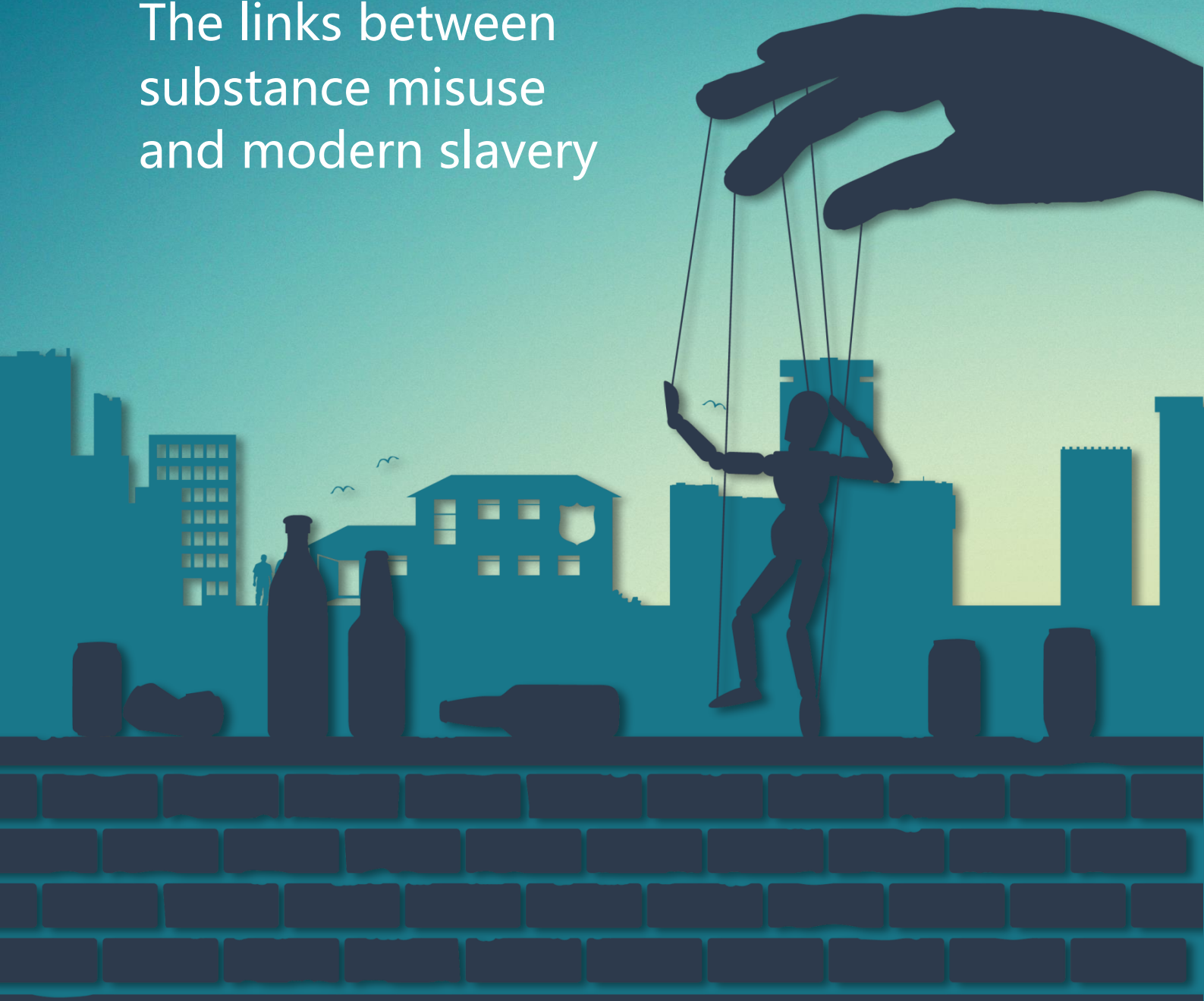
A few doors down

The links between substance misuse and modern slavery



Black Country Women's Aid
we listen, we support, we care

THE SALVATION ARMY

Bright Day Consulting
People Partnership Projects

'If I get found out I will be killed. I never stop looking out for someone who might recognise me or someone who could tip off those who kept me locked up and addicted. It would be easy to have me lifted, taken back to where they are and inject me with heroin. I'd just be another overdose: no one would know, and no one would care.'

Victoria X, January 2018.
(See Victoria's story, addendum 5.)

CONTENTS

LEAD PROJECT PARTNERS

The Salvation Army
The Salvation Army's anti-trafficking work takes place on an international scale. They have been protecting and caring for vulnerable victims of human trafficking since The Salvation Army's early beginnings in the 1880s, and since July 2011 they have delivered the UK government's contract to manage support services for adult victims of modern slavery. Since they were awarded the government contract in 2011, they have designed a specialist support programme across England and Wales with a range of Non- Government Organisations who specialise in the care and support of victims. It is their priority to preserve the dignity of survivors, protect and care for them in safe accommodation, and provide access to confidential client-based support services including:

- Advocacy
- Financial assistance
- Legal Advice
- Health Care
- Counselling
- Educational Opportunities

The Salvation Army work with first responders to assess eligibility of potential victims for the service and start the process of making sure they receive the most appropriate support.

They operate a 24-hour Modern Slavery Victim Referral Helpline.

Black Country Women's Aid
Black Country Women's Aid is an independent charity which has supported survivors of domestic abuse and sexual violence in the West Midlands for 30 years. Their sensitive and holistic support and refuge services help victims of domestic abuse, rape and sexual violence, child sexual exploitation, modern slavery and women involved with the criminal justice system to escape from violence, cope with trauma and rebuild their lives.

BCWA is the regional subcontractor of The Salvation Army, which administers the national NRM support services. BCWA's Modern Slavery Support service includes refuge and outreach for victims of modern slavery and international human trafficking. Since 2011, they have supported over 800 women and men of over 30 different nationalities who have been referred through the National Referral Mechanism (NRM).

Lead researcher.

Neil Parkes qualified in both general and mental health nursing in the 1980s. After some years in community mental health and in-patient clinical management, he worked directly with general practitioners to improve quality by the implementation of the Quality and Outcomes Framework in a Primary Care Trust. He was the alcohol strategy manager for Sandwell and then programme manager for drugs, alcohol and sexual health with Sandwell Public Health where he chaired the drug and alcohol partnership.

He has a keen interest in developing the potential for partnership working, co-planning and co-commissioning; after successfully working to develop partnerships in commissioning in Sandwell across both the statutory and non-statutory sectors, he took early retirement in 2017 to set up Bright Day Consulting Ltd. He has a particular interest in how effective partnerships across a wide range of agencies can reduce the impact of abuse and exploitation.

FOREWORD

There is no one definition which can adequately convey the range of exploitation, cruelty and mistreatment found in victims of enslavement and human trafficking. Like all forms of abuse, modern slavery is an abhorrent crime. That traffickers can systematically and calculatingly plan such abuses on an international scale is truly horrifying. It is believed that there are more people enslaved now than at any other time in history. Although it feels that slavery is something a long way from the comfort of our 21st century lives, it is much closer than we think: it may well take place on the street where we live, just a few doors down. It is a crime that can be hidden in supply chains of the goods and services that we use every day and it is possible the money we spend could be fuelling the problem.

In the undertaking of this project it became clear that substance misuse is just one aspect of a range of complexities exhibited by victims which are co-related. It is impossible to consider the issues and consequent vulnerabilities of drug and/ or alcohol misuse exhibited by adult victims, without setting them in the wider context of modern slavery and human trafficking.

People who have substance misuse problems can be exploited because of their dependence and vulnerability, while attitudes towards them can often be judgmental and unsupportive. This project has given us the opportunity to gain some insight into the issues and links with substance misuse and modern slavery, yet we have only just scratched the surface. It is clear that there is so much to learn, so much to connect, so much to do, to recognise victims and to give them all the care and hope they deserve.

Neil Parkes
Lead researcher.

EXECUTIVE SUMMARY

The report was written after extensive consultation with commissioners of drug and alcohol services, subcontractors who provide support services for victims and a range of other professionals and agencies. Commissioners described some knowledge of modern slavery and were aware that it was an emerging issue. Service specifications for drug and alcohol services do not, however, reflect this growing concern. Subcontracted providers of service displayed commitment and dedication in their provision of services while reporting an increasing complexity of need in those who are presenting as victims due to the interaction of substance misuse, mental health problems, fear and previous trauma that victims carry with them.

There was evidence of alcohol misuse and links between the vulnerability of those who are homeless or have mental health problems or learning difficulties. There is also anecdotal evidence of victims being paid in drugs or alcohol rendering them easy to control and coerce. Drug use was less in evidence, and the reasons for this are not clear: It is suggested that further work be undertaken to look at this issue.

Subcontractors did not generally have formal connections with local statutory services and relied on building ad hoc (but often effective) relationships to access healthcare and specialist services for victims. There was little evidence of statutory services having full understanding of the status and needs of victims and therefore pathways into care were not straightforward.

There was little current evidence of joint planning or co-operative commissioning between commissioners, statutory partnerships such as Community Safety Partnerships, Health and Well Being Boards, Safeguarding Boards and subcontractors. Local authority statutory partnerships are well placed to take a strategic lead in the development of co-planning, arranging and commissioning of the local response but this would need to be underpinned with national support for such development. Working in partnership across agencies is essential in the development of services, not only to identify and liberate victims but to provide them with ongoing care and support.

Future service provision supporting victims of modern slavery would be greatly enhanced by sharing of intelligence and skills between agencies, both on a local and national level. The creation of mutually agreed care pathways would also support the care of victims who may need to access specialist interventions from health services, including primary care, sexual health, mental health, substance misuse services, housing, and environmental health teams. Cross-directional training would increase competence and confidence in subcontractors and statutory services at a local level and support the development of joint planning.

There are undoubtedly links between substance misuse and vulnerability, control and coercion, mental ill-health and modern slavery. The issue would benefit from more exploration.

BACKGROUND

The initial idea for this project emerged from dialogue between The Salvation Army Contract Management National Team and subcontractors across England and Wales highlighting their perception of increased complexities of victims presenting through the National Referral Mechanism. The subcontractors highlighted the need for increasing integration between agencies within their respective localities. In particular a recurring theme emerged, that victims are presenting with alcohol and drug misuse that in some cases is not acknowledged by the victim. Subcontractors indicated victims may be reluctant to fully disclose personal narratives to first responders and other agencies for fear they will be harshly judged or summarily returned to their country of origin.

The original brief for the project was to focus on a specific geographical area, the West Midlands, establishing links with the West Midlands subcontractor, Black Country Women's Aid and commissioners of drug and alcohol services to examine the extent of, and connections between, drug and alcohol misuse and modern slavery/ human trafficking.

The project expanded to cover subcontractors in both the north and south of England. This wider consultation would allow comparison of any regional variation.

Modern slavery

'Modern slavery is a complex crime that takes a number of different forms. It encompasses slavery, servitude, forced and compulsory labour and human trafficking. Traffickers and slave drivers coerce, deceive and force individuals against their will into a life of abuse, servitude and inhumane treatment. Victims may be sexually exploited, forced to work for little or no pay or forced to commit criminal activities against their will. Victims are often pressured into debt bondage and are likely to be fearful of those who exploit them, who will often threaten and abuse victims and their families. All of these factors make it very difficult for victims to escape. (Modern Day Slavery Strategy HM Government 2014)

Right Hon. Theresa May MP
Modern Slavery Strategy
HM Government, 2014

Slavery exists today: The Global Slavery Index estimated in 2016 that there were 45.8 million people involved in some form of slavery in 167 countries. (**https://www.globalslaveryindex.org/findings/**)

The Home Office estimate that there are between 10,000 and 13,000 victims of modern slavery in the UK (**Home Office, 2014**)

Throughout the project, the term 'modern slavery' and 'human trafficking' were used when introducing the project to subcontractors and commissioners. Modern slavery and human trafficking cover the following exploitative situations:

- Sexual exploitation
- Forced labour
- Domestic servitude
- Organ harvesting
- Cannabis cultivation

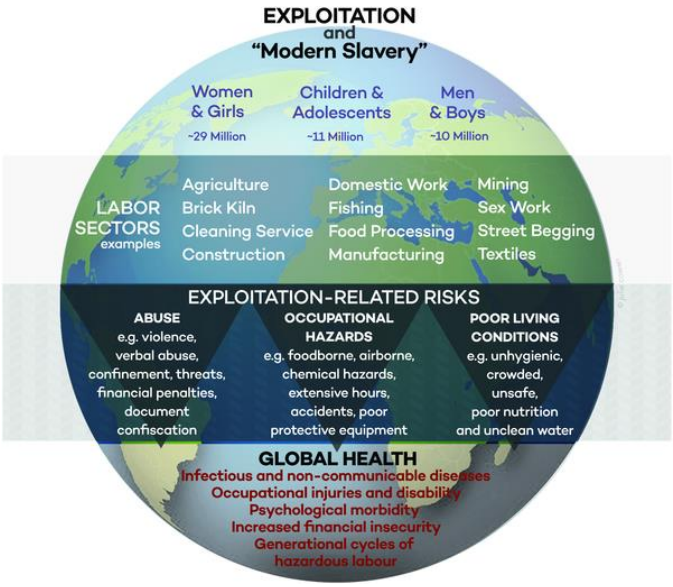
- Child related crimes such as child sexual exploitation, forced begging, organised theft, and benefit fraud.

The National Referral Mechanism Statistics from the National Crime Agency for 2017 show:

- 5145 potential victims were submitted to the National Referral Mechanism in 2017; a 35% increase on 2016.
- Reporting showed potential victims of trafficking from 116 different nationalities in 2017.
- Albanian, UK and Vietnamese nationals remain the most commonly reported potential victims.
- The most common exploitation type recorded for potential victims exploited as adults and minors was labour exploitation, which also includes criminal exploitation. There was a 66% increase in minor exploitation. **(NCA 2018)**

Zimmerman and Kiss (2017) illustrate the global impact of exploitation and modern slavery:

Fig 1. Exploitation, risks, and global health.



Zimmerman C, Kiss L (2017) Human trafficking and exploitation: A global health concern. PLOS Medicine 14(11): e1002437. https://doi.org/10.1371/journal.pmed.1002437
http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002437

PLOS | MEDICINE

A cross-sectional survey of 150 men and women in England who were in contact with support services found that participants had been trafficked for:

- sexual exploitation (29%),
- domestic servitude (29.3%), and
- labour exploitation (40.4%).
- 66% of women reported forced sex during trafficking, including 95% of those trafficked for sexual exploitation and 54% of those trafficked for domestic servitude.
- 21% of men and 24% of women reported ongoing injuries, and
- 8% of men and 23% of women reported diagnosed sexually transmitted infections.
- 78% of women and 40% of men reported high levels of depression, anxiety, or post- traumatic stress disorder symptoms.

(Human Trafficking and Health: A Survey of Male and Female Survivors in England 2016 http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303095 -)

There is clear evidence to link between the privations suffered by trafficked and enslaved victims and damage to both the victim's physical and mental health.

Influences on a victim's health may include pre-existing chronic or genetic conditions, exposure to infectious diseases, repetitive physical, sexual and psychological violence, chronic deprivation, hazards related to various forms of labour exploitation, and deterioration of conditions resulting from lack of diagnosis and care. As is the case with victims of torture, individuals who have been trafficked are likely to sustain multiple physical or psychological injuries and illnesses and report a complex set of symptoms.

https://publications.iom.int/books/caring-trafficked-persons-guidance-health-providers

‘Mental health problems including depression, anxiety and post-traumatic stress disorder (PTSD) occur frequently among survivors, regardless of the form of human slavery to which they have been subjected’ **(Helen Bamber Foundation, Addressing Mental Health Needs in Survivors of Modern Slavery, critical review and research agenda, 2015)**

Modern slavery is a serious problem across the United Kingdom and affects women, men and children regardless of age being trafficked into the country as well as UK nationals.

The Modern Slavery Strategy (HM Government 2014) proposes 4 ‘P’s to underpin the response:

- Pursue: locally and internationally, through strong and coordinated law enforcement. Police forces will have a key role in identifying victims. The National Crime Agency and the Gangmasters Licensing Authority will also be involved in the coordinated approach.

- Prevent: to pro-actively stop people from becoming involved in modern slavery and to deter offenders by robust policing. There will also be local work in understanding the nature of the crime and working to help people understand the consequences of being involved in modern slavery crime. This prevention work will also be international, working in targeted way in priority countries to deter potential perpetrators. Targeted community work will work with ‘at risk’ communities to prevent child abuse and child sexual exploitation.

- Protect: by strengthening the local authority response to child abuse and organised child sexual exploitation. This aspect of the strategy also recognises the vulnerability of the homeless and the links between vulnerability and those targeted by traffickers. The strategy will strive to create a victim-focused culture within the police, health and children's services. The Border Force agency will strengthen capabilities to detect victims and traffickers at our borders. Public awareness will be raised, and the private sector engaged in partnership.

- Prepare: the Home Office will support front-line professionals to identify victims and help them get support. Victims will be supported to reintegrate back into society and compensation will form part of bespoke reparation, funded from money recovered from convicted traffickers.

DRUGS AND ALCOHOL

The 2017 Drug Strategy (HM Government 2017) makes links between the production and supply of drugs, serious and organised criminality, violence associated with human trafficking, modern slavery, child sexual exploitation and abuse. It highlights the vulnerability of the homeless and the links between homelessness and the use of novel psychoactive substances (NPS). There are also links with drug use and mental health problems. There are high levels of drug use with those with severe and enduring mental health problems.

The strategy has 4 main themes to its approach:

1. Reducing demand through universal action which has a positive impact on young people and adults, giving them the confidence, resilience and risk management skills to resist drug use as well as through a targeted approach for vulnerable groups.

2. Restricting supply using a partnership approach to criminal activity.

3. Building recovery by improving treatment quality and outcomes for different user groups and facilitating the delivery of a joined- up approach to commissioning services.

4. Global action by taking a lead role in international action and sharing best practice and promoting evidence- based approaches.

The Government Alcohol Strategy (2012) states:

A combination of irresponsibility, ignorance and poor habits – whether by individuals, parents or businesses – led to almost 1 million alcohol-related violent crimes and 1.2 million alcohol-related hospital admissions in 2010/11 alone. The levels of binge drinking among 15-16-year olds in the UK compare poorly with many other European countries and alcohol is one of the three biggest lifestyle risk factors for disease and death in the United Kingdom after smoking and

obesity. It has become acceptable to use alcohol for stress relief, putting many people at real risk of chronic diseases.
Society is paying the costs - alcohol-related harm is now estimated to cost society £21 billion annually. Cheap alcohol is too readily available, and industry needs and commercial advantages have too frequently been prioritised over community concerns. This has led to a change in behaviour, with increasing numbers of people drinking excessively at home.
(HM Government 2012)

Although the strategy does not deal specifically with modern slavery it does clearly state that cheap alcohol has made it easier for people to drink to excess. There is evidence that alcohol misuse in some victims will be as a direct result of their experiences of being trafficked or enslaved. Some victims were certainly rendered vulnerable by an existing alcohol addiction, enabling traffickers to exert control and coercion by controlling the supply of alcohol.

One of the main ways in which the strategy aimed to tackle cheap alcohol was through the introduction of a minimum price per unit of alcohol although this has not been brought into legislation in England, so alcohol remains cheap and readily available.
Drug and alcohol services are commissioned through Public Health departments. Public Health has been part of local government (local councils) since the changes introduced in the Health and Social Care Act 2012, having previously been part of the NHS.

Services for drugs and alcohol are commissioned for fixed periods of several years, sometimes with optional extensions. Re-commissioning a service allows the commissioning team to shape service according to changing needs or trends and to influence service delivery. A local strategic needs assessment is undertaken to allow commissioners and practitioners to understand the patterns of alcohol and drug use within a locality as well as emerging trends and changing demographics. Commissioners also utilise guidance and data from Public Health England, the National Institute for Clinical Excellence (NICE) and data. Public sector procurement follows the rules set out by the Official Journal of the European Union.

The regular commissioning and tendering of services allows for budgetary changes to the contract value. During interviews it became clear some authorities had reduced the budgets to commission services. The impact of this reduction will need to be measured against strategies employed to deliver services over time.

OTHER FORMS OF EXPLOITATION

Criminal exploitation linked to modern slavery

Other forms of criminal exploitation must be borne in mind: while these do not form a part of this research, they are nevertheless integral to it:

Cuckooing: Drug dealers target vulnerable people and take over their homes to allow them to conduct business, leaving victims with little choice but to cooperate. Vulnerable tenants with learning disabilities, mental health problems and substance misuse problems are particularly vulnerable. The dealers may initially befriend the tenant but that quickly changes. The dealers become increasingly intimidating, possibly violent, and move in other dealers who run their drug selling from the property.

County Lines: *A group establishes a network between an urban hub and county location, into which drugs (primarily heroin and crack cocaine) are supplied. The group exploits young or vulnerable persons, to achieve the storage and/or supply of drugs, movement of cash proceeds and to secure the use of dwellings (commonly referred to as cuckooing). The group or individuals are exploited by them regularly travel between the urban hub and the county market, to replenish stock and deliver cash. The group is inclined to use intimidation, violence and weapons, including knives, corrosives and firearms.* **(National Crime Agency, 2017)**

Pop up brothels: The growth of "pop-up brothels" in short-term let properties has been subject to scrutiny by police, as have adult services websites. There is huge potential for traffickers to exploit short term lettings and the vulnerable to create brothels:

The internet has changed the shape of the off-street sex trade, allowing customers to contact hundreds of workers more easily. Those running temporary brothels also advertise for customers through adult websites.

(https://www.theguardian.com/society/2017/oct/22/sex-workers-popup-brothels-airbnb-mps)

SUMMARY OF DISCUSSIONS WITH DRUG AND ALCOHOL COMMISSIONERS

Discussions with West Midlands substance misuse commissioners

The research targeted senior representatives from each local authority responsible for the procurement and commissioning, performance and standards and partner engagement in substance misuse. The aim was to investigate the extent of connectivity between modern slavery and the commissioning of substance misuse services and to explore what level of organisational structures there were, either actual or potential, to increase and promote knowledge and awareness of modern slavery and human trafficking.

The methodology used was a series of semi- structured interviews either by telephone or face to face. Interviews were noted. The template in addendum 3 was used to guide the interview.

The commissioners interviewed represented the following areas:

- **Birmingham**
- **Dudley**
- **Sandwell**
- **Solihull**
- **Stoke on Trent**
- **Walsall**
- **Wolverhampton.**

Summary

The following summary is drawn from interviews with West Midlands commissioners of drug and alcohol services. The responses represent a snapshot of activity at a certain point in time.

- It was clear that modern slavery is an emerging agenda however, knowledge and strategy was limited. There was some understanding of the potential for coercion and control using drugs and alcohol for victims of modern day slavery but little connection between victims and services. The quality of the responses varied which suggests a strategic disconnect in some areas.

- There is increasing pressure on commissioners to work with reducing budgets. Modern slavery victims are likely to need the support of intensive face to face intervention to fully engage. Substance misuse services could act as a gateway to other services. There was no evidence to indicate that victims of modern slavery had been knowingly treated by and/or identified by drug and alcohol services and therefore able to benefit from onward referral.

- Open referral pathways are positive and non-discriminatory but do not focus or target the highly vulnerable. Victims may be actively prevented from accessing services and commissioners need to take into account the barriers and difficulties victims encounter when in need of specialist interventions.

- Traffickers who are using alcohol and drugs to control and coerce victims, paying victims in alcohol or drugs may also be involved in illegal drug markets. There is little evidence of connectivity between strategies for substance misuse services, victims of modern slavery and strategies to tackle the illegal drugs market.

- Training and information about modern slavery is an emerging theme but one in its infancy. There appears to be little coordination between the role of the substance misuse commissioner and other activity in the local authorities. It is assumed that the commissioned providers of substance misuse services can access any available training however, this was not made explicit or a mandatory training requirement. There was evidence to demonstrate attempts were being made to include modern slavery under the umbrella term of safeguarding. This complex series of responsibilities has the potential to cloud the importance of safeguarding and protecting this group of vulnerable people.

- Data capture meets national and contractual requirements but the absence of local data around modern slavery to support future strategic commissioning should be addressed. There is the potential for the needs of victims of modern slavery to be lost without specific data. It was difficult to gauge how commissioners utilised anecdotal information to influence future commissioning or how they worked with drug and alcohol providers to ensure variations in local need are addressed. It was felt that commissioners were unaware of infrastructure that has developed to respond to modern slavery and Black Country Women's Aid as the regional subcontractor.

- It was clear there is a positive culture of sharing information, but it is less clear how information from the emerging theme of modern slavery was gathered and disseminated. There is no doubt that commissioners would benefit from exploring the wider partnerships within the voluntary and community sector who could be a valuable local resource. Traffickers operate cynically and outside of any of the strategic infrastructures that exist. Rigid boundaries set by strategic partners have the potential to keep traffickers and victims hidden.

- There was an absence of strategic coordination for modern slavery: the theme has little space on strategic partnerships such as Community Safety Partnerships, Children's Safeguarding Boards, Adult Safeguarding Boards, or Health and Wellbeing Boards. It is acknowledged that there has been significant development within statutory partnerships and they are at

different stages of development. Some have chosen to incorporate this agenda into the Violence Against Women and Girls. The modern slavery agenda does not yet fully impact on cross-cutting partnership agendas and it will take time to embed common understanding.

- There is no evidence of pathways between key services such as primary care, mental health services, sexual health services, substance misuse services or A&E for victims.

SUMMARY OF DISCUSSIONS WITH SUBCONTRACTORS AND OTHER AGENCIES

Discussions with subcontractors and commissioners outside the West Midlands

The research targeted senior subcontracting managers in the North and South of England. The aim was to investigate the nature and extent of their links, formal or otherwise, with their commissioners of drug and alcohol services and how they fitted in with local statutory frameworks to ensure that victims of modern slavery had access to the full range of service available within their localities, including local authorities, health services, criminal justice partners including the police and drug and alcohol services. During the course of the project the networks expanded in order that a fuller picture be drawn. The methodology used was a series of semi structured interviews within their own locality.

The following areas were represented by modern slavery subcontractors:

- **Sheffield (City Hearts)**
- **Sunderland (City Hearts)**
- **Liverpool (City Hearts)**
- **London (Hestia)**
- **Birmingham and the Black Country (Black Country Women's Aid)**

Additional supportive information was provided by:

- **Public Health England in Birmingham**
- **Substance misuse commissioners and providers in Redbridge, Royal Berkshire and Windsor**
- **An NHS England Commissioner in Central London**
- **A third sector legal expert in modern slavery**
- **Subcontractors from a large rural area**

- **A local authority trading standards and licensing manager in Sandwell**
- **The Adavu Project, which supports survivors of modern slavery (Birmingham)**

Summary

- Subcontractors described widespread problematic alcohol misuse amongst victims leading to behavioural problems, exacerbation of pre-existing mental health problems and aggression. Indeed, substance misuse is closely linked with mental ill- health, and this is especially true in the case of victims of modern slavery, given their history of trauma and abuse. Subcontractors identified a common theme of existing cultural relationships with alcohol, particularly in men from Eastern European countries. There was evidence of alcohol being used by victims to block out bad news or uncomfortable memories. This was not linked to aggression, but such heavy, episodic use increases risk. It is felt that subcontractors may be working in isolation and may not be able to fully meet the needs of victims with heavy alcohol misuse or dependence.

- There is no doubt that the commitment, compassion and skills among subcontractors are at a high level and these continue to evolve and develop over the lifetime of the contract. The national contractor should feel confident that they are developing and supporting this specialist area of work. However, subcontractors felt there was a need for more support and specialist knowledge, especially around drugs, alcohol and mental health to allow them to assess risk and provide adequate support for victims with higher levels of need. It was clear that there are variations in the confidence of subcontractors and subsequent response to address increasing complexity of need in presenting victims.

- Subcontractors indicated that they were often presented with limited information about victims upon referral, and from an operational perspective they were unable to fully prepare an appropriate care package in advance or make necessary connections with other agencies. It is felt that as more victims access the NRM, they present with more diverse needs and

the ‘one size fits all’ of service provision does not provide all aspects of the support required. It is clear that not all victims need higher intensity services, but there needs to be a range of different levels of intensity of service offered. The majority of subcontractors operated a 9-5, office - hour direct support service, however one operated 24- hour direct support and this was felt necessary due to the risks presented outside of the current contracting arrangements.

- When addressing alcohol misuse, subcontractors reported difficulty eliciting information from victims, especially where they have been threatened by traffickers and have difficulty with trust in those they consider to be in authority. Traffickers may also have threatened to harm their families. Subcontractors indicated that victims were reluctant to disclose alcohol or substance use. This may be because of a perception that authorities may not fully understand the complexities of some victims. This reluctance may mean that information is missing from initial assessments. Unwillingness in some cultures to talk about or recognise mental health issues makes victims difficult to treat, especially when coupled with post- traumatic stress disorder and alcohol misuse.

- Subcontractors demonstrated a varied understanding of the statutory partnership arrangements, such as Adult Safeguarding Board, Children’s Safeguarding Board, Community Safety Partnership and Health and Wellbeing Boards and thus there was limited connectivity and accountability. One subcontractor was integrated into the statutory partnership arrangements of one local authority and this was associated with their broader organisational remit. This organisation demonstrated links with only one drug and alcohol commissioner despite there being 7 within the contracted area. It was evident that no other subcontractors had any formal links with local authorities or statutory partnerships and consequently they were not able nor were they asked to contribute intelligence that would support strategic planning. Subcontractors would benefit from being part of regular and mutual participation within all partnerships that covered their geographical areas.

- Subcontractor data recording could not quantify exact numbers of those presenting with drug problems. However, there needs to be a point at which each of the issues of drug and alcohol problems need to be addressed separately. While it was not possible to sufficiently evidence drug addiction there was anecdotal evidence of sex- trafficked victims being given ketamine to keep them awake and therefore sexually active for longer, as well as recreational drug use, particularly cannabis. Subcontractors felt there is an increased risk where alcohol is consumed in relation to health and safety, security, to the victim, to their accommodation and potentially to other residents. Although data was lacking it is of significant concern that victims with drug problems are not being identified and therefore not accessing the NRM. It is possible that the control exerted by traffickers who coerce victims with addictive drugs is sufficient that victims are less likely to be identified rescued.

- It was clear that subcontractors had established good local arrangements and in some areas relationships with primary care, sexual health services, health visiting, social work and midwifery although mostly arranged on an ad-hoc or 'as needed' basis. Subcontractors felt that some service providers, such as mental health providers, substance misuse services and healthcare services, lacked understanding and awareness of the needs of victims. Consequently, subcontractors felt that this did not help them to get the best and most appropriate services for victims within their time-limited involvement with the victim. It was clear that subcontractors were always striving to get the best outcomes for victims. Pressures within healthcare services can mean time delays in accessing assessment and treatment.

- Subcontractors expressed concern that there was limited knowledge of what constituted modern slavery and human trafficking within some statutory services. There was evidence that some services were not fully aware of the difference between those seeking asylum and victims of modern slavery. A lack of knowledge of immigration status also was felt to contribute to a bias in professionals in some services feeling unable to offer care to someone who would have no recourse to public funds, although this was difficult to quantify. It is acknowledged that services are under pressure, however

subcontractors observed and commented anecdotally some statutory agencies dealt with victims flippantly, displaying little or no understanding of their needs. It is clear that traffickers will have prevented access to essential services so the importance of victims being recognised, understood and that every possible opportunity of engagement is an opportunity for rescue.

- Subcontractors reported that language remained a barrier despite access to a national service especially with regard to the specialist and complex needs when interpreting emotional needs and trauma. Regard should be given to the possibility of interpreter bias. While this is difficult to detect it may limit the opportunities for the victim to fully express their needs.

RECOMMENDATIONS

1. Strategic Partnerships

It was evident that there was an absence of modern slavery subcontractors at local strategic partnerships, a lack of awareness of local partnership arrangements and no dialogue between subcontractors and drug and alcohol commissioners. There is no doubt bringing together commissioners and subcontractors would be mutually beneficial. Subcontractors cover large geographical areas and more than one local authority/statutory partnership area – and thus more than one commissioner. This approach will need active support at a national level. It is acknowledged that 'Partnership' is a key priority in the Independent Anti-Slavery Commissioner's Strategy.

- It is recommended that there is national leadership and guidance to support the development of effective, responsive and accountable local partnerships

- It is recommended that subcontractors ensure that they are aware of all the local strategic partnerships within their contracted areas.

- It is recommended that subcontractors are aware of local commissioners and commissioning arrangements so that they are able to reflect the specific needs of the victim.

- It is recommended that partnerships create a positive environment in which knowledge and experience can be shared.

2. Data and intelligence

There is a wealth of data around modern slavery and substance misuse, from the National Crime Agency, from Home Office sources concerning trends in illicit drug use, from the National Drug Treatment Monitoring Service and local needs assessments. The 2017 Drug Strategy has within it a commitment to develop a broad set of indicators to reflect changing trends. This data can drive change,

actions and innovation. The sharing of data from local, regional and national sources between statutory partnerships, local commissioners and subcontractors would ensure that work at a local level would be appropriately informed. All statutory partnerships have information sharing agreements to allow them to work within legal framework to address issues such as criminality, violence and abuse.

- It is recommended that there is clear understanding of available data and intelligence. It may be necessary to review local strategic partnership information sharing agreements. Strategic partnerships should ensure that they are aware of all local resources and intelligence, e.g. trading standards and licensing teams who may have intelligence via operational activity around serious organised crime, illicit tobacco and alcohol which can be utilised by the partnerships.

- It is recommended that information sharing should be a mutually supportive and beneficial endeavour

3. Contributing to the strategic plan

There has been significant movement in the concept of developing services via co-design and co-planning arrangements. Co-planning between different agencies can be challenging but it is clear that if commissioners and local strategic partnerships are not aware of the subcontracted support for modern slavery there will be an unhealthy disconnection.

- It is recommended that subcontractors and commissioners work together on local needs assessments to ensure that specific knowledge is shared, and the needs of victims are fully met.

- It is recommended that drug and alcohol commissioners ensure their commissioned substance misuse services have the knowledge, skills and confidence to recognise and support victims of modern slavery.

4. The modern slavery agenda

It is evident that the modern slavery agenda is being discussed at some strategic partnerships despite a lack of connection between the partnerships and subcontractors. There is, however a lack of consistency with this.

- It is recommended that each statutory strategic partnership identifies the appropriate strategic group to routinely discuss modern slavery, and this should be a standing item on the partnership agenda, to include the work of the subcontractors. Subcontractor involvement in the group will need to be reflected within subcontracting arrangements to allow them to attend and contribute fully in the agenda. The national contractor for modern slavery support services should be fully involved in these developments.

5. Victim pathways

It is clear that the National Referral Mechanism has created a comprehensive response to support victims of modern slavery. The pathway ensures that subcontractors are confident in their responsibilities, and key aspects to ensure responsibilities are carried out are accurate assessment and risk assessments. The assessment information that travels with a victim is likely to be the only narrative they have, and this will influence what happens to them thereafter. The relationship with The Salvation Army ensures standards are maintained via robust monitoring arrangements. It is clear that there is a lack of formal connection with healthcare providers, and those providers may have limited or no access to training on modern slavery. It was noted that relationships with healthcare providers were made by subcontractors on behalf of victims and they were often on an ad -hoc basis. It is acknowledged that victims are entitled to NHS services and that the NHS is committed to delivering them. The importance of the emotional impact on those who provide care for victims should not be overlooked.

- It is recommended that responsible local strategic partnerships, such as Health and Wellbeing boards, ensure that subcontractors and commissioners work together to include the standards within the Trafficking Survivor Care

Standards (Human Trafficking Foundation 2014) when co-planning and commissioning future services.

- It is recommended training around modern slavery should be available for healthcare providers and support and training available for subcontractors. This two-way training should be supportive of the development of co-planning and working in partnership.

- It is recommended that each partner identifies their responsibilities in relation to identification, rescue and on-going support before, during and beyond the NRM, especially healthcare providers. The agenda is complex, and the response needs to be planned yet reactive. The offer of open-access and available for all is not sufficiently assertively reaching out to either subcontractors or victims.

These partner agencies could include (but not be limited to):

1. Primary care, to include general practitioners, health visitors, district nurses, allied staff and walk- in centres. Reception staff should be trained in awareness;
2. Sexual health services, to include contraception and advice clinics, drop- in clinics and genitourinary medicine (GUM) clinics within the NHS, and other commissioned services for sexual health for young people with a given local authority;
3. Emergency Departments and clinics within general hospitals, other clinics, e.g. fracture clinics, and general wards within hospitals;
4. Termination of pregnancy services (abortion clinics);
5. Mental health services, to include mental health trusts and access to psychiatry, clinical psychology, in-patient mental health services, occupational therapy, community mental health nursing and allied mental health services;
6. Specialist drug and alcohol services and their prescribing services as appropriate; mutual aid and 12 step programmes – these are available in most areas and are free to access;

7. Housing services, both within local authorities and registered social landlords;
8. Women's Aid services;
9. Pharmacies;

- It is recommended that care pathways should be designed by subcontractors and partner agencies by utilising the following principles:

- Mutual decision- making and organisation of processes;
- Explicit statement of goals and key elements based on evidence and best practice;
- Communication between team members, partners and victims;
- Coordination of processes by coordination of roles and sequencing of activities;
- Documentation, monitoring and evaluation of outcomes;
- Identification of appropriate resources

- It is recommended that all agencies review assessment and risk assessment information, especially the information to be used for onward referral. It should be borne in mind that due to the effects of modern slavery on victims, they may not divulge all of their personal information until they feel comfortable to do so.

CARE PATHWAYS AND SKILL MIX

This agenda has so far been led by criminal justice partners, the charitable sector and partners at a national level. There is much that can be learned from the skill mix model used within the health service. It is a concept that other organisations and partnerships can use to ensure that they have the most cost-effective combination of roles and staff to meet their needs.

It is clear that the subcontractor workforce provides inclusive and dedicated support to victims. However, given the apparent increasing complexity of need in the presentation of victims, subcontractors may need to work in a more integrated way with locally commissioned specialist services, particularly those related to mental health and substance misuse. Rapid access to specialist advice would bolster the support given by subcontractors, reducing pressure in the workforce and the likelihood of crisis. Increasing the skills within the existing workforce reduces the need for specialist intervention: it would allow for greater definition of function and less blurring of roles, boundaries and accountability, as well as give subcontractors the confidence and competence in dealing with difficult situations.

Recommendations

- It is recommended the current workforce be assessed in terms of expertise and skill, the geographical area(s) covered and the operational provision, including operational hours.

- It is recommended that training needs in the workforce should be identified, together with sources of available training. Where possible this training should be cross-directional with statutory services.

- It is recommended that telephone support be considered to provide coverage over a wide area. The geographical area should be cross-referenced with the number of staff and victims within a subcontractor's area to begin to ascertain level of need.

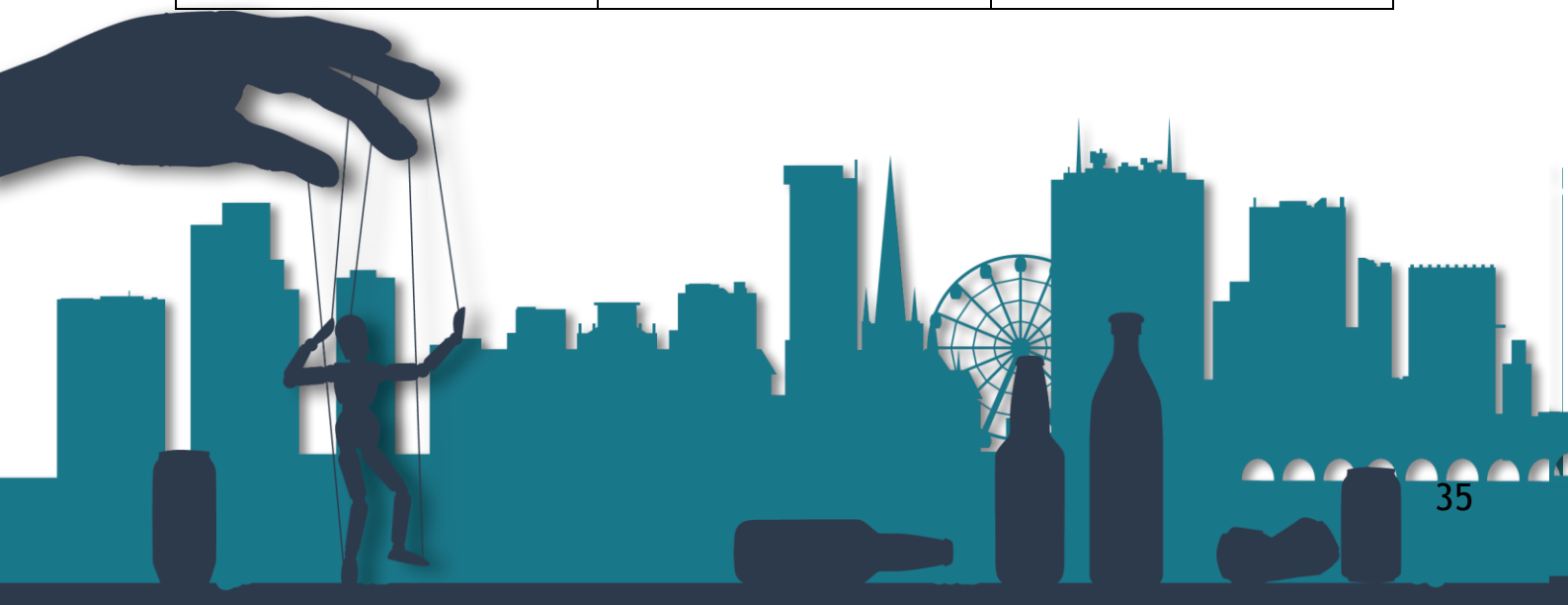
- It is recommended that any assessment of need should include input from local authority and health commissioners and the opportunity for co-working and co-development.

- It is recommended that skills should be shared between subcontractors where appropriate and training programmes established and updated as necessary.

- It is recommended that operational practitioners within subcontracted services should still connect with statutory services and be clear when the situation calls for such action.

SUGGESTED CROSS- DIRECTIONAL TRAINING PACKAGES

Area of knowledge/skill	Training delivered by	Received by
Knowledge of common mental health problems: • Post-traumatic stress disorder; • Management of self-harm • Depression • Psychosis • Personality disorders • Pathways • Conflict management • Anger management • Assessment of risk	Local mental health services	Subcontractors, those charities working with victims
Local authority/statutory service protocols and governance awareness	Local authority designated partnership officers	Subcontractors, those charities working with victims
Drug awareness: • Types of drugs and administration • Signs of overdose and basic treatment	Local substance misuse services	Subcontractors, those charities working with victims



• Current legislation • Pathways • Dual diagnosis		
Alcohol misuse awareness • How to recognise alcohol misuse • Current legislation • Pathways	Local substance misuse services	Subcontractors, those charities working with victims
Awareness raising of modern slavery and human trafficking: • Recognising victims of modern slavery • What to do if you recognise a victim • Local agencies who can help • Current legislation • The National Referral Mechanism	All statutory services, local authorities, police, fire services, mental health, primary care, hospitals, schools. This list is not exhaustive.	Subcontractors

SUGGESTED FURTHER RESEARCH

The lack of evidence of victims with addictive drug problems needs more interrogation and clarification. There is anecdotal evidence that drugs are being used to coerce and control in those trafficked from overseas, but this is difficult to quantify. It may be that those with drug addictions ae easier to control and keep hidden, thus making them more difficult to identify. Paradoxically, drug use featured heavily in the interview undertaken with a victim (See Victoria's story, addendum 5).

Victoria was not a victim of trafficking from overseas but was very much controlled and coerced by addictive drugs in what does not appear to be an isolated case. There is anecdotal evidence of indigenous victims of slavery being coerced, controlled and forced to beg while dependent on crack cocaine, and some eastern European men being given amphetamines to force them to work 20 hours a day. Those suffering mental health problems, the homeless and the alcohol or drug - dependent are especially vulnerable to being targeted and enslaved. There is anecdotal evidence within services that the use of Novel Psychoactive Substances (NPS, previously known as legal highs) within the homeless population is common. The use of NPS in coercion is less clear but warrants further investigation.

Subcontractors from a very large, broadly rural area spoke of real difficulties with transfer of clients who have an existing drug dependency. An example was of two people who were in receipt of substitute medication for opiate dependency. Methadone is the drug used as substitute medication, it is a controlled drug and thus requires assessment, monitoring, continuous engagement and specialist prescribing. The drug service treating the couple were slow to action the transfer when the couple were identified and put into the NRM, and the receiving drug service initially refused to pick up the responsibility for treatment. The onward referring drug service eventually issued a prescription for one week but offered no interventions to support the transfer and handover of care. The subsequent delay meant the couple lost their offer of accommodation, failed to receive a timely prescription and went back to sourcing street drugs in their new area, thus putting themselves at risk of re-enslavement.

As well as the apparent reluctance of statutory services to become fully involved, there are sometimes discrepancies in local protocols for assessment and thresholds for prescribing that present difficulty to the effective, seamless and safe transfer of victims across areas. An existing prescription for a certain dose of substitute medication may be subject to more stringent prescribing guidelines in a different area. The subsequent assessment may add barriers and delay to effective care and there is a real danger of losing the victim back to the illegal drug market – and back into slavery.

- It is recommended that the use of addictive drugs to subjugate and coerce victims should be investigated further.
- It is recommended that commissioners and local authorities support statutory providers of drug and alcohol services to work across boundaries and develop seamless transfer protocols.

ADDENDUM 1: The National Referral Mechanism

The National Referral Mechanism is a framework for identifying victims of modern slavery and human trafficking. It also collects relevant data.

Referral to a UK competent authority (first responders)

To be referred to the NRM, potential victims of trafficking or modern slavery must first be referred to one of the UK's two competent authorities. This initial referral will generally be handled by an authorised agency such as a police force, the National Crime Agency, the UK Border Force, Home Office Immigration and Visas, Social Services or certain NGO's. The referring authority is known as the 'first responder'.

The first responder will complete a referral form to pass the case to the CA. Referral to a CA is voluntary and can happen only if the potential victim gives their permission by signing the referral form. In the case of children their consent is not required.

All completed NRM forms are sent to the MSHTU in the first instance. The MSHTU will then determine which CA will deal with the case and will forward the papers if needed.

Competent Authorities (CA)

In the UK the two Competent Authorities are:

- The NCA's Modern Slavery Human Trafficking Unit (MSHTU)
- The Home Office Visas and Immigration (UKVI)

All referrals to the NRM from first responders must be sent to MSHTU initially. MSHTU also manages the data on NRM referrals. MSHTU makes reasonable and conclusive grounds decisions on all cases involving:

- a UK national

- a European Economic Area (EEA) national (except where there is a live immigration issue)

When MSHTU receives a referral relating to an EEA or non-EEA national who is subject to immigration control, they will refer the case to the Home Office Competent Authority, who will make the reasonable and conclusive grounds decisions.

If a case involves a non-EEA national with no active immigration issues, MSHTU also refers the case to the Home Office Competent Authority who will make the reasonable and conclusive grounds decision.

Stage one – "Reasonable grounds"

The NRM team has a target date of 5 working days from receipt of referral in which to decide whether there are reasonable grounds to believe the individual is a potential victim of human trafficking or modern slavery. This may involve seeking additional information from the first responder or from specialist NGOs or social services. The threshold at Reasonable Grounds stage for the trained decision makers is; "from the information available so far I believe but cannot prove" that the individual is a potential victim of trafficking or modern slavery.

If the decision is affirmative, then the potential victim will be:

- allocated a place within Government funded safe house accommodation, if required
- granted a reflection and recovery period of 45 calendar days. This allows the victim to begin to recover from their ordeal and to reflect on what they want to do next, for example, co-operate with police as required, return home etc.

The potential victim and the first responder are both notified of the decision by letter.

Stage two – "Conclusive decision"

During the 45- day reflection and recovery period the Competent Authority gathers further information relating to the referral from the first responder and other agencies.

This additional information is used to make a conclusive decision on whether the referred person is a victim of human trafficking or modern slavery. The expectation is that a Conclusive Grounds decision will be made as soon as possible following day 45 of the recovery and reflection period. There is no target to make a conclusive grounds decision within 45 days. The timescale for making a conclusive grounds decision will be based on all the circumstances of the case.

The trained decision makers threshold for a Conclusive Decision is that on the balance of probability "it is more likely than not" that the individual is a victim of human trafficking or modern slavery.

The first responder and the potential victim will both be notified of the decision. If the potential victim is conclusively identified as a victim of trafficking or modern slavery, what happens next depends on their wishes.

What happens next?

Co-operating with police enquiries

The victim may be granted discretionary leave to remain in the UK to allow them to co-operate fully in any police investigation and subsequent prosecution. The period of discretionary leave can be extended if required.

Other circumstances

If a victim of trafficking or modern slavery is not involved in the criminal justice process, the Home Office may consider a grant of discretionary leave to remain in the UK, dependent on the victim's personal circumstances. Circumstances may include leave for those pursuing compensation, asylum seekers, EEA nationals exercising treaty rights and British Citizens.

Returning home

Subject to eligibility criteria, confirmed victims of modern slavery can receive help and financial assistance to return home through the Home Office Assisted Voluntary Return Service. The Salvation Army and its subcontractor organisations will seek to refer or sign-post victims to relevant NGOs who may be able to help them in their home country.

(http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism)

ADDENDUM 2: Commissioner responses

Area A

Current contract	MDS in specification?	MDS Training Available?	Evidence of local need	Local partnership structures
The service is provided by a single provider organisation and is an integrated service: drug and alcohol services are provided under one contract. The service was commissioned in 2015 for 3 years with an optional extension for up to 2 years. The contract value is £3.1 million, but this will reduce by £250,000 each year of the first 3 years.	Modern Day Slavery not referenced in specification, but it is planned to be in future specifications.	Training events for Modern Day Slavery available throughout the organisation. Community cohesion department has linked with the housing department to develop a response to modern slavery.	No formal evidence of need, but anecdotal evidence of homeless seasonal workers in the town during winter. No formally acknowledged contact between victims and drug and alcohol services. Anecdotal evidence of an individual who was trafficked for sex work and who was coerced with injected opiates. The	Senior commissioner attends the local Community Safety Partnership. The Housing Department is working actively to deal with rogue landlords, and houses of multiple occupancy. The commissioner also suggested the authority would be willing to work with other areas or with Public Health England to produce

			victim was identified as needing an opiate detoxification but did not present at services.	standardised guidance on modern slavery to be put into drug and alcohol specifications.

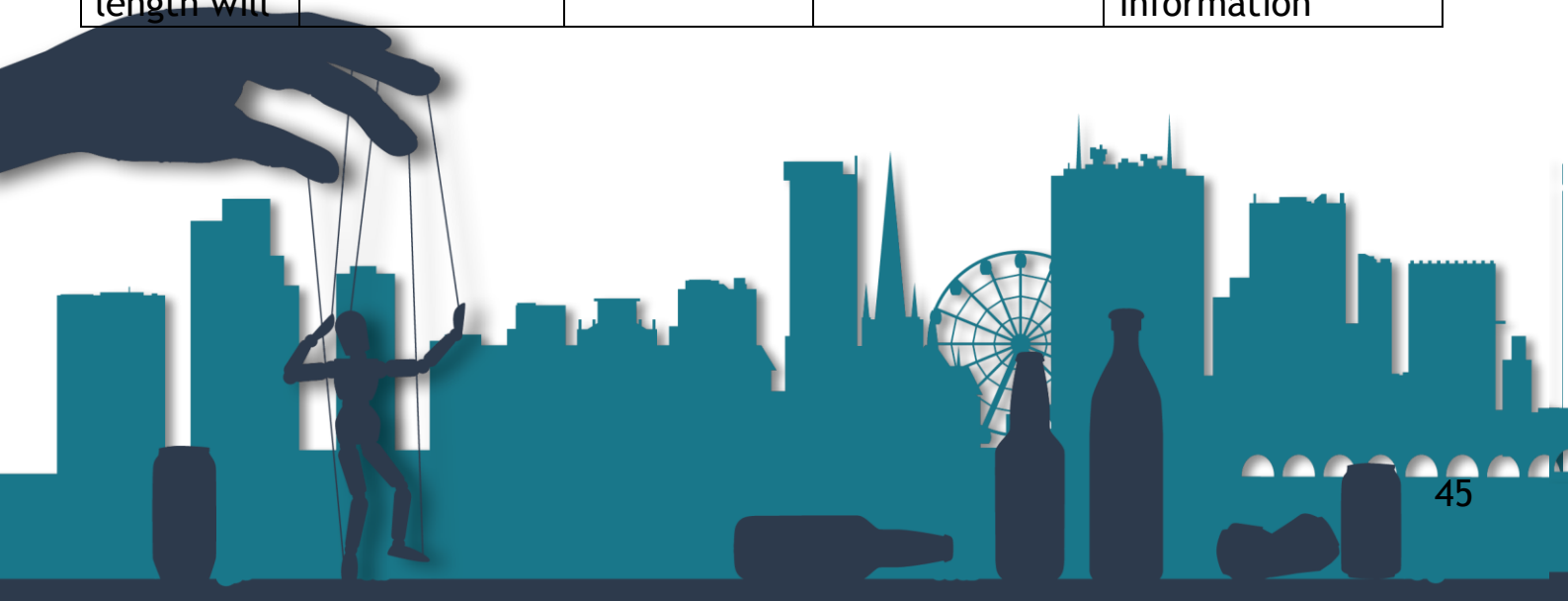
Area B

Current contract	MDS in specification?	MDS Training Available?	Evidence of local need	Local partnership structures
Drug and alcohol services are integrated provided by a group of providers in partnership agreement. The service is currently being retendered for 5 years with a possible	No	Mandated training in Childhood Sexual exploitation available but it isn't known whether this makes specific reference to MDS. Some work around MDS has been undertaken by the Violence	No formal evidence.	Information from the local Community Safety Partnership filters down to commissioners although commissioners don't attend formally.

extension of 2 years. The value is £4 million per annum. This has been reduced by £1 million.		Against Women and Girls group (VAWG)		

Area C

Current contract	MDS in specification?	MDS Training Available?	Evidence of local need	Local partnership structures
Services currently provided by two providers although there are plans to integrate services and commission a single provider. Services currently being re-tendered: contract length will	Specification mentions vulnerable groups in the specification under the heading of safeguarding, including childhood sexual exploitation, female genital mutilation and modern slavery.	Police have undertaken training specifically in Modern Slavery. There is an officer with specific responsibility for modern slavery who developing training across the authority.	No formal demographic information but anecdotal evidence points to a high level of alcohol misuse in victims of modern slavery.	The authority has an officer with specific responsibility for modern slavery. A substance misuse partnership reports to the community safety partnership. This partnership has strong links with other departments such as Trading Standards and Licensing. The authority also has a good model for information



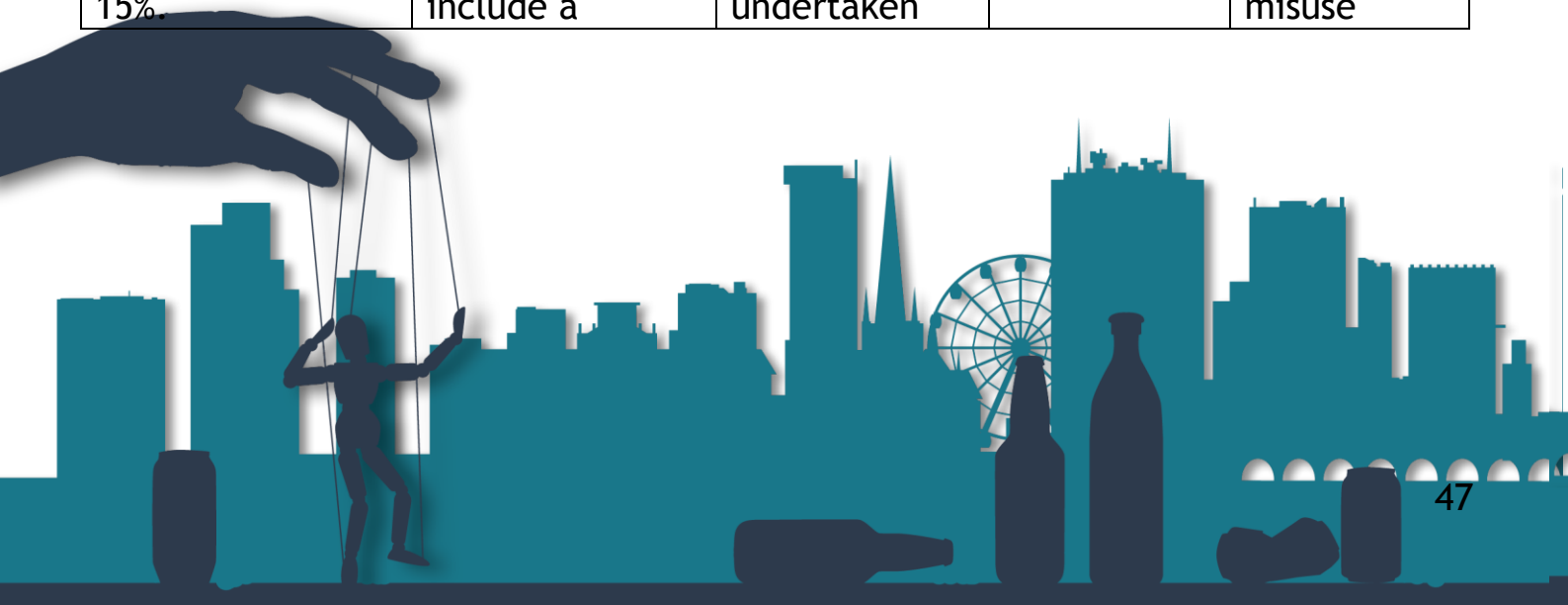
be 3 years with an optional 2-year extension. Contract value reduced from £3.6 million to £3.1 million per annum and will reduce a further 10% each year for 3 years.				sharing via a multi-agency group which focuses on the needs of high volume service users where alcohol is a factor.

Area D

Current contract	MDS in specification?	MDS Training Available?	Evidence of local need	Local partnership structures
Services provided by a partnership of 3 agencies. Some difficulties experienced as previous provider went into administration, leaving the local authority to re-organise rapidly. The total contract value is £3.6 million.	No specific reference although there is mention of safeguarding. It is intended that modern slavery will be in future specifications.	No specific modern slavery training that the commissioner is aware of.	No formal data but anecdotal speculation that a recent drug death may have been due to coercion, but this has not been substantiated.	Links between Community Safety Partnership and commissioners. Drug and alcohol services have good links with primary care, the Clinical Commissioning Group and sexual health services.

Area E

Current contract	MDS in specification?	MDS Training Available?	Evidence of local need	Local partnership structures
Drug and alcohol services are integrated with a single provider. Contract value is £2.4 million per annum. This has been reduced by 15%.	No specific mention in the current specification but there are discussions taking place currently to include a	Commissioners not aware of specific training but some awareness raising has been undertaken	No formal demographic information currently available.	There are links between the local safeguarding board and the substance misuse



	variation in the contract for modern slavery. The local authority has produced guidance around vulnerability to be included in all contracts. The provider of drug and alcohol services also has its own organisational guidance around modern slavery.	across the authority.		partnership board. A coordinating role within community safety links things further.

Area F

Current contract	MDS in specification?	MDS Training Available?	Evidence of local need	Local partnership structures
Drug and alcohol services are integrated and provided by a single provider. The contract was awarded in 2015 for 5 years with an optional 2- year extension. The contract value is circa £16	No mention of modern slavery within the specification.	Commissioner not aware of any training available.	No formal evidence or data. Drug and alcohol service provider has its own organisational guidance and asks questions regarding modern	Some links with the community safety partnership and information is disseminated. Regular attendance by commissioners at the meeting is

million.			slavery at assessment	made difficult by capacity issues. The community safety partnership does not invite providers: the commissioner feels this an opportunity missed to share information providers may have.

Area G

Current contract	MDS in specification?	MDS Training Available?	Evidence of local need	Local partnership structures
Drug and alcohol services are separate services provided by several organisations working in partnership. Contract value currently £2.3 million; this has been reduced from £2.6 million.	Not currently but there is clear intention to include it in future specifications.	The authority has good links with the West Midlands anti- slavery network and information is disseminated from this group,	Commissioner is not aware of formal demographic information. Service provider assessment asks questions about modern slavery.	The community safety partnership and health and wellbeing boards have focused on modern slavery and information is disseminated.

Services will be re-commissioned in 2019 but the future model and costings have not been finalised.		including shared responses to the protection of victims across the region.		Good links with the West Midlands anti- slavery network.

ADDENDUM 3: Guidance questions for commissioners of drug and alcohol services.

1. *Who provides drug and alcohol services in your locality? Please could you describe the services and how they interact. What is the locality?*

2. *What is the total contract value for drugs and alcohol?*

3. *How are referrals made into the service?*

4. *Is there specific reference or guidance in the local specifications regarding victims of MDS? If yes do you measure in contract reviews? And If no, currently are there plans to include in in commissioning plans? When are you commissioning again?*

5. *Do you have access to current local data and demographic information regarding MDS?*

6. *Are you aware of your organisation /local authority having a lead for with HT and MDS? And what they have done?*

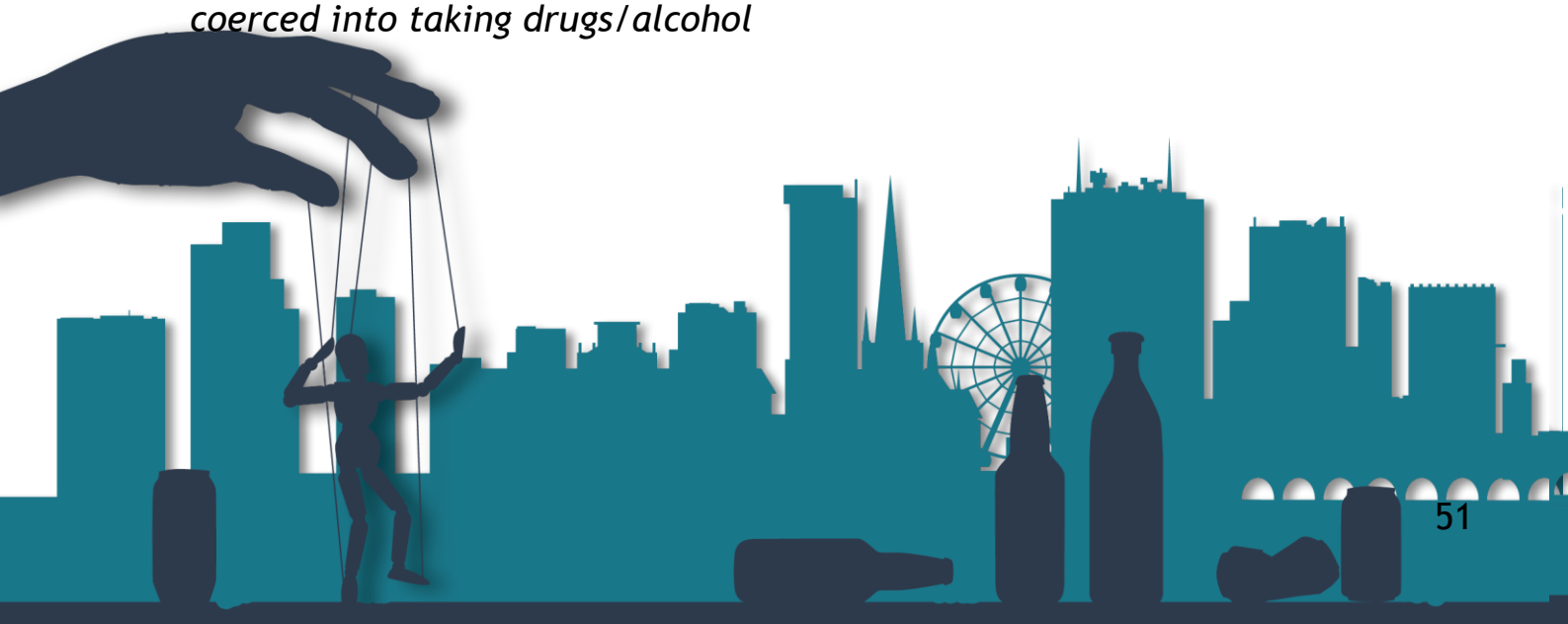
7. *How would you or your services recognise/identify victims of HT and MDS?*

8. *What links exist in your organisation between substance misuse commissioning and HT and MDS e.g. Community Safety Partnerships/ Health and Wellbeing Boards/ commissioning boards?*

9. *Have you got any evidence of the need for drug and alcohol provision for the victims of MDS?*

10. *What, if any, additional funding has been made available to you to support victims of HT and MDS*

11. *To what extent do you believe victims of HT and MDS have been coerced into taking drugs/alcohol*



12. *Is there training on Modern Day Slavery available in your area? If so, what is the nature of the training and how many people have accessed it (if known)?*

13. *In your opinion what are the barriers for this client group accessing services if any? How could they be overcome?*

14. *Are there examples of good practice in delivering services in your area?*

15. *Anything you'd like to add?*

ADDENDUM 4: Guidance questions for providers of support services to victims of modern slavery (subcontractors)

1. *Can you describe a typical – as much as there is such a thing - pathway into your services?*

2. *What connections do you have with:*

    Local authorities
    Police
    First responders
    MDS leads
    Commissioners of drug and alcohol services (who is the contact?)
    Providers of drug and alcohol services (who is it in your area?)

3. *What do you think are the levels of substance misuse you've observed in victims and would you have information to surmise whether the use is:*

    Pre-existing
    Inflicted for coercive purposes
    Started after enslavement
    What substances have you observed being misused?

4. *How easy is it to meet the level of need for those victims with substance misuse problems?*

5. *What 3 things would you recommend to improve:*

    The National Referral Mechanism
    Access to healthcare for victims (primary care, sexual health services, mental health services)
    Substance Misuse services for victims

ADDENDUM 5: Victoria's story.

'If I get found out I will be killed. I never stop looking out for someone who might recognise me or someone who could tip off those who kept me locked up and addicted. It would be easy to have me lifted, taken back to where they are and inject me with heroin. I'd just be another overdose: no one would know, and no one would care.'

I wasn't from a deprived area. I went to college after school but had some bad experiences and left. I got into the party scene and started to use recreational drugs, particularly cocaine. I had a son who passed away when he was very young. His birth father was killed.
My drug use got worse and I got involved in some of the gangs near where I lived.

I became involved in the sex trade. I was taken to sex parties and fetish parties. Some of these were in high class areas of the city and had barristers and professional men involved. There was a lot of cruelty and abuse of the women. Some of the women were working girls but some were taken there, supplied to order by gangs. The gang members gave us money and drugs for taking part. I got addicted to crack cocaine because of this. There were also young men and boys at the parties. I think some of the boys and girls were as young as 13 or 14. They were certainly under age.

Some of the gangs have military ranks – everybody has a place in the organisation, from generals at the top down to privates and recruits. People can move up through the ranks as they get known and more trusted. They are very organised.

Some gangs dealt in drugs but never got involved in really heavy stuff. They would invest their money and get out when they could. But the gangs began to splinter and change. The drug market increased, and competition increased too. Gangs became more violent and Somalis and Yardies got involved and they became really brutal. They forced younger members into committing acts of violence even if they didn't want to.

I was kept supplied with drugs to keep me within the gang and to coerce me into

doing whatever they wanted me to do. I was threatened with having to sleep with men who were known to have a bad reputation for sexual violence. I was sometimes locked in a room while gang members went away for a few days to look at another area where they might be able to move in, sometimes using county lines. When I was locked in I would be given lots of cigarettes and Coca Cola but I'd have no food or access to sanitary towels. This in itself made it impossible to escape – I was often covered in blood. Gang members would make me watch while they ate takeaways, knowing I hadn't eaten. If I could I would eat their leftovers from the bin.

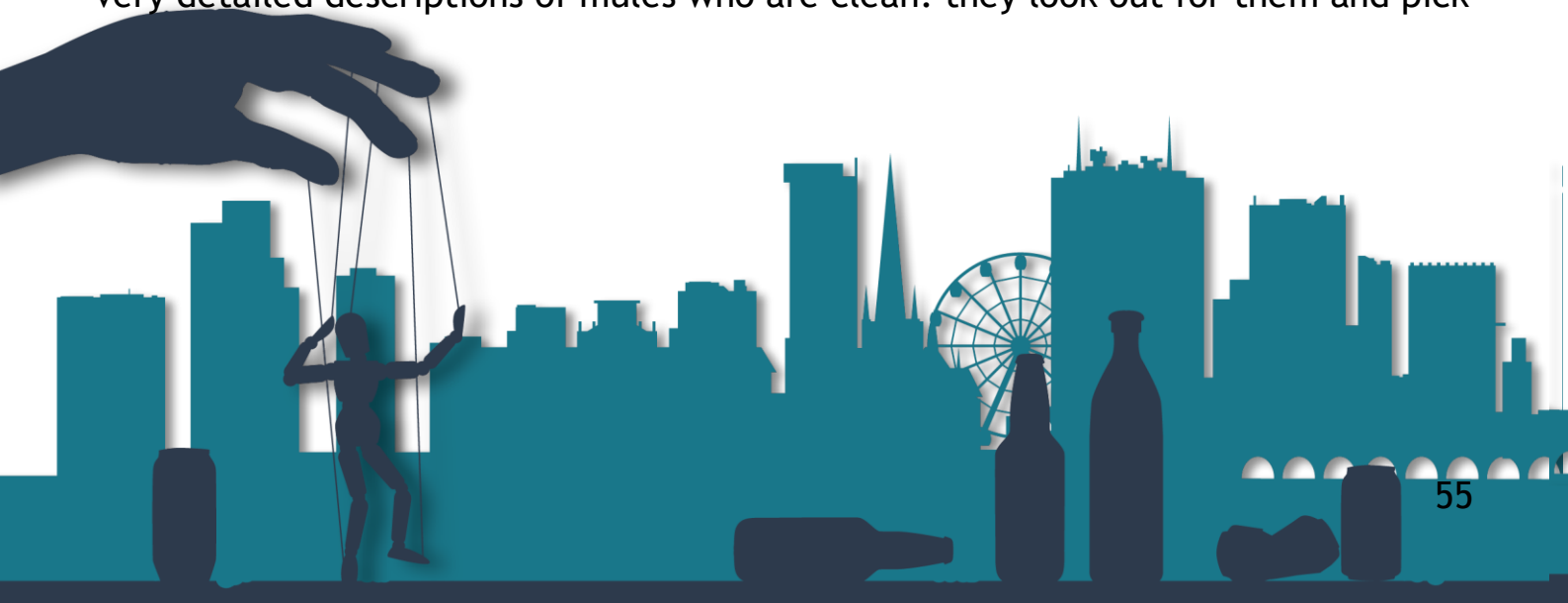
Once, after some money and drugs went missing I was tortured by someone who was called in by the gang. He brought a tool box and tortured me with a screw driver and pliers. He asked me to choose what tool he could torture me with from the box. He told me I was going to die.

Despite all of this cruelty the gang had a psychological hold over me. It's so difficult to explain: I was scared of the gang, but I was also scared when I was away from them. I was completely broken down psychologically, like they had taken everything away from me. Even when I was outside felt I could not escape – everything I had was in the flat where they kept me.

There was a network of flats and hostels. Some Eastern European women had been trafficked and kept in the hostels. The gang members gave landlords and hostel owners drugs to keep them on side. I think lots of important people knew about this but turned a blind eye. I felt let down and that I didn't have opportunities to tell anyone in authority my story. Sometimes I didn't know who I could trust. You're always looking for someone who might be able to help you get out.

Sometimes women were let go after gang raids and arrests of gang members, but we weren't given any protection or asked questions by the police. I think I was looked at as just another heroin or crack addict.

One time I was taken abroad to be a drugs mule. Police rarely catch the mules because authorities are often corrupt. Sometimes the customs people are given very detailed descriptions of mules who are clean: they look out for them and pick



them up while the real mules get through.

I have only maintained this level of recovery because of the 12- step programme, mutual aid and the support I got initially from a women's aid organisation. I fight my addictions every day. I know if I went back they would give me drugs and take me back in. They would keep me for as long as I was useful. My help when I was finally rescued was immediate – and that immediate help was a key factor in keeping me rescued.

I think if victims, if they felt they had some protection and could be interviewed after a raid, they could tell their story. If authorities and rescuers could identify and give support with addictions that would help enormously – women's aid, 12 step programmes and mutual aid would help support victims.

If I had a wish I would set up a mutual aid facility for women where they had access to support and some level of independence, like chalets where they could be close to others but live independent lives to an extent. They would feel that they could become assets to society rather than just addicts. I think we should be talking to kids in school about the dangers. I would like to help support people into trades, so they can earn a wage. I'd like to do up houses with victims so that trades could be learned on the job, the houses sold when they are done up; victims could share in the profit or move into the house. I'd like to work with other organisations to do this. I think there are lots of barriers to people getting the right care. I want to put something back and help people.

I also wish lots of agencies and individuals had training in the administration of Naloxone* when people have an accidental overdose – I have seen it in the streets when the homeless sometimes overdose.

**(Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids (such as methadone, morphine and fentanyl).*

The main life-threatening effect of heroin and other opiates is to slow down and stop breathing. Naloxone blocks this effect and reverses the breathing difficulties.

Naloxone is a prescription-only medicine and cannot therefore be sold over the counter. It can however be supplied without prescription by drug services. It can be used by anyone to save a life in an emergency.)

https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone

This is a quote which always gives Victoria inspiration:

Henry Ford once made a wise remark to the effect that experience is the thing of supreme value in life. That is true only if one is willing to turn the past to good account. We grow by our willingness to face and rectify errors and convert them into assets. The alcoholic's past thus becomes the principal asset of the family and frequently it is the only one!

The painful past may be of infinite value to other families still struggling with their problem. We think each family which has been relieved owes something to those who have not, and when the occasion requires, each member of it should be only too willing to bring former mistakes, no matter how grievous, out of their hiding places. Showing others who suffer how we were given help is the very thing which makes life so worthwhile to us now. Cling to the thought that, in God's hands, the dark past is the greatest possession you have - the key to life and happiness for others. With it you can avert death and misery for them. (The AA Big Book)

ACKNOWLEDGEMENTS

I am really very grateful to all those who generously offered their time and expertise to support the development of this report (in no particular order):

Victoria X;
Sara Ward;
Ann-Marie Douglas;
Andrew Hardwick;
Vebi Kosumi;
Tony Mercer;
Stephen Gabriel;
Louise Durham;
Allison Hilton;
Liisa Wiseman;
Khizra Dhindsa;
Sarah Greene;
Ben Twomey;
Tamara Barnett;
Phillipa Roberts;
Steve Ball;
Nick Lacey;
Stephen Philpott;
Sadia Wain;
Bob Charnley;
Max Vaughan;
Annie Steele;
Michelle Marie Smith;
Patrick Duffy;
Juliet Grainger;
Euan Fraser;
Mary Bailey;
Vicky Yates;
Sian Smith;
Geena Virdi;

Beki Nightingall;
Bob Morris;
Rose Makilagi;
Baldish Sohal;
Phill Clayton;
Andrew Houghton;
Robin Brierley;
Elaine Hopwood;
Sara Rooney;
Sally Simpson;
Claire Pennell;
Karen Saunders.