Refining a public health approach to modern slavery

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Introduction

A public health approach to modern slavery offers an opportunity to coordinate effort across the counter-slavery sector. It has emerged as a promising framework for prevention, for planning at a national and local level and as a means of bringing together existing frameworks with a humane focus. Its potential also lies in its application to other socially complex and long-standing problems. Public health approaches have been applied to serious violent crime, for example. This has laid the foundations for rethinking other issues that have traditionally been approached as a criminal justice problem. Indeed, a public health approach offers the opportunity to think of modern slavery as not only an issue of law, order and policing but as a problem that affects the whole of society and its wellbeing. In short, modern slavery is a public health issue. This report builds on earlier research done in partnership with Public Health England on the case for a public health approach to modern slavery in the UK (Such et al. 2017, 2020).

Background

Public health is a broad and inclusive field of thinking and practice. It can be defined as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society" (Acheson 1988). Its focus is health and wellbeing protection and promotion and the prevention of ill-health. Its breadth of focus means there are many strands to public health work. Practitioners try to both address urgent health needs (such as controlling infectious disease) and promote the conditions for a more equal, healthy population over the long term. Doing this work means that public health practitioners join up with many other agencies who can protect and promote health and prevent harms. Local public health practitioners, for example, work with the police, fire and rescue services, local community organisations, local businesses and health services to promote, protect and prevent. Importantly, public health both *leads* and *is led by* the work of other agencies who seek similar goals. A public health approach to a problem does not mean that public health practitioners have to lead it. Moreover, *it is a way of thinking and acting collectively* to address a problem that can damage health and wellbeing. Addressing modern slavery is one example of how this collective approach can be applied across a broad base of partners seeking similar goals.

Taking a public health approach means:

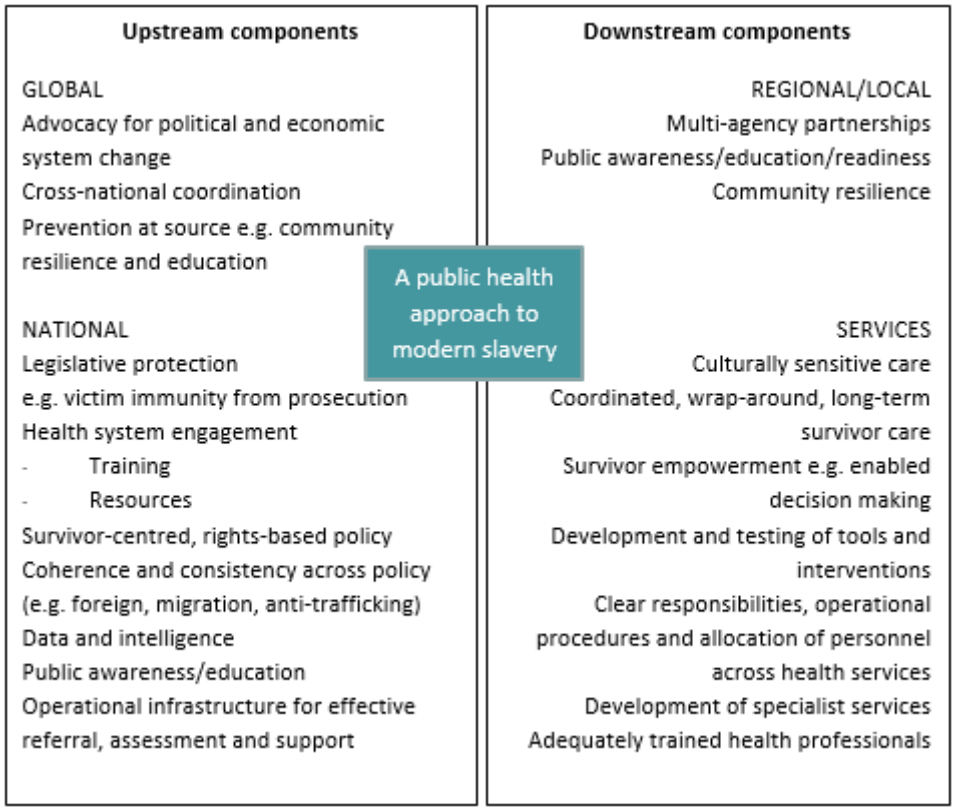
- Understanding the problem at a population level
- Looking at what is driving or causing the problem and framing it as part of a complex, multi-level and interdependent system
- Collating data and evidence of what works/what happens
- Being prevention focussed

- Protecting and promoting health and wellbeing
- Multi-agency/partnership working
- Addressing inequalities, social justice and human rights

These characteristics of public health sit well with pre-existing ways of thinking and working in the counter-slavery sector. It is a strong starting point from which to build and refine a framework for action.

Initial research and emerging practice reveal that a public health approach to modern slavery has gained momentum. The Independent Anti-Slavery Commissioner identified it as an area of significant interest in her annual report (Independent Anti-Slavery Commissioner 2020) and some anti-slavery networks have explicitly used a public health framework in their activities (for example, the West Midlands Anti-Slavery Network; VITA Network). Research conducted with Public Health England identified the basis for public health engagement in addressing modern slavery and a subsequent emergent framework has been developed (Such et al. 2017, 2020). This framework (Figure 1) offers the opportunity for further development and refinement and is the starting point for this research.

Figure 1 The components of a public health approach to addressing modern slavery



Source: Such et al. 2020. Reproduced with permission from Elsevier license number 5075291208897

Aims and objectives:

The aim of this project was to refine a public health framework to address modern slavery in the UK. To meet this aim, the project included the following objectives:

1. To use coproduction techniques with stakeholders from the counter-slavery sector to devise, design and deliver a refined public health framework to tackle modern slavery;
2. To develop a clear definition of 'prevention' in the context of modern slavery and human trafficking;
3. To deliver some practical tools to support prevention and a public health framework among anti-slavery partnerships (coproduced with stakeholders).

Methods

The project was designed using participatory principles (Bergold and Thomas 2012). As such, the research sought to develop a public health framework with people who intentionally engaged in counter-slavery action. Participants, in this context, were both the producers and users of collective knowledge.

With social contact constrained during the research period, online participatory research workshops were chosen as the primary method of data collection. Participants were recruited using digital methods: potential participants were contacted by a broad range of email distribution lists through Public Health England, the Office of the Independent Anti-Slavery Commissioner and through additional relevant research and practice networks available to the research team. After expressing an interest on an online form, 74 people across the counter-slavery field were invited to take part.

Research workshops were conducted in small groups between February-March 2021. Each workshop was two hours, except one which was 90 minutes long. They were designed to be loosely structured, facilitated sessions with two or three members of the research team guiding each workshop. The content of the sessions was aligned with the research aims and objectives. After a short introduction to public health as a field and where the research had taken us to that point, research participants discussed in detail the topics of prevention, a public health framework for modern slavery and the different components of a public health approach. Details of the workshop discussion agenda are available in the Annex.

Recordings of research workshops were made on the software Blackboard Collaborate, anonymised, transcribed in detail and analysed with the help of the qualitative research software NVivo 12 Pro. Drafts of project outputs were sent to a sub-group of workshop participants for comments and refinements. Ethical approval for the project was granted by the School of Health and Related Research Ethics Committee (reference 037607).

Findings

In total, seven research workshops were conducted with 48 participants. The study included input from people working with the police, the health sector, local authorities in England, third sector organisations, the UK Home Office and the National Crime Agency. People from

across the anti-slavery partnerships and networks across the UK were represented. Some participants identified as survivors of modern slavery. The following reports on the case for a public health approach to modern slavery, the refined framework and how the sector can develop its approach to prevention.

The case for a public health approach to modern slavery

The development of a public health approach to modern slavery was strongly supported among this self-selected sample of counter-slavery workers. There were several reasons for this. First, participants commented on the limits of a criminal justice approach, a sentiment reflected in the published literature (George et al. 2017). Some felt that the criminal justice system was "finite" in its capacity to deal with modern slavery and that the application of such an approach was a "cul de sac" (P5, W3). A public health approach was a counterpoint that could reset values and the narrative around addressing the problem:

> The word on the street is that the criminal justice system is not helpful. … There is a mistrust in the justice system. An advantage of a public health approach is the value system that comes with it, not just the tangible activity. The more that we can bring that value system into the approach, with understanding of precarities and vulnerabilities, that will cause a shift. … with new eyes looking forward, that will move the culture change, rather than using sticking plasters which peel off (P1, W1)

This enthusiasm was matched with an appetite to see the development of a unifying approach. This meant generating something that was holistic, human rights focussed, linked to other cross-cutting social injustices (e.g. homelessness) and was framed in a way that encouraged different people across sectors to be involved. On this last point, there was concern that the label 'health' implied it would be the health sector that would lead public sector effort:

> I think if our decision makers had feedback on the past about what we've presented to them as public health approaches, there's no question that we agree with all of the elements of what's in the public health approach, but they've been concerned that if we call it Public Health, does that give a license to the other departments to say "That's public health, that's not us." (P6, W3)

Counteracting this risk was a sense that public health approaches were sufficiently resonant in contemporary debate and practice to be useful. The example of serious violence was used:

> My sense is that there is enough of an understanding of and commitment to public health approaches that I don't know that it does limit it, or lets people off the hook. What I'm concerned about, in terms of serious violence, is when you start to call things multi-agency responses, it lets people off the hook in terms of prevention. When you name it, you leave stuff out. Public health leaves it general. (P4, W3)

Prior work on evidence-based approaches to violence reduction has helpfully articulated when and how different approaches such as public health, multi-agency, problem-solving and contextual safeguarding are most helpful (Contextual Safeguarding Network 2021). In sum, such approaches cross sover significantly and are *fundamentally complementary* when applied in the right context. The workshop discussions highlighted that a public health

approach allows us to *zoom out* or see the broad problem of modern slavery in the UK at a helpful distance. This enables the sector to view counter-slavery actions and interventions strategically and build in those complementary, more service-level, and individually targeted approaches into an overall response.

Points to take away:

- A public health approach to modern slavery is desirable and feasible
- A public health approach could help unify the counter-slavery sector around their common cause
- A public health approach can be adopted by anyone and does not have to be led by health professionals

Refining and devising a public health framework to address modern slavery

The framework in Figure 1 was used as the basis for discussion on what the components of a public health approach to modern slavery would look like. Participants confirmed that the existing framework was adequate and helpful. Many dimensions of the framework were reinforced in discussions. In several cases, the components of the draft framework were considerably expanded upon and illustrated through policy and practice examples.

Two dominant themes emerged from an assessment of the overall framework: 1) That the framework should demonstrate permeability and dynamicism, and 2) That the upstream, global factors, while important, should be de-emphasised for the purposes of developing a workable framework that could be applied to local settings in the UK.

On this first point, one participant noted:

> I agree it's a great framework. Something could be built in to demonstrate that it's dynamic – it's not just a series of factors to keep in mind. It's a journey. If the framework could show that it'd be fantastic. (P1, W6)

The research team sought to address this need in the development of the accompanying practical tools and by using online, interactive outputs to visualise the refined framework. Representing dynamicism and trajectories within the framework, however, remains a challenge that requires further consideration.

On the second point, discussion reinforced and expanded upon existing components of the framework while introducing a few others. For example, cross-national coordination was considered necessary to remove the drivers of modern slavery. Participants also suggested that global commerce should be included to ensure they engaged proactively in addressing modern slavery, particularly 'big tech' and social media companies who had the power to enable or restrict opportunities for exploitation through their technologies and platforms.

Overall, however, the workshops explored elements of a public health framework at three levels: i) the national, ii) the regional/local, and iii) the service level.

National components

Table 1 briefly outlines the existing components of the framework, if/how they were reinforced or otherwise in discussion and what additional components emerged.

Table 1 National level factors in a public health framework to address modern slavery

Existing components of the framework	Reinforced in workshop discussion? If so, in what terms?
Legislative protection e.g. victim immunity from prosecution	✓ Reference to consistent application of Section 45 of the Modern Slavery Act
Health system engagement (Training, Resources)	✓ Moreover, whole system engagement including business, schools, police
Survivor-centred, rights-based policy	✓ And criminal justice system
Coherence and consistency across policy (e.g. foreign, migration, anti-trafficking)	✓ All policy. Also, welfare and health (e.g. Charging Regulations a disincentive to care)
Data and intelligence	✓ And research and evaluation
Public awareness/education	✓ A fundamental starting point for prevention
Operational infrastructure for effective referral, assessment and support	✓ Additionally, legislative protection for survivors outside referral (NRM) framework and a clearer duty of care
Additional components suggested at the workshops	
Relevant training across sectors including on prevention strategies *before* harm has occurred	
Whole-systems response	
Cross-government co-ordination role e.g. UK Cabinet Office. Joined up commitment	
Equity-driven belief or values system (ideology) with policy addressing wider determinants and the drivers of modern slavery	
Evidence-led interventions; 'what works'	
Perpetrator strategy or fair means of establishing victim-perpetrator status	
Fully resourced, long-term strategic and operational plan	
Sustainable, resourced prevention coordination e.g. Anti-Slavery Network coordination	
Explicit political commitment and leadership. Non-partisan party political approach	
Strong regulatory compliance mechanisms e.g. inspection of care standards, labour regulations	
Policy implementation guidance that can be consistently applied in the local context e.g. dealing with Child Criminal Exploitation as a modern slavery crime	
Non-punitive system e.g. removal of detention, deportation from the survivor experience	

Participants generally viewed the national components of a public health approach as critical in creating an environment that made modern slavery more or less likely. There was strong support for national-level policy interventions that were **coherent** across the board**, consistent** with counter-slavery goals, were **coordinated** across government departments and **comprehensive** in terms of legislative protection for victims and survivors**.** National factors were felt to determine the starting point for regional-, local- and service-level activity. This was sometimes expressed in stark terms:

> The UK's legal framework has many gaps, with Brexit especially. The UK government has not addressed these vulnerabilities. The UK has been removed from access to

criminal databases and intelligence systems. The lack of coordination, with global factors, will hinder the UK's capacity to work on prevention campaigns and help victims. So, the lack of victim support is not in the legislation. The Victim Support Bill could help this. There are costs associated with recruitment due to visas, which is a risk factor for debt bondage and human trafficking. *We are setting ourselves up to fail in this preventative work*. (*emphasis added* P3, W4)

Regional and local components

Table 2 outlines the local and regional factors considered important in a public health approach to modern slavery.

Table 2 Regional- and local-level factors in a public health framework to address modern slavery

Existing components of the framework	**Reinforced in workshop discussion? If so, in what terms?**
Multi-agency partnerships	✓ Additional characteristics include sustainable funding/resource; multi-disciplinarity; safeguarding leads from different institutions involved e.g. Local Authority/NHS safeguarding leads; action oriented; effort to share a common language; clear escalation routes to 'systems leaders'
Public awareness/ education/ readiness	✓ Coordinated campaigns e.g. Crimestoppers; possibly using a 'social communications' approach that is tailored to local people. 'All of locality' awareness/ ownership
Community resilience	✓ But this is a broad concept that requires explaining and developing
Additional components suggested at the workshops	
Bespoke local strategies/ Context-driven, fully resourced response; e.g. rural/urban context differences	
Ways of bringing survivors together for peer support	
Early-warning systems/local community sentinel-type mechanisms	
Well-resourced, mandated, locally integrated infrastructure to support survivors	
People with power and authority to drive change in local partnerships	
Use of a range of policing tools that reduce risks of perpetration e.g. civil orders	
Political and senior leadership – 'system leadership'	
Trusting relationships with at-risk populations and local authority figures e.g. youth work, community orgs	

Aligning with earlier work, multi-agency partnerships were seen as the primary mechanism through which local factors could be addressed. It was noted that local anti-slavery partnerships had an important oversight and coordination role but that structures, processes and resources at this level were highly variable (reflecting research from the Rights Lab 2017). There was a call to regularise and formalise anti-slavery partnership resourcing so that this

important function could deliver more consistent outcomes for local areas tackling modern slavery.

Local work was considered critical to counter-slavery action and could compensate for the damaging effects of some aspects of the broader policy system. For example, the effects of immigration control and crime and justice policies:

> On the bigger picture it's fear of immigration control if they come forward as victims of trafficking. Thinking about county lines and certain communities, there isn't a good relationship with the law. How do we then, at local levels, develop the good relationships? Youth work, early on, which would help for many things. Or whether it's part of campaigns in areas to make people aware that we are there to support them, don't be afraid to come forward, you are victims. Messaging to the people who are at risk. A lot of fear is already with them. (P4, W4)

Service components

Discussion highlighted that service factors were divided into two main considerations: Service *design* and service *delivery*. The two were interlinked and complementary. For example, a contextual safeguarding service response required consistency across both design and delivery. The components of this part of the framework built substantially on the original work. Descriptions of each component are presented in Tables 3 and 4.

Table 3 Service design components of a public health approach to modern slavery

Component of service design	**Description**
Responsive	Rapid, early-stage response services for victims/survivors and people at risk that focus on: i) safety, ii) meeting survivors' immediate needs, iii) dignity and autonomy. Responsiveness also includes ensuring services are designed to enable survivors to access entitlements throughout recovery.
Planning	Transparent design processes that identify clear responsibilities, operational procedures and allocation of personnel across services including social care, social work, police, border force, labour inspectorates and health services
Reporting	Clear reporting structures and mechanisms with actionable outcomes
Specialist	Development and adequate resourcing of services designed to meet specific needs, bearing in mind intersecting vulnerabilities and ability to access services e.g. outreach services, free legal advice
Mainstreaming	Ensuring mainstream services are 'modern slavery aware' and responsive e.g. 'Making Every Contact Count' approach
Training	Adequately trained practitioners
Survivor-informed	Involving survivors in the design of services
Diverse	A diverse, especially ethnically diverse, workforce of service delivery practitioners

Coordinated	Coordinated services between multi-disciplinary professionals. Design is wrap around, holistic, personalised/tailored, long-term survivor care that meets specified standards
Evaluated	In-built, robust development and testing of tools and interventions

Underscoring these factors are principles reflected in other fields of service design, especially those intended for marginalised populations. Well-established research from the health services field has identified that improving access requires attention to enhancing: 1) approachability, 2) acceptability, 3) availability and accommodation, 4) affordability and 5) appropriateness (Levesque et al. 2013). These principles could be usefully adapted to the similarly complex environment of access to survivor services so that service users are better able to seek, reach and engage with services intended for their benefit.

Table 4 Service delivery components of a public health approach to modern slavery

Component of service delivery	**Description**
Trauma-informed survivor services	All interventions adopt trauma-informed principles
Empowerment-driven	Services for survivors and affected communities seek to empower. Empowering practices include enabled decision-making, communication support for speakers of languages other than English and attention to the dignity and autonomy of individuals and their families. Peer-/survivor-led services are underdeveloped and should be considered as a potentially useful route to service development
Culturally competent	Services are delivered to meet the needs of people with diverse backgrounds. Culturally competent service delivery flexibly responds to the backgrounds and practices of communities, families and individuals. Psychological support, for example, should be responsive to diverse understandings of mental health and illness.
Tailored	Services should be flexible enough to tailor to the needs of affected communities, families and individuals and should enable informed choice. Delivery of services are tailored to what 'good' looks like to service users.
Person-centred	Survivors, their families and people at elevated risk of exploitation can expect services to be delivered in a way that meets their specific needs

Table 4 identifies the components of service delivery that are consistent with a public health approach. Trauma-informed practice sat at the core of delivery. This was applicable to all services including policing, social work and healthcare. There was concern that trauma-informed language and principles were learnt across the sector and that this learning was applied properly in practice. There are multiple sources of useful information and guidance on trauma-informed practice (e.g. Helen Bamber Foundation 2020; Wilton & Williams 2019; Law et al. 2021); workshop participants were keen to see enhanced training and its widespread adoption. It is notable that the service design and delivery principles described in

the workshops align closely with those outlined in the Survivor Care Standards (Human Trafficking Foundation 2018). These considerations were, however, expanded upon in the workshops to apply to communities at elevated risk of modern slavery. In other words, services to prevent modern slavery further upstream also required a set of working principles that enhanced service access and best protected people from the threat of external harms *before* exploitation had occurred.

Defining and representing prevention

Preventing modern slavery was seen as a core element of counter-slavery activity. Yet there were multiple challenges. Notably, prevention was seen as an underdeveloped dimension in the counter-slavery field:

> I think that the area of prevention is something we collectively need to do a lot more about. We've spent a lot of time looking at victim care and the NRM, and it's far from perfect, but prevention gets a bit overlooked. (P5, W5)

This was partly because that prevention was hard to evidence. Put simply: "A big challenge for prevention is that it's hard to prove something hasn't happened." (P7, W5). Additionally, successes in prevention were messages that were hard to mobilise:

> Prevention doesn't make headlines. You don't say "We prevented 500 victims from being trafficked", we say "We have arrested the two bad guys that were convicted for manslaughter of the Vietnamese nationals who died". So, that's important for prevention, we know that sometimes what makes the noise and headlines is what gets the funding and attention. (P3, W4)

The workshops explored public health models of prevention, particularly the framework of primary, secondary and tertiary prevention (Box 1).

Box 1 Primary, secondary and tertiary prevention

Primary prevention is preventing the problem occurring in the first place

Secondary prevention is intervening early when the problem starts to emerge to prevent it becoming established

Tertiary prevention is making sure an ongoing problem is well managed to avoid crises and reduce its harmful consequences

(Christmas and Srivastava 2019)

Participants had an appetite for a unifying definition of prevention that the sector could operationalise together. An emphasis on primary prevention was apparent, particularly as participants reflected on the circumstances that gave rise to modern slavery and allowed it to flourish:

> What are the factors that create the precarity we've discussed and who do we need to bring into the loop [national and local government departments] to address them before people are exploited? I would love it if the multi-agency working was happening when someone was identified as at risk of becoming vulnerable rather than once they are demonstrating indicators of being exploited. (P3, W1)

Primary prevention meant not only 'empowering' people to avoid victimisation but making the environment for exploitation 'hostile':

> As well as the workers, we also look at the businesses. So, making the environment hostile to the exploiters, making it as difficult as possible for them to operate and continue to be able to commit offences and exploit individuals. It's creating a hostile environment that prevents them from being able to operate, but also really focusing on empowering those that may be subject to that exploitation. (P1, W2)

Participants commented that it would be useful to develop a visual model of prevention and that everyday language should be used to express it; the notion of primary, secondary and tertiary prevention was generally viewed as too opaque. In addition, prevention was seen as a continuous process with a range of activities offering benefit across different levels. One participant noted a public health prevention model needed to address: "the cyclical nature of the problem. Tertiary prevention is actually the primary prevention against future exploitation". (P1, W3)

Bringing it all together: A revised public health approach to modern slavery for the UK

Learning from the workshops led to the development of a refined public health framework to address modern slavery. It is represented in Figure 2 as a static diagram. In the accompanying support materials, the framework is described in full as an interactive model. There is also an accompanying guide to support implementation.

When using this model, it is important to note its intended audiences and value. The framework is primarily aimed at the work of Anti-Slavery Partnerships and Networks, although the concepts employed and components described are useful for national and local policy makers, third sector organisations and service providers. Arguably, it is a framework that could be most powerfully employed if mobilised across a wide range of anti-slavery actors. It is intended to represent a public health approach to modern slavery as:

i) An **umbrella framework** that can help guide policy, strategy and practice. It may be particularly useful for Anti-Slavery Partnerships and Networks who are seeking to review and develop their work strategically across geographies
ii) An opportunity for users to assess their counter-slavery work at a **systems level** and answer questions about what is being provided, to whom and why
iii) A way of **achieving coherence** across both strategy *and* delivery
iv) A way of embedding a **clear narrative** around counter-slavery action that is inclusive of many partners working in different fields at the local level
v) A model that sets **high aspirations** for the modern slavery response
vi) Providing a **long-term, flexible** structure for thinking and doing anti-slavery work
vii) A model that **fits well** with many existing approaches to address harm e.g. contextual safeguarding, multi-agency working
viii) Something that easily sits with **what practitioners already do** and/or seek: a humane response to disadvantage that delivers the best outcomes.

The model offers opportunities for practical application. The user guide provides examples of the workshop participants' organisations' activity that aligns with a public health perspective. Further examples are required. An NHS England and Improvement (South West region) commissioned study is underway to test how the framework and the supporting materials can be applied to local counter-slavery action.

The revised framework should be seen alongside models of prevention, created as a result of workshop participant discussion and feedback. Figures 3 and 4 offer visual ways of representing cycles of harm and opportunities for prevention. Figure 3 represents harms as a spiral or cycle that, if left unchecked, can do significant damage across generations. The cycle can be stopped, however, through preventative effort, with primary prevention or action *before* harm occurs offering the most protection. The BEST prevention framework (Figure 4) offers a simple way of understanding prevention. Again, the practical materials accompanying this report will help users apply these frameworks to their local setting.

Figure 2 A public health approach to modern slavery and its components

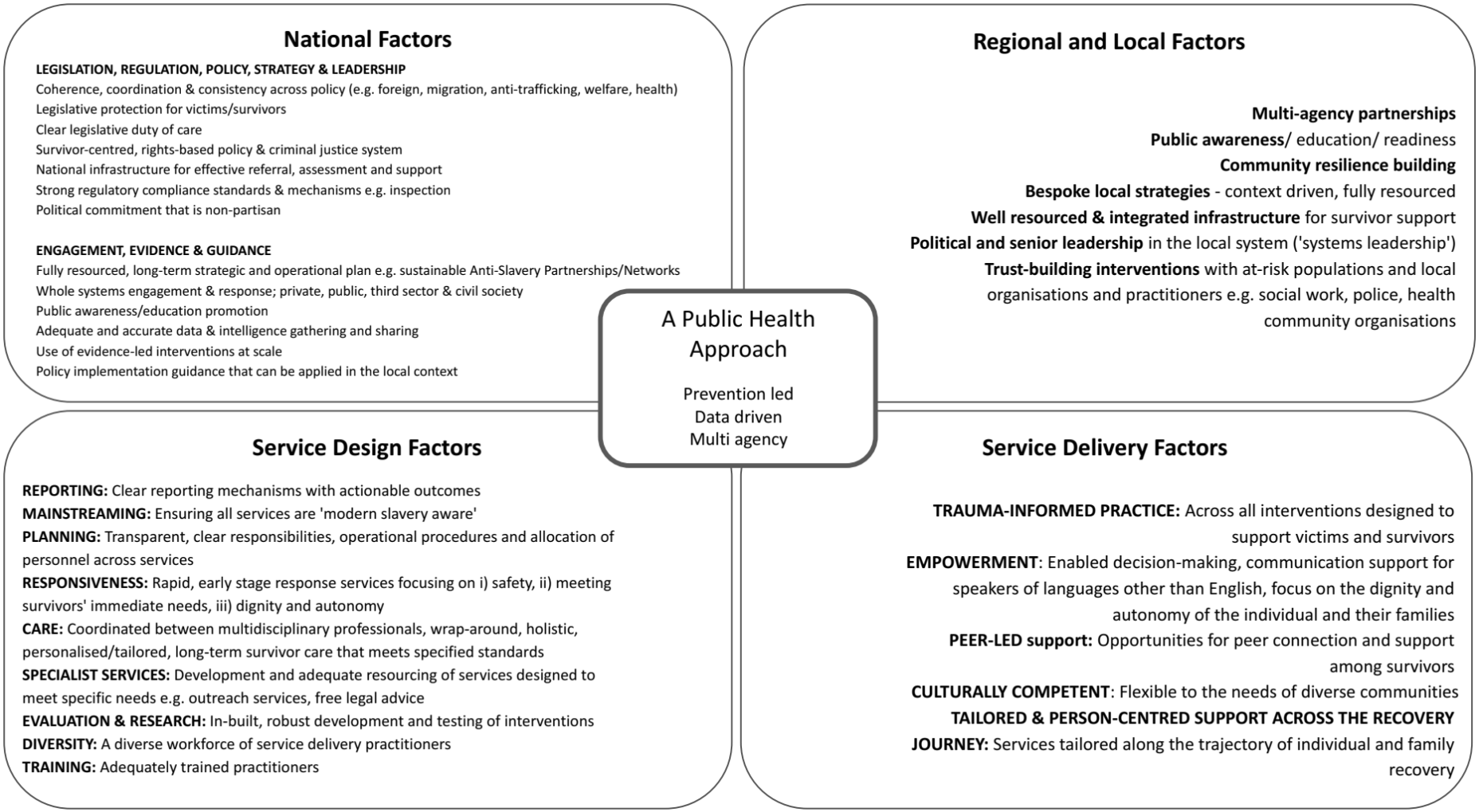


Figure 3 The cycle of exploitation and harm and where preventative activity can intervene

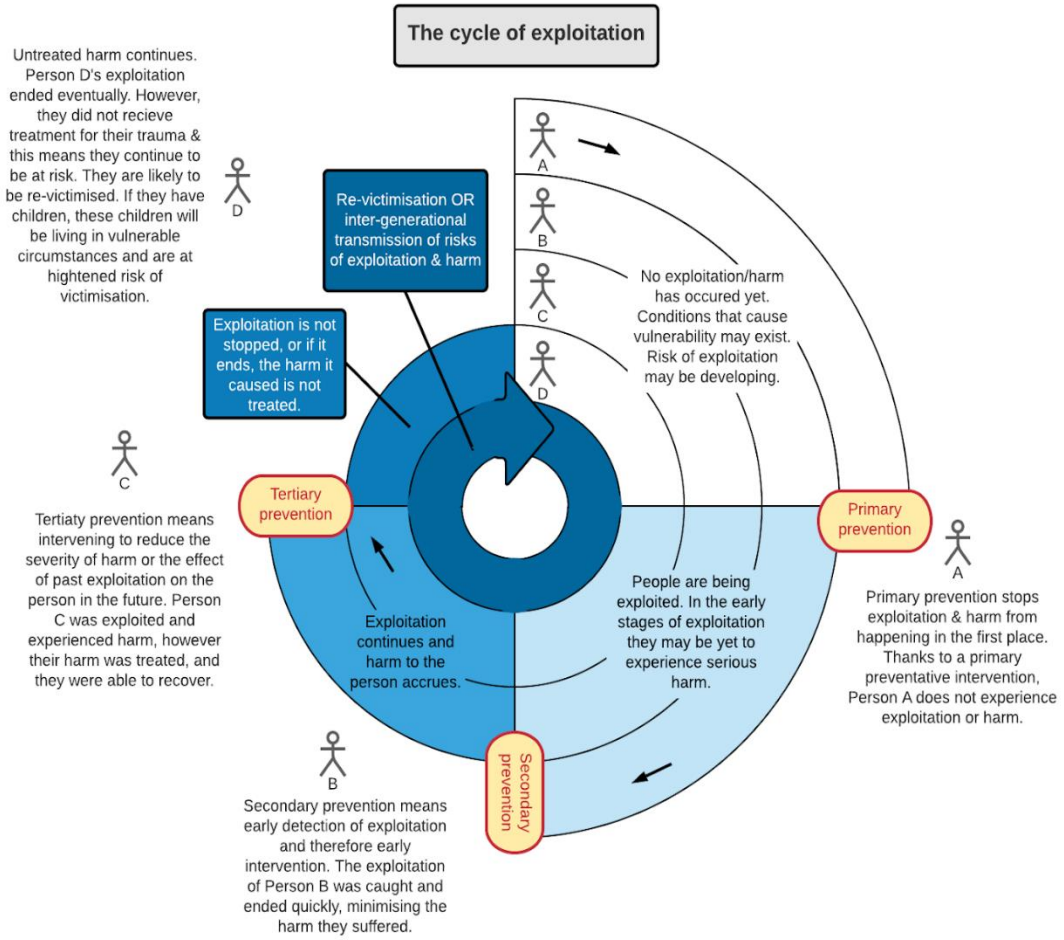
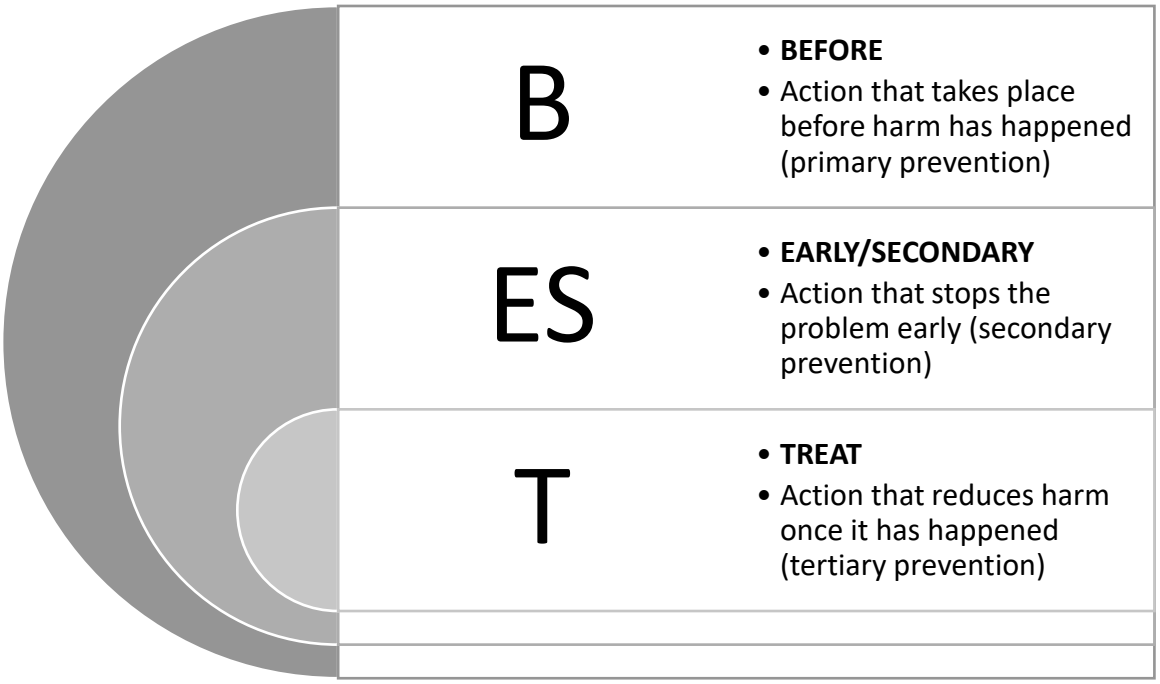


Figure 4 The BEST prevention framework



Conclusion

A public health approach is a promising way to address the problem of modern slavery. This report has built on previous research and practice by drawing together people from across the counter-slavery sector to co-construct the components of the approach and models of prevention. Sitting alongside this report are several practice and policy support tools, including an interactive online framework and a guide to a public health approach with some implementation support. These now require application and testing and further development through operational feedback. We intend this work to be used by partners across the counter-slavery sector, including national policy makers and local anti-slavery partnerships. While many challenges remain, this report demonstrates how and why a public health approach may address, what is, a challenging and important public health problem.

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For further information about this work or if you are interested in working towards a public health approach to modern slavery in your local area and would like some support, please contact Liz Such e.such@sheffield.ac.uk

Annex

Workshop design/agenda with notes for discussion

Time	Content
PRE WORKSHOP	**1. BACKGROUND 'PACK' FOR PARTICIPANTS** • Plain English version of public health approach to modern slavery • Agenda for the workshop + few notes of how the workshop will be run • Ask participants to bring with them ONE EXAMPLE of their work and how it prevents modern slavery/HT **2. CONSENT PROCESS** Need all participants to complete the consent process before the workshop to avoid delays at the start of the workshop. Make this clear in emails. **3. ENSURE EVERYONE HAS THE RIGHT DATES IN THEIR DIARIES** For each workshop we need 1 lead and at least 1 facilitator, preferably 2 Pre-meeting checklist: • Confirmed list of participants • Mobile numbers of each participant/facilitator • Blackboard Collaborate link for facilitators and participants
15 minutes before workshop	• Workshop facilitators join the session • Check everyone knows their roles, how to use the interface, including DMs • Check everyone knows the agenda, the protocol for distress, to watch for any signs of unhappy participants
5 minutes before workshop	• Start to admit participants • Make sure we start promptly
20 mins	**Welcome and introductions** • Introduce everyone; aims of workshop • Request permission to record session • Start recording • Working agreement – house rules. Include general rules as a slide and then ask participants if there is anything they want to add/discuss/change. 5 mins max. • Include statement about process of raising concerns/issues with organisers; using 'time-out' mechanism • Background and rationale for workshop • Outline aims of the session: 1. To look at the emergent PH framework and focus in on action at Global, National, Local and Service level 2. To critique/add to that framework from your own lens and experience 3. To examine what we understand by prevention in the context of a public health approach and how we can move 'upstream' to prevent MSHT 4. To flag examples of how a public health approach is in evidence in existing practice and how these could be developed 5. PURPOSE: Not to develop a 'cook book' of 'how to do' a public health approach to modern slavery; but to develop an organising framework within which a series of tools can be used to help you assess what you

	do, how you do it, devise ways of recognising opportunities to intervene, develop ways of intervening to operationalise the approach and how to reinforce a public health approach to ensure its sustainability and adoption across your spheres of influence.
10 mins	**Brainstorming** **What is 'prevention'?** *"The goal of prevention is primary prevention of causing harm. "Primary prevention" means we aim to prevent human trafficking before it has ever occurred by shifting knowledge, attitudes, behaviors, and social conditions that contribute to human trafficking" NCCASA* CONTRAST with awareness, outreach and (advocacy) TEST Public health model of prevention – 1y-3y. Useful? Ensure participants spend time discussing 1y prevention – what is the value of this? What are the challenges/problems? How can these ideas be best communicated? *Aim: to explore range of understandings; can we start to build a consensus? How might we start to do this?*
30 mins	**Structured group discussion** Opportunity for participants to present some examples of their work and how this might fit within a public health framework PROBE: • Detail of the work • Who is involved – single or multi-agency? • Any of this documented? Accessible? • What have been the challenges and successes of the work? • Have you been able to evaluate the work? • How does this example fit within your overall approach to modern slavery in your organisation? • Are there ways you would like to build on this example? • Are there any specific ways of working that facilitate or hinder this work? • What interferes with its effectiveness? • How do you know it is effective? *Aim: to identify examples of practice/policy approaches and how they might (not) fit within a public health framework*
20 mins	*Aim: To appraise the 'sense' of the framework (**collective sense-making**)* To get people to think about the framework and comment on a) what the framework does that is helpful/unhelpful as a whole and b) what the different aspects are – what do they mean? c) What is missing? d) How does it apply to their work? e) What are the greatest challenges to using a framework of this sort? f) Do they use any other frameworks to structure their thinking and practice? Focus on National, local and service factors
10 mins	**Close of workshop (Check out)** • Quiet time: Note down your 'take homes' from today – on a Google Doc? What would you like to see from a PH framework for addressing MSHT? • Go round: What's the most important 'take away' thing for you personally? • Notify – June event to 'launch' the workshop findings and some of its outputs in June; you will all be invited.

	• Invitation to stay online to see what worked well and what could be improved for subsequent workshops and/or what sort of follow-up participants would like to see *Aim: get identify the most salient points to take note of*
POST WORKSHOP	**Follow up with feedback form** **Email, phone, invitation to iterate model and receive ongoing feedback**