survivors to constantly re-explain their story.

Implement standardised training aligned to the National Training Standards for supporting adult survivors and ensure that all first responders and support workers are adequately trained to support victims safely into recovery and (re)integration.

Seperate the provision of emergency personal support (particularly emergency housing, mental health support and legal advice) from wider decision-making about whether an individual has conclusive grounds to be regarded as a victim of modern slavery. Our workshop particpants suggested an initial 30-day support period would be more effective than referring people straight into the NRM. This will better enable the provision of accessible information to people entering the system, help to fast track people into alternative support mechanisms - if appropriate - and support informed consent.

Undertake a recovery assessment for all people referred into the NRM, to ensure needs are properly understood at the outset and help to provide more individualised support. The focus should take account of strengths as well as needs, including education, skills and work-experience which might support independence.

Establish six months of post NRM transition support as standard, and prior to the existing Recovery Needs Assessment process.

Give careful consideration as to whether it is necessary to move individuals to alternative towns and cities, where they may not have existing networks. Decisions on the timing and destination should involve the individual and be subject to full and informed consent.

Provide more help to enable survivors to build connections within their host community. This could include access to communication basics, such as wifi and phone credit, help with travel costs through local transport passes, and signposting to local networks and community groups that might be of interest.

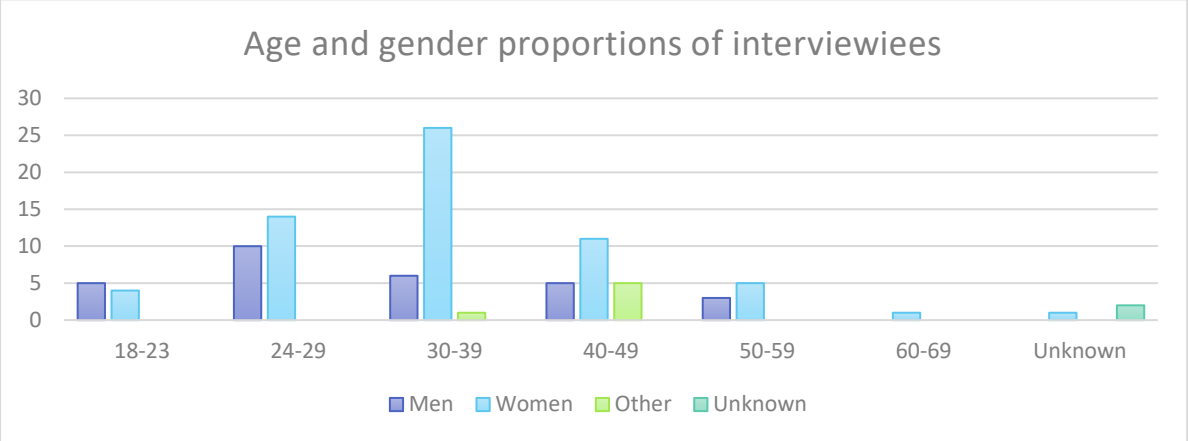
Methodology

The study involved an initial literature review, the aim of which was to examine existing data on the experiences of potential victims of modern slavery both inside and outside of the National Referral Mechanism. The literature review was followed with an analysis of Home Office NRM Data, and primary data collection though in-depth interviews carried out with 95 survivors across the UK nations and from 36 different countries of origin. These interviews were conducted in three tranches to identify the support journeys of this population, their support needs, and barriers to accessing support. World Health Organisation Quality of Life surveys were also carried out with the majority of participants (where permission was granted).

Data collection took place between January 2022 and February 2023, with workshops conducted March 2023-June 2023. Analysis of interviews was conducted using Constructivist Grounded Theory in order to develop theory emerging from the data.

Three design-thinking workshops were run with survivors who formed a lived experience researcher group, recruited following interviews to contribute their expertise to the project findings and outputs. The workshops were carried out in England, Scotland and Northern Ireland, to validate findings, explore key themes, and prioritise aspects of survivor experiences of the NRM for change.

Two further design thinking workshops were conducted, bringing lived experience researchers and stakeholders together to address the identified priorities for change and develop recommendations.



Survivor participants in three initial workshops by nation and gender:

	Scotland	Northern Ireland	England and Wales
Male	2	2	4
Female	4	7	5
Total	*6*	*9*	*9*

Areas identified as priorities for change by nation:

Scotland	Northern Ireland	England and Wales
Training	Training	Training
Consent	Consent	Consent
NRM reform	NRM reform	NRM reform
Asylum reform	-	Police service improvements

Participants in two subsequent combined final workshops:

Training and Consent, Workshop 1	Re-imagining the NRM, Workshop 2
9 lived experience researchers	9 lived experience researchers
Parliamentarian representative	Parliamentarian representative
NRM first responders	NRM first responders
Law enforcement	Law enforcement
Ministerial department	Ministerial department
Legal sector	Legal sector
NGOs	NGOs

Main Findings

The study found substantial variation in survivor journeys in and outside of the NRM with the current contract-based delivery mechanism fragmented and not always able to support recovery. The varation in survivors' experiences can be explained by the location of identification, support available in that location, timeliness of service delivery, length of engagement, and immigration status. In later stages of the recovery process, limited access to educational opportunites, lack of rights to work and to suitable accommodation compounded earlier negative experiences of the fragmented system on survivors' recovery journeys.

One fundamental challenge with the NRM is that at present it performs several distinct roles:

- Providing emergency support to those who may be in immediate danger, crisis, and frequently destitute;
- Offering stabilisation support to those who are recovering from exploitation, with the goal of enabling them to sustain freedom and support themselves;
- Officially recognising crimes of exploitation and offering access to justice and compensation.

These roles require different approaches to service delivery. The first role is akin to an emergency service, and arguably requires a consistent style of management and delivery to ensure rapid and consistent access to support, advice and healthcare. The second two roles benefit from a more co-productive approach, where the resources of government are combined with those of stakeholders and service beneficiaries to make services more effective. However, whereas engagement and involvement is pro-actively sought from the voluntary sector through the contracting process, the study reveals that survivor agency is actively being constrained and diminished by the current system.

The research finds that there are systemic failures in the provision of efficient services for survivors at the appropriate times in their recovery journeys which proves debilitating to their well-being, independence and recovery.

Conflicts in policy-making

Analysis of the data provided by the Home Office (comprising data from 55,462 individual NRM referrals) indicates that there is a problematic conflation between immigration and human trafficking policies in decision making. This data reveals that British nationals received 17% higher positive Conclusive Grounds decisions compared to any other nationality, indicating bias in current decision making. In this respect, where a fully independent body might not be possible, it is considered that decision making on services for Modern Slavery survivors in England and Wales would be better positioned in the Department of Health and Social Care.

Recommendation:

Re-house decision making and contract management within the department of Health and Social Care to prioritise care needs and prevent conflation with immigration policy objectives.

Fragmented and unequal support across the UK

Our research found that experiences of support differ dramatically across various parts of the UK, resulting in unequal outcomes for survivors' wellbeing and recovery. In some areas, case-support or advocacy workers were able to assist survivors with access to key services and community networks, but this often depended on factors such as the resources of the safe-house provider and whether services were available in the locality, as well as the knowledge and caseload of individual support staff.

Contact with statutory services was frequently problematic. Our research showed that in contracts to England and Wales, participants in Scotland were able to access mental health support much more quickly than survivors in England, a factor that was significant to enabling recovery and which reduced the length of time spent in support overall. This was a result of the Scottish Government implementing early stage specialist 'in house' mental health support.

Participants also highlighted poor information exchange between agencies, which meant that they were frequently required to re-tell their story to different agencies. Sometimes staff were not familiar with slavery and trafficking cases, which meant that survivors were sometimes treated with scepticism.

Our study also found that individuals seeking legal advice are frequently misadvised by non-specialist solicitors, yet information that should be routinely distributed, concerning the right to complain to the legal ombudsman, was not being made available.

Recommendation:

Develop local or regional hubs for survivor services, involving local statutory services as well as statutory and NGO support providers, to help overcome fragmentation in the existing system and ensure that survivors are assessed consistently.

The Contract Model

The research revealed differences in styles of commissioning and contract management across devolved nations, which were reflected in the responsiveness of survivor support services. In Scotland, the organisations providing survivor support had direct contact with the Scottish Government, with some stakeholders suggesting that this enhanced the ability of the Scottish system to join-up services in response to survivor needs, for example by embedding mental health support into the NRM.

In England and Wales, however, the responsibilities for contract management lie with the Salvation Army as principal contractor, with sub-contracted support providers who deliver the Modern Slavery Victim Care Contract (MSVCC). Although there is good evidence of support providers working relationally with beneficiaries and each other to try and overcome limitations of their contracted duties, there is arguably less opportunity for co-ordinating service delivery across wider government structures and institutions such as local statutory agencies, and greater fragmentation across multiple providers.

In addition, there are few opportunities within the NRM for service users, advocates or the wider electorate to hold the system to account. Although safe house accommodation has been quality-assured by the Care Quality Commission, the main responsibility for service efficiency and quality has been delegated to service providers under the MSVCC. This gives limited opportunity to review how services are impacted-by and connect with those of wider agencies, and for raising

concerns or highlighting insufficiencies, especially among those being sheltered by those same organisations.

Recommendations:

Create greater relational coordination between service providers and Government, and enable more responsive interaction between government representatives and service responders.

Commission NRM services within a framework that creates clearer lines of accountability to service users and government. Details of performance against the contract should be available for public scrutiny and that of Parliament, for example through inclusion in the Independent Anti-Slavery Commissioner's annual report.

Delays

The study found that not only are delays causing a significant decline in survivor wellbeing, but that they result in the creation of significant dependency. The average (median) time taken from referral to CG rose to 543 days in 2022. Waiting occurred in all aspects of survivors' journeys, from shortly after being identified, to post-NRM support. The waiting can be associated with two distinct strands of the process: State decision making processes (both NRM and asylum claims), and delays in accessing wider support within health and social care.

Respondents reported feelings of hopelessness, depression, anxiety, and self-harm among a range of other mental health challenges. Many respondents also experienced poor physical health, often as a consequence of their experiences of exploitation and abuse. The impact of poor physical health on mental health and vice versa is recognised within the NHS and the UK government,[2] and the Home Office reported that the median perceived likelihood of victims experiencing depression, fear and anxiety across all exploitation types was 100%.[3]

While lenghty waiting times for therapy are widespread among the general population. For the cohort of respondents in this study who have suffered significant trauma, extended delays in accessing psychological support can contribute to a significant decline in mental health and chronic mental health conditions placing further pressure on NHS resources in the long-term.

For asylum seekers in particular, the cumulative effect of these delays can at times be debilitating, resulting in withdrawal, depression and anxiety. These symptoms are further impacted by the conditons in which many seeking asylum find themselves. They are often housed in unsuitable accommodation, especially those in asylum accommodation such as mixed gender hostels or hotels. They lack access to cooking facilities, and can be reliant on food provided by the State that does not take account of their specific dietary needs. Even for those provided with temporary accommodation in the community, lack of adequate facilities, such as too few bathrooms, filthy conditions, mould and damp, contributed to experiences of being treated with a lack of dignity. Denial of the right to work, and/or limited or no access to meaningful education prevented survivors' reaching their goals or improving future opportunities, resulting in a decline in engagement with prosecution processes and the wider community, impacting criminal justice efforts and limiting their prospects for recovery and integration.

[2] Public Health England, Severe mental illness (SMI) and physical health inequalities: briefing - GOV.UK (www.gov.uk), 27th September 2018.
[3] Home Office, The Economic and Social Costs of Modern Slavery (Research Report 100, July 2018) 19: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729836/economic-and-social-costs-of-modern-slavery-horr100.pdf.

Recommendations:

Provide ‘in house’ mental health support within 30 days of entering the system of support

Develop a Charter of Rights for victims/survivors that commits to survivors being treated with dignity and respect.

While survivors were keen to retain the two stage decision making currently employed in all NRM systems, as it was seen as validating, it was noted that a positive conclusive grounds decision had no other effect. Given the above findings on the importance of work and education, and the impacts of poor accomodaton to survivors’ recovery and (re)integration, we recommend granting 12 months of automatic leave to remain on receipt of a positive Conclusive Grounds decision, which includes the right to engage in paid employment and access to education.

Limited survivor agency

The current delivery of support also resulted in significant survivor dependency, as opposed to supporting survivors through a journey to develop independence and resilience. Survivors reported having to rely on their caseworkers for advocacy with numerous state and other processes. This included communicating with UK Visas and Immigration (UKVI), housing, amenities, GPs and counsellors, as well as translators. Some survivors were not supported adequately with learning English due to a lack of access to classes or funding, and many did not understand the multiple systems they needed to engage with in order to access support, accomodation, and physical and mental health services. Their communications with the Home Office were often fraught due to last minute appointments, lack of translators, the perceived attitude of the interviewers, being disbelieved and having to recount their stories multiple times. They often were not aware of the distinction between the NRM, UKVI, or the Police if they were involved in a potential legal case as a witness. They were not offered clear explanations of these processes, and, due to time constraints, were forced to rely on caseworkers to make progress in their lives. Survivors also highlighted a problematic lack of legal advice as a factor in their sense of disempowerement, as they did not understand their rights and entitlements and were confused about how decisions were made. This was compounded by a lack of understanding of different systems, with survivors typically conflating NRM, asylum, and prosecution processes.

Once out of support, and left to themselves, survivors reported experiencing anxiety and fear, not knowing which way to turn for support. For this reason, many remained in contact with, and relied on, their support worker for lengthy periods following exit from services. In this way, the goodwill of caseworkers was arguably exploited by the system to fill gaps outside their job descriptions.

19% of survivors interviewed had also experienced street homelessness or local authority emergency homeless services, and 35% had experienced hidden homelessness. Hidden homelessness includes experiences such as sofa surfing and staying with friends or members of the community and would not be recorded in official homelessness statistics. These arrangements were often coordinated by community organisations or churches, and so were typically provided by strangers who were part of wider faith-based or ethnic networks. In other cases, housing was provided on a longer term but informal basis by friends or sympathetic strangers but could be revoked at any time without any protections afforded to the guest. Worryingly, 29% of those examples of hidden homelessness were transactional in nature, with accommodation being provided to survivors in exchange for them cleaning, cooking food and/or looking after children,

demonstrating a real risk of re-exploitation among homeless survivors, particularly of sexual exploitation and one of the most hidden types of modern slavery, domestic exploitation.

In the absence of modern slavery support, survivors who are in unsafe accommodation, lack income, language skills, and knowledge of UK systems often depend on strangers or acquaintances within their ethnic and/or faith-based communities for information about their options which led to dependency on individual kindness. This commonly results in victims receiving poor advice, accumulating further debt, and experiencing transactional exploitative support relationships, which also puts them at risk of re-trafficking.

Recommendations:

The introduction of a 'hub' system modelled on the current system available in Scotland (see further below). We argue that this system will be more cost effective in the longer term.

Improve decision making mechanisms (NRM) and asylum (UKVI) and instigate protocols for timely communication with applicants during the waiting period.

Community Networks

Strong networks between survivors and their communities are important for assisting recovery, and promoting independence. While legal advice and counselling was consistently identified as foundational for recovery, interaction with wider communities and in particular community-based learning or leisure activities were commonly represented as more broadly empowering and leading to the establishment of cultural capital and wellbeing.

Community support was found to be crucial to survivor recovery, wellbeing, and independence, enabling survivors to sustain and build friendships and networks within local communities and reduce reliance on case workers. Such support included survivor peer support, but also day-to-day contacts, such as faith and community groups, further-education classes, local gym membership and sports clubs, and parenting and toddler groups. Community groups based around arts, practical skills (such as bike sheds) and charity services provided survivors with opportunities to access services, meet others as peers and to gain experience volunteering. Volunteering in particular was identified as a good way to build confidence, to interact with others as equals, 'give back' to their communities and learn new skills and experience in preparation for re-entering work. The broad nature of available groups and activities experienced provided a level of individualism and an opportunity to draw on past experience that had a self-actualising impact on survivors.

However, barriers such as the costs of travel could be prohibitive, especially for those on benefits or seeking asylum. Our participants also described the traumatic disruption of having to move location to access safe housing or National Asylum Support Service accommodation, with very little choice over their destination and sometimes at very short notice. Some survivors reported such a lack of communication they were informed about their destination by taxi drivers en route to new locations. The disruption, lack of choice and of information decreased their sense of personal agency, broke links with advocates, friends and family, and resulted in an increased sense of isolation.

Recommendations:

Give careful consideration as to whether it is necessary to move individuals to alternative towns and cities, where they may not have existing networks. Decisions on the timing and destination should involve the individual and be suject to full and informed consent.

Provide more help to enable survivors to build connections within their host community. This could include access to communication basics, such as wifi and phone credit, help with travel costs through local transport passes, and signposting to local networks and community groups that might be of interest.

Consent

Survivors demonstrated a very low awareness of the NRM prior to referral (and in some cases at time of interview) and this was issue was found throughout the UK. This suggests that few survivors give truly informed consent to enter the NRM. Survivors explained they did not feel they had a choice on whether to enter the NRM, or have the system explained to them in any detail. One survivor felt that 'consent was the fastest part of the whole process' and more of a formality (i.e obtaining a signature) than an involved and thorough process. Survivors throughout the study were unable to explain how their data was being shared or used. They frequently conflated the NRM, Asylum and prosecutions systems, failing to understand that these were separate, involved different parties and required different levels of evidence.

While survivors recognised that they were highly traumatised at the time of identification and were not in a position to absorb all the information provided to them on referral. They related receiving lots of 'pieces of paper' to the point they were unable to identify which were central or crucial to know. Participants therefore strongly advocated for consent to be viewed as an ongoing process.

Recommendation:

Implement a two stage consent process, with initial consent re-visited after 30 days so that survivors have time to understand the implications of the NRM and the information they have received. While this may not change survivors' decisions, it would ensure proper consent is gained (including to data usage) and provides survivors with a sense of control over their involvement.

Training

Training of first responders was identified by all survivor participants as a priority area for improvement and was explicitly linked to their trust in the system and to their perceptions of justice.

Survivors agreed that training was a powerful tool to improve the experiences of survivors but that a whole culture shift was needed in this respect. Concerns were raised particularly about: the consistency of training of caseworkers and what this meant for them in terms of communication and knowledge about their case; and the lack of training for/understanding from the Police, health services, immigration personnel, and solicitors.

The study found widespread confusion about the availability of training which tended to be in house and service responder specific. There is currently no standardised training in place. Survivors highlighted a number of problems, including:

- feeling that decisions were made without (or with limited input) from them as individuals with agency,
- a belief that first responders did not understand the NRM fully, or otherwise chose not to give a proper explanation before making referrals,
- the inaccuracy of detailed (or accurate) information about the NRM as both a support and decision-making system, the reality of waiting times for decisions, and the availability of alternative forms of support,

- a significant proportion of survivors felt like they were treated with suspicion or ‘like criminals’, especially when the first responder role was filled by the Police and where survivors were pressed to explain their situation rather than being asked what support they needed,
- interviews related to NRM referrals, especially when conducted by the Police, were identified by most survivors as intimidating and in some cases re-traumatising. During these interviews, survivors felt judged and/or disbelieved,
- a focus on prosecution rather than protection led to the Police rushing referrals and focusing on evidence gathering rather than supporting survivors. In some cases, this had led to mistakes being made that had a long-term impact on the affected survivors and their cases,
- survivors commonly experienced being ‘passed on’ to other individuals or agencies (including support services within the NRM) where they would have to re-tell their stories of exploitation.
- professionals rarely reading their files ahead of meetings to obtain already recorded information.
- information not being recorded or passed on properly.

Recommendations:

Investigate further how digital records and data-agreements can help professionals work across agencies to communicate details such as case histories without requiring survivors to constantly re-explain their story.

Implement standardised training aligned to the National Training Standards for supporting adult survivors and ensure that all first responders and support workers are adequately trained to support victims safely into recovery and (re)integration.

Such training would:

address the full detail of the NRM system, including the decision-making elements, realistic timeframes, types of support offered, potential long-term impacts, and data protection and privacy terms and conditions. Such training would ideally include:

establish a **survivor advisory panel** for the development of standardised training to incorporate survivor perspectives (with survivors properly compensated for their involvement)

foster cultural awareness and sensitivity, for example by covering the contexts of different cultural communities service providers may come into contact with. Examples given included training about various ethnic communities and potential distrust of interpreters and authorities more generally, as well as the need to challenge biases and assumptions about who experiences modern slavery or of negative cultural stereotypes.

We are conscious that a number of these recommendations are already carried out by some first responders. However, given these issues have arisen consistently, generally survivors are not able to identify where this has occurred. An explanation for this likely involves the volume of information provided early on, the effects of survivor trauma, inconsistency in support (particularly where case workers change, or between different services), limits to staff time, and a lack of standardised training. The time needed to both deliver and engage with continuous training also needs to be adequately resourced.

Reimagining the NRM

Our workshops with survivors and stakeholders suggested the NRM system needs to be somewhat, but not fundamentally, re-designed to better enable recovery. Critically, the long waiting times for basic support services and decision-making undermine existing efforts to promote recovery and access to justice.

Our findings are that the Scottish NRM system out-performs other UK nation systems, particularly in comparison to survivors' experiences and outcomes in England. Service providers reported that most survivors in Scotland do not need support beyond 90 days, and our interviews confirmed that the system in Scotland is more effective than other systems in the UK at facilitating survivors' ability to build independence, external support networks and community, and improve their mental health and wellbeing.

The data indicates this significant difference is *not* primarily down to number of referrals per head of population and that three key factors for the difference are responsible:

1) the geographic centricity of services creating a 'hub' model of support, currently centred around Glasgow,

2) the associated and, crucially, early colocation of services including mental health care and legal services,

3) the flexibility and relational nature of the working partnership between service providers and the Scottish Government.

The positive experiences of survivors in Scotland compared to England and Wales were mainly facilitated by the existence of an established network of specialist support providers working together across Glasgow, in particular refugee support services. The Scottish government has funded in house (telephone) counselling which survivors access at the start of their journey. A close relationship between NRM providers and the refugee and legal sector (Migrant Help and Just Right Scotland) meant that survivors were signposted quickly to a broad range of existing and well-established services, including both grassroots community groups and organisations such as the Scottish Refugee Council and British Red Cross. The hub model ensured that the provision of legal advice and mental health support were provided at a very early stage resulting in less time in support (typically 90 days) and fewer chronic mental health concerns. Our data suggests that where legal advice is not accessible, survivors are at risk of further indebtedness trying to pay for (often poor) non-specialist legal advice and therefore at risk of further exploitation. Further, the relational mode of working in the Scottish model resulted in close links and frequent communication, between support providers and with the Scottish Government, which enabled them to work effectively to assist survivors.

The early provision of mental health support was found to be fundamental to the success of the Scottish system. Survivors in England and Wales often reported waiting for over a year to access mental health support, at which point they found counselling came 'too late' and worse, re-traumatising. The provision of early mental health support at this initial stage seems to have had a significant impact on survivors and their ability to build independence, cope with the pressures of the system(s) they are navigating, and ultimately, to 'move on' with their lives.

Early legal advice was also vital in facilitating long-term options by helping in the regularisation of immigration status, and in some cases survivors were helped to claim compensation relating to their exploitation. Early legal advice was also identified by survivors as empowering in providing more information about the NRM and other systems (such as asylum), and it was through early access to legal advice that most survivors first came to really understand the NRM. This is in part

due to survivors' later ability to take in detail concerning the NRM compared to the current system of initial, single, early consent gathering at a point when survivors are traumatised and overwhelmed with a lot of information.

The provision of a holistic and specialist early stage 'wraparound' support in Scotland has fostered a strong cooperative network between NRM support providers, legal advisors, and mental health services, encouraging collaborative working and learning, and enabling those within the NRM to receive a broader support package at an early juncture. Crucially, this early support package also meant that survivors were more trusting and confident in services, and led to more favourable perceptions of other systems and organisations (for example, the asylum system, the Home Office, and the Police). This also had a significant impact on survivors' own wellbeing, with those in Scotland demonstrating greater tolerance of system delays.

The Scottish model therefore offers useful lessons for adoption across the rest of the UK.

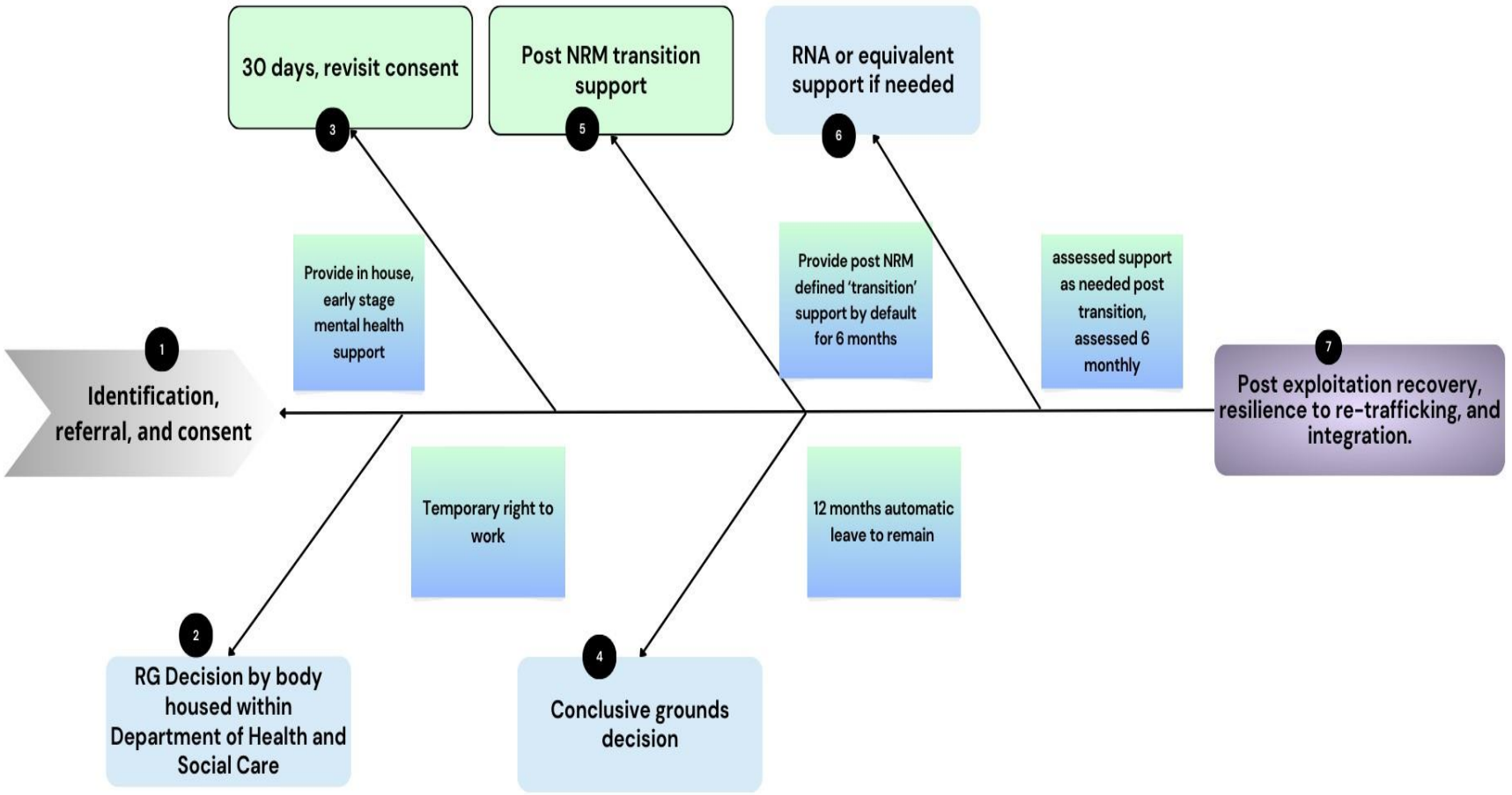
Recommendations:

Seperate the provision of emergency personal support (particularly emergency housing, mental health support and legal advice) from wider decision-making about whether an individual has conclusive grounds to be regarded as a victim of modern slavery. Our workshop particpants suggested an initial 30-day support period would be more effective than referring people straight into the NRM. This will better enable the provision of accessible information to people entering the system, help to fast track people into alternative support mechanisms - if appropriate - and support informed consent.

Develop local or regional hubs for survivor services, involving local statutory services as well as statutory and NGO support providers, to overcome fragmentation in the existing system, and ensure that survivors are assessed consistently and offered access to 'scarcer' services such as specialist legal advice. Such a model could also better help to connect survivors with appropriate community-based services, and enable on-going support and advocacy, depending on the stage of their journey.

Undertaking a recovery assessment for all people referred into the NRM, to ensure needs are properly understood at the outset and help to provide more individualised support. The focus should take account of strengths as well as needs, including education, skills and work-experience which might support independence.

Re-Imagined NRM



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