# BREAKING THE CYCLE

*The Case for Early Intervention in Adult Sexual Exploitation and Substance Use*

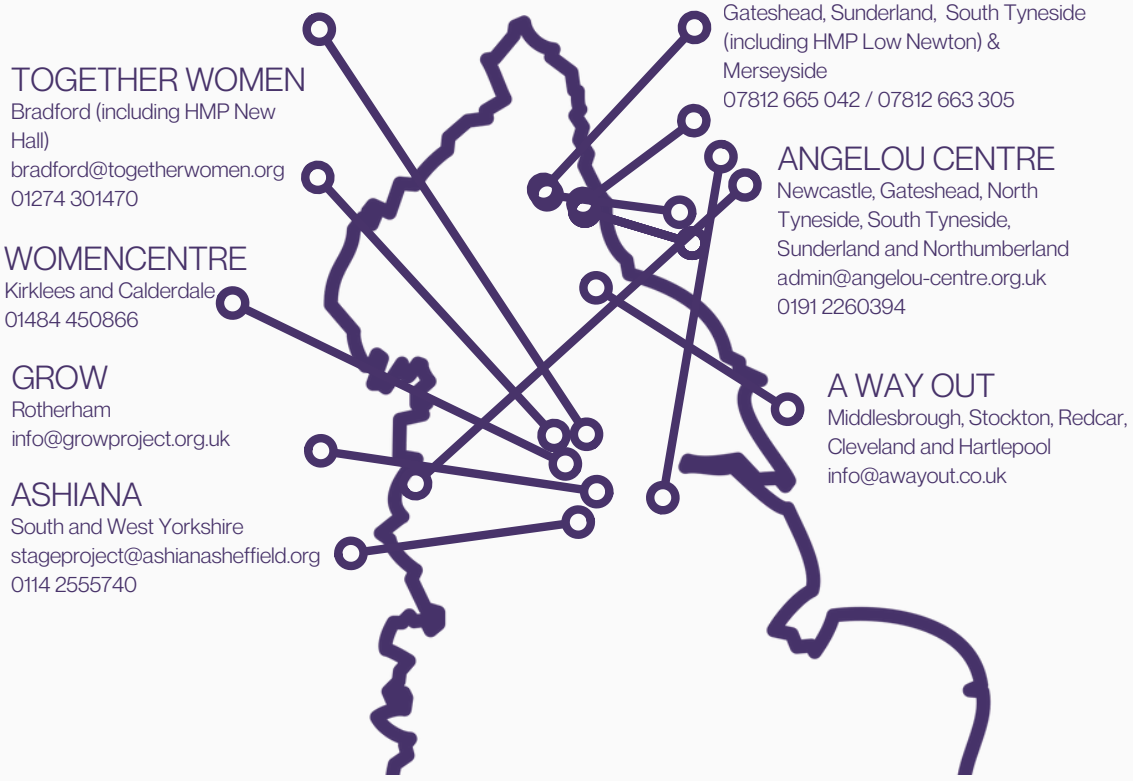
Prepared by
ASE Partnership

# Table of Contents

# ASE Partnership

In 2019 the ASE Partnership (ASEP), then known as STAGE, was formed to support women who had been targeted for sexual exploitation. The ASE partnership is a consortium of charities; A Way Out, Ashiana, Angelou Centre, Basis Yorkshire, WomenCentre, Together Women, GROW and Changing Lives, who form a collective voice to share the experiences of women living on the margins of society, who have been forgotten, left behind and judged. Each organisation has a dedicated exploitation caseworker to support women through a trauma responsive model of care. Parallel to this work, the partnership advocates for local and national change. With the voices of the women we support at the heart of our work, we challenge the systems with direct, up to date, practical knowledge and experience and campaign for long-term structural change.

Since the partnership was created, we have supported over 900 women who have been groomed for sexual exploitation. However, we know that this issue is far more widespread than what we have already seen. The sexual exploitation of adults is hidden in the cracks of society across the country, whereby the most vulnerable people are systematically targeted for abuse and trapped with no way to escape.



BASIS
Leeds
info-basis@basisyorkshire.org.uk

CHANGING LIVES
Northumberland, North Tyneside, Newcastle & Doncaster
07812 663 505
Gateshead, Sunderland, South Tyneside (including HMP Low Newton) & Merseyside
07812 665 042 / 07812 663 305

TOGETHER WOMEN
Bradford (including HMP New Hall)
bradford@togetherwomen.org
01274 301470

ANGELOU CENTRE
Newcastle, Gateshead, North Tyneside, South Tyneside, Sunderland and Northumberland
admin@angelou-centre.org.uk
0191 2260394

WOMENCENTRE
Kirklees and Calderdale
01484 450866

GROW
Rotherham
info@growproject.org.uk

A WAY OUT
Middlesbrough, Stockton, Redcar, Cleveland and Hartlepool
info@awayout.co.uk

ASHIANA
South and West Yorkshire
stageproject@ashianasheffield.org
0114 2555740

ASE Partnership

# A Note on Language

## Defining Adult Sexual Exploitation

*Adult sexual exploitation (ASE) is a form of sexual abuse of people aged 18 or over whereby an individual or group coerce, manipulate or deceive the victim into sexual activity for the disproportionate benefit of the perpetrator(s). Sexual activity does not always involve physical contact; it can also occur through the use of technology. It is distinguished from consensual sex work as the act of coercion, manipulation and deceit removes the freedom and choice to consent.*

For a detailed outline of this briefing including accompanying guidance on complex terms and nuances, please follow this link.

## Substance Use

This briefing uses the language of 'substance use' to refer to a diverse spectrum of experiences involving drugs and alcohol. In line with our data collection, this is classified through self-identification by the women in our services and is up to their own understanding and definitions of 'substance use' and 'dependency.'

## Women

Due to the nature of this project, this report focuses on the experiences of women who have experienced adult sexual exploitation. The ASE Partnership is a gender-specific project that supports all women including trans women. However, we acknowledge that sexual exploitation can happen to people of all genders. Trauma-informed and inclusive support for all genders is available from many of the ASEP partners outside of this project. The ASE Partnership also works with girls aged 16+ to meet their needs as adolescents who are transitioning into adulthood and require transitionary services.

## The Language of Victim/Survivor

Throughout this report we sometimes refer to those who have experienced sexual exploitation as 'victim/survivors.' People who access support through the ASE Partnership refer to themselves and their experiences differently. Some have expressed a feeling of a journey from victim to survivor. Others can use one or the other, or both. Both terms serve different purposes and hold different meanings to each individual. The use of the term 'victim/survivor' throughout this report aims to acknowledge this variety of experiences, and convey the empowerment held in these words.

## Content Warning

This report includes case studies and quotes that depict in detail the realities of adult sexual exploitation. This may be triggering or retraumatising to readers.

# Our Approach

We are aware that nationally, we lack in depth data collection on the experiences of survivors of adult sexual exploitation. Therefore, we have built a robust evidence base on the lived experiences of the women who access our services across the UK. Each quarter, we receive detailed quantitative and qualitative reports from our ASE Partnership caseworkers using a standardised form for each of the women accessing our support services.

We also carried out three focus group sessions with the ASE Partnership caseworkers, drawing on the findings from our quarterly data collection forms, to develop a more robust evidence-base on the correlation between substance use and adult sexual exploitation.
To ensure a trauma-informed approach to this research, all evidence was collected through caseworkers who worked closely with the women they support at a pace that works for them. All information was given voluntarily, and consent could be withdrawn at any time.

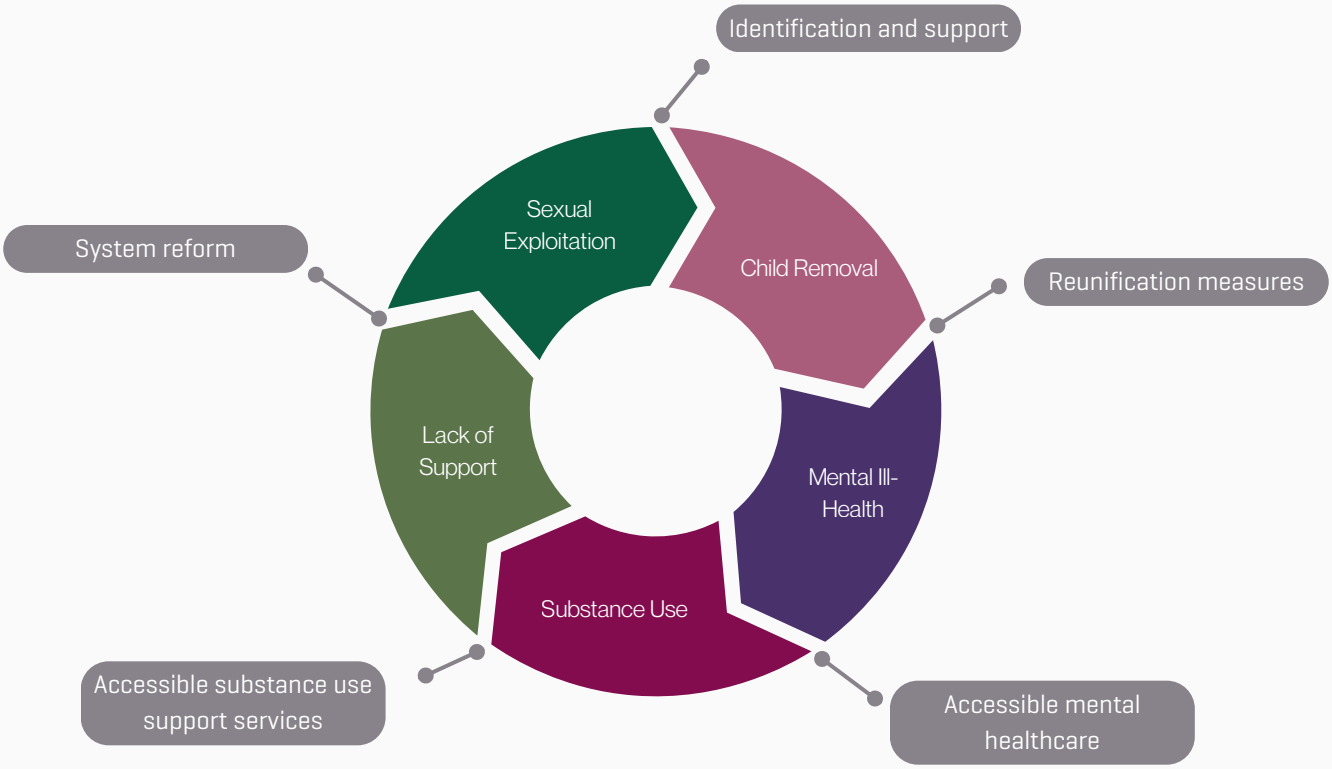
All stories included in this report are the real experiences of people supported by the ASE Partnership. For the safety of those involved we have removed or altered any identifying features including names, ages, locations or other identifying information associated with their experiences.

# Our Findings




Our research found that women who have experiences of sexual exploitation and substance use are often let down by support systems. This can trap them in a cycle of further trauma, mental ill-health, child removal, and further substance use and exploitation. Without early intervention or appropriate support systems being put into place, victim/survivors are left feeling as though they are being set up to fail with no way out of this cycle. The above diagram illustrates how this cycle can become self-perpetuating.

However, at each stage, intervention measures and support could be put in place to break this cycle.




ASE Partnership

# Policy Recommendations

## Our fundamental ask of government is that adult sexual exploitation is understood and recognised in policy and practice.

The first step towards victim/survivors experiences improving is to create an understanding of adult sexual exploitation. We are calling for the introduction of a statutory definition of adult sexual exploitation with accompanying guidance. (See page 2 for further detail.)

We recommend that all funding for services supporting women who have experienced gendered violence, including those specialising in sexual exploitation, should include ringfenced funding for by-and-for services to allow for the provision of peer support. (See pages 6-7 for more detail.)

There is a need for a review and redistribution of funding to adequately support public and third sector services to identify support needs early on, before a crisis point is reached. This should include long term funding plans including provisions for 6+ year contracts to ensure viable support is offered to those with complex unmet needs. (See pages 11-12 for more detail.)

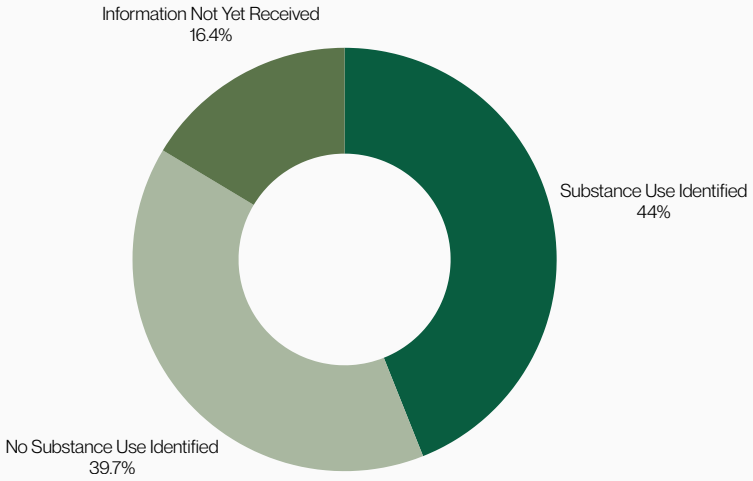
We recommend that the same legal aid offered to survivors of domestic abuse is offered to survivors of adult sexual exploitation. (See page 12 for more detail.)

In line with the government's 10-year health plan, we recommend that the NQB's quality strategy and the CQC's data collection addresses care inequity for those experiencing a dual diagnosis. (See pages 15-17 for more detail.)

Survivors of ASE should be entitled to the same housing provisions and pathways as survivors of domestic abuse. We call for Integrated Care Systems to create clear referral pathways between mental health, substance use, and housing services. (See pages 17-18 for more detail.)

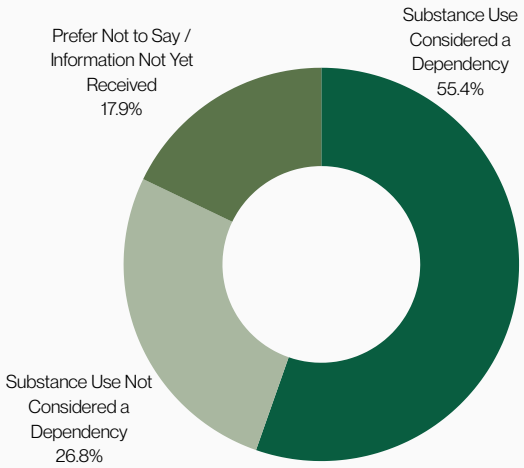
We recommend the implementation of housing first principles by housing providers to adequately support victim/survivors facing complex trauma. (See pages 17-18 for more detail.)

# Correlation Between Substance Use and Adult Sexual Exploitation




Of the women supported by the ASE Partnership between April 2024 – June 2025, a total of 113, 44% self-identified as currently using substances (this increases to 52.6% when excluding cases where the information hasn't been received yet from caseworkers.) We believe that this number may be even higher when considering the potential limitations of self-identification.

Several caseworkers highlighted the sensitive or re-traumatising nature of discussing substance use with the women they support, so have not had these conversations until it is psychologically safe to do so. Our by-and-for specialist BAMER partners also highlighted that there can be cultural stigma and shame surrounding substance use which may result in lower rates of self-identification.




*"In many BAMER communities, substance use is considered deeply shameful and may be seen as a moral failing, making it difficult for survivors to open up. If the survivor does decide to tell us, they could risk ostracization from their community, religious circles or even their family. There is also a fear that acknowledging drug or alcohol use could undermine their credibility and bring forth victim-blaming, especially given the dual stigma of sexual exploitation and addiction."*

Specialist by-and-for caseworker working on the ASE Partnership

ASE Partnership

Out of nine women supported by Ashiana, a by-and-for BAMER specialist organisation, only one woman identified as using substances, and out of 28 racially minoritised women supported across the partnership, only 4 identified as using substances. We recognise that this sample size is small, and value the importance of self-identification, but equally acknowledge the significant differences in cultural attitudes towards substance use that may skew our data.

In our specialist by-and-for services, we have identified peer-support groups as an example of good practice for supporting racially minoritised women. In settings where women can share common lived experience in a thoughtfully designed space to ensure cultural responsiveness and freedom from judgement, women have been more likely to share their experience than in one-on-one settings. Group-based interventions are particularly valuable where collective narratives and communal support play a vital role in dismantling stigma.

We therefore recommend that all funding for services supporting women who have experienced gendered violence, including those specialising in sexual exploitation, includes ringfenced funding for by-and-for services to allow for the delivery of this peer support.

# Reasons for Correlation

Several reasons for using substances were highlighted in our research:

- Pre-existing addictions being exploited to facilitate abuse
- Substance use being entwined with sexual exploitation including instances of substances being used to groom individuals or forced use of substances
- Self-medication or a coping mechanism linked to trauma and mental ill-health
- Social circles and normalised behaviours

*"There was no acknowledgement of a dependency, although they were acknowledging that they had to use it every day, they said 'it's part of my routine, it's part of my friendship group.'"*

ASE Partnership Caseworker

# Substances as a Facilitator of Exploitation



For some women supported by the ASE Partnership, substances were used to directly facilitate the exploitation and abuse they experienced. This may be through forced use or the exploitation of a pre-existing addiction that formed part of their abuse.

Janet was 51 when she was referred to the ASE Partnership by probation for historical experiences of sexual exploitation by an intimate partner. Her perpetrator kept her prisoner, locked to a radiator for days to weeks on end, lasting several years. She was forced to take Class A substances to keep her subdued to perpetrate physical and sexual abuse.

Shannon used crack cocaine as a coping strategy following exploitation. She was relying on food banks, didn't have any clothing or clean underwear. She told her caseworker, "If I went back to those men, they'd make sure I had running water, I'd have gas and electricity, and I'd be able to use."

For others, perpetrators construct or manipulate drug debts to initiate exploitation.

Denise was introduced by her friend to a group of men who gave her drugs and told her they were free. However, this group of men then used this to create a debt bondage whereby she was told she would need to have sex with the men who were providing the drugs. This quickly escalated to her being forced to have sex with their friends and eventually with numerous men who would pay the organised crime group (OCG) to have sex with her. Denise has now found an advert for herself on an adult service website which she did not know was being posted.

# Self-Medication and Coping Mechanisms



*"Most of my clients have disclosed that they use substances to cope with everyday life and to block out painful memories of the past."*
ASE Partnership Caseworker

The women supported by the ASE Partnership have experienced significant and complex trauma and therefore may rely on substances as a coping mechanism. Some victim/survivors have identified a direct link between the exploitation they have experienced and their substance use. For example, one woman told us "I wasn't like this before I met those males, I wasn't like this, and I wasn't using." For others, the substance use may occur after the exploitation ends, but once the victim/survivor begins to process what they experienced. The nature of sexual exploitation can also leave individuals feeling powerless, and so substance use can be associated with regaining a sense of control.

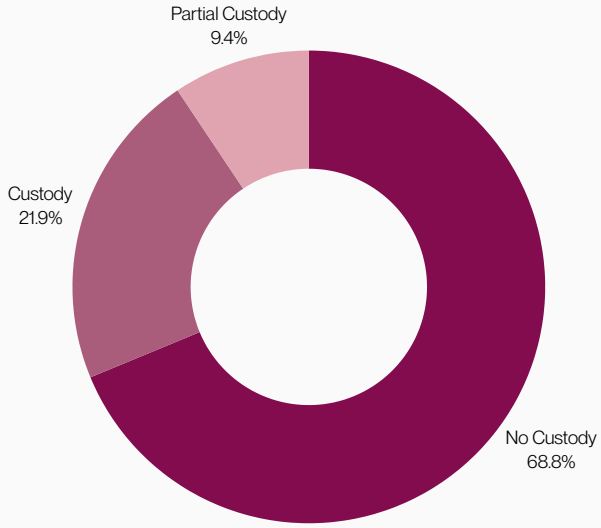
The women we support often feel let down by services meant to help them, the systems that currently exist aren't adequately set up to meet complex unmet needs. Therefore, substances may be used as a form of self-medication. One caseworker told us, "They were kind of prioritising (substances) as their coping strategy over using things like mental health services, because they'd previously had poor experiences." And another highlighted that "Some medications can only be prescribed by a psychiatrist, they can't be prescribed by a GP, but people are able to access things like codeine or cannabis off the street quite quickly, **so it feels like it's almost a more responsive service**."

# Child Removal



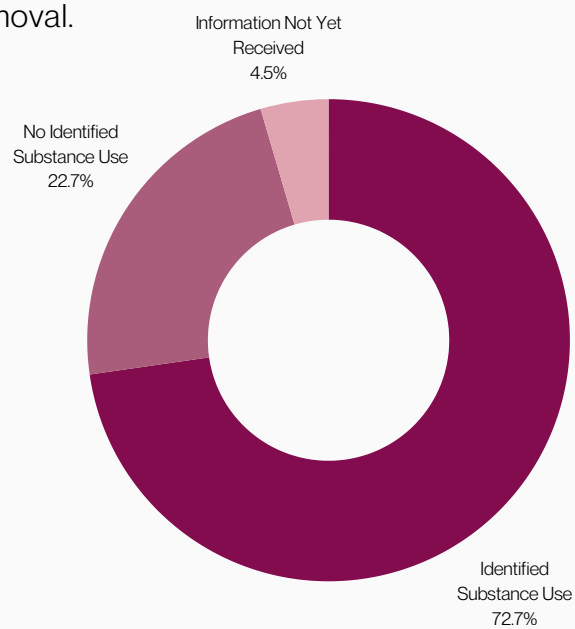
*"She had her child removed, she was told it was for her benefit, that they'd reunite her with the child as soon as possible, but now she's two years down the line. She's done everything that they've asked her to do, and yet she's still not any closer to being reunited with her child, which is further increasing her substance use, which is then further putting her at risk of not being able to be reunited."*

ASE Partnership Caseworker




The majority of woman supported by the ASE Partnership who have one or more children do not have custody of their children[1]. The overlap between women supported by the Partnership who have experienced child removal who also identified a substance use was significant at 72.7%. Our focus group of caseworkers highlighted that experiences of sexual exploitation, child removal and substance use are often intertwined. Most commonly, caseworkers identified substance use as a coping mechanism in response to experiences of sexual exploitation, that then worsened in both frequency and strength of substance, following instances of child removal.

In most cases highlighted by our focus group, child removal occurred because of the exploitation and abuse being experienced by the women we support. This could be formally through the courts whereby the victim/survivor is seen as failing to protect the child, or informally through the family whereby a safer home for the child is agreed upon. We recognise that in many cases child removal is the safest option for the child when exploitation and abuse is ongoing.




[1]Discounting cases where we have not yet received data on child custody. In an effort to ensure trauma-informed data collection, all information is collected through caseworkers, and every question is optional.

However, we have found that early intervention to prevent this, or support for the mother following the child removal is often missing. **This has led to a cycle of increased trauma for the victim survivor who then rely on substances as a coping mechanism due to the failure of other systems to support them, this then puts them at higher risk of perpetration of sexual exploitation.**

# Missing Early Intervention

Early intervention and support in cases of sexual exploitation, mental ill-health and substance use is vital to ensure the safeguarding of victim/survivors, and, where possible, to avoid child removal by creating a safe environment with the parent. However, our research shows that due to services being overrun and underfunded, this early intervention isn't happening.

Lynsey had experienced significant trauma before accessing support through the ASE Partnership. She struggles with her mental health and was experiencing homelessness as a single mother with a young child. She had been placed into temporary crisis accommodation, one small room for herself and her child. While struggling with her mental health, Lynsey repeatedly went to support services looking for help. However, they were overstretched and were only able to take on high-risk cases. Lynsey's ASE Partnership caseworker told us, "It's not that the support options weren't there, it's that they were too stretched to take her on. She was slipping through the net because her daughter was well cared for, because she was putting in the time to make sure her daughter was fine." From this, Lynsey's mental health continued to deteriorate, and she made a comment to Children and Adult Services out of desperation that raised concern for the safety of herself and her child. This led to Lynsey losing custody of her child.

While it was right for Children and Adult Services to step in to protect her child, Lynsey felt frustrated and let down by the system. She had been doing all the right things, she had asked for help before she reached a crisis point, but it wasn't until she reached a crisis that anyone intervened.

Lynsey still isn't receiving mental health support outside of what the ASE Partnership can provide. Thankfully, her child is well cared for, but Lynsey has been left without the support she knew she needed.

Lynsey has now returned to the perpetrator of her exploitation.

Early intervention is vital, therefore, we recommend a review and redistribution of funding to adequately support public and third sector services to identify support needs early on, before a crisis point is reached. This should include long term funding plans including provisions for 6+ year contracts to ensure viable support is offered to those with complex unmet needs.

# Communication Barriers

Women supported by the ASE Partnership have identified negative past experiences with Children and Adult Services resulting in secondary trauma in cases of child removal. For some women the reasons for child removal have not been properly communicated, leaving parents feeling stigmatised, judged and powerless. In cases where child protection plans have been put in place for women with multiple complex unmet needs, other members of their support team, such as their caseworkers, have not been included in child protection meetings or received the communication they were told to expect. It is vital that where women have a support team around them, services work together in a joined-up multi-agency approach.

We urge services to clearly communicate with parents in cases of child removal to reduce the additional trauma that can come from this. It is vital that this communication is done via a joined-up multi-agency approach, particularly in cases of multiple complex unmet needs where large teams are involved. Caseworkers should be invited to child protection meetings when this is agreed by the parent they are supporting.

# Financial Barriers

Where women who have experienced child removal make significant changes to their life and circumstances and wish to regain contact or custody with their children, they often face further barriers due to financial constraints. Often, they are unable to take cases back to court because they are unable to afford the associated costs. Legal aid that is available to survivors of domestic abuse is not made available to survivors of adult sexual exploitation. Therefore, while the parent has put in every effort to make themselves and their situation safe for their child, financial barriers prevent them from even having the opportunity to regain custody or contact.

We recommend that the same access to legal aid offered to survivors of domestic abuse is granted to survivors of adult sexual exploitation.

# Access to Children to Perpetrate Abuse



"If you want to see your child, you need to have sex with me first."

This is what one woman supported by the ASE Partnership was told by the father of her child after they came to an informal (out of court) decision for him to have custody of their child. She had experienced complex trauma and multiple unmet needs, and had experiences of home invasion (cuckooing), spiking and sexual exploitation and used substances to cope with this. She agreed that she was unable to have custody of her child. However, the father exploited her desperation to have a connection with her child to perpetrate further sexual abuse.

She tried to regain custody of her child through the courts. Due to a distrust in the court systems from past negative experiences and shame around what she'd been forced to do to see her child felt she couldn't disclose this sexual abuse perpetrated by the father to the courts. Therefore, she did not regain custody of the child, who remains with their father.
This, unfortunately, is not an uncommon story for the women supported by the ASE Partnership. Our focus groups highlighted several instances victim/survivor's experiences of substance dependency being weaponised alongside access to the child to perpetuate abuse.

Another woman supported by the partnership had experienced child removal formally through the court system and was experiencing addiction to alcohol. Her child had been put into the care of their father, and she was not allowed to have contact with the child. The father exploited both her substance dependency and her desire to have a connection with her child to perpetuate abuse. He coerced her with the promise of alcohol and to see where her child was living and his belongings. Initially she refused but, after some convincing, she went to the house. Here, he plied her with alcohol and physically and sexually assaulted her.

The women supported by the ASE Partnership, and their stories of child removal are incredibly complex. It is vital that systems remain in place to protect the children involved in cases of abuse and exploitation, and often the appropriate action is to remove them from these situations. However, in each of these cases, the mothers are being let down by this same system. The protections put in place for the children and young people are not granted to the women facing abuse. We have seen women get stuck in a cycle of exploitation, child removal and substance use that they are unable to escape due to the lack of effective support and intervention.

Through a redistribution of funds to facilitate early intervention, child removal could be avoided in the first instance. Where Children and Adult Services become involved, improved communication from them and a focus on multi-agency approaches is necessary. Improved protections from further perpetration are needed, as women facing complex unmet needs, particularly those dealing with trauma and substance use are often at a higher risk of exploitation. And re-unification should always be the priority in cases of child removal, which means putting the welfare of both parent and child at the core of all actions taken.

# System Failure and Barriers to Accessing Support

*"These women have such bad experiences, which stops them from ever going back to statutory services."*

ASE Partnership Caseworker

Many women supported by the ASE Partnership face multiple complex unmet needs. We have found that services set up to support them are not adequately meeting these needs. Across service provisions, key issues are seen repeatedly:

- ·Women are blocked from accessing services as they are seen as 'too complex' or 'too high risk'
- ·Services lack understanding of adult sexual exploitation, and therefore aren't set up to support victim/survivors
- ·Services are over-stretched and therefore, time isn't given to properly understand women's experiences
- ·Services have a 'one-size-fits-all' approach to recovery

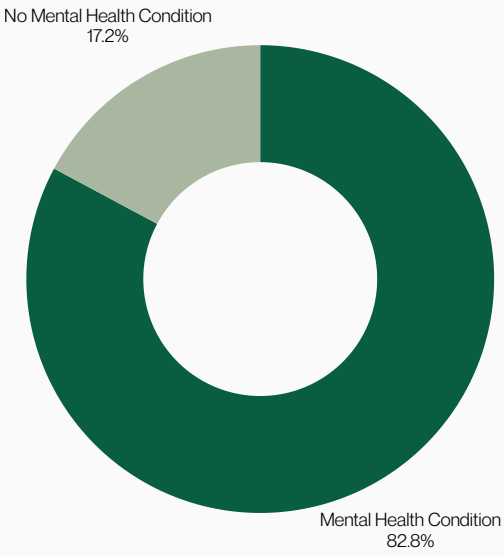
We recommend that provisions be put into place to allow for individualised and person-centred approaches to be taken to recovery and support including taking a harm reduction approach.

# Dual Diagnosis



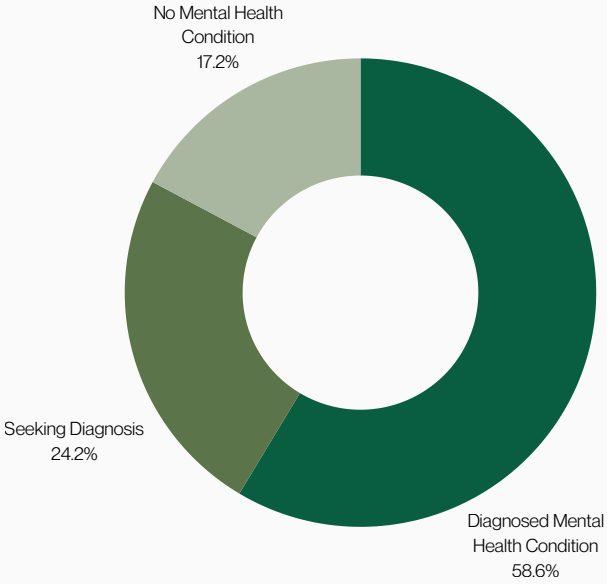
*"Accessing support from mental health services is difficult when there is also a substance use. Often, women are told they must stop using substance in order to get support."*

ASE Partnership Caseworker




**82.83%** of of women supported by the ASE Partnership have identified a mental health condition, either diagnosed or seeking a diagnosis (58.6% diagnosed and 24.2% seeking a diagnosis[2].) Of the 82.83% who have a mental health condition, 48.78% also have identified as using substances.

There is a significant overlap between people with a mental health condition and those who use substances. We refer to this as a 'dual diagnosis' or co-occurring conditions. However, despite this high overlap, this co-existence of conditions can often block individuals from accessing support from either service provision. Despite NICE Guidance outlining that secondary mental health services are not to exclude people with co-existing severe mental illness because of their substance use, and that they are to "undertake a comprehensive assessment of the person's mental health and substance misuse needs,"[3] we have found this not to be the case for women supported by the ASE Partnership.




[2] We recognise that receiving a mental health diagnosis can be difficult, especially for women facing multiple complex unmet needs. Therefore, when collecting data on mental health we included options for both diagnosed and undiagnosed conditions.
[3] National Institute for Health and Care Excellence [NICE] (2016). *Coexisting severe mental illness and substance misuse: community health and social care services* [NG58] . https://www.nice.org.uk/guidance/ng58/chapter/Recommendations

ASE Partnership

*"It's been horrendous because they won't even touch you, they won't look at you."*

Woman supported by the ASE Partnership

Tina, a woman supported by the ASE Partnership had been prescribed medications for her mental health conditions. However, she was finding that they weren't working for her, and she was still struggling with the symptoms of mental ill-health and complex trauma. To cope while waiting for a medication review, Tina used substances as a form of self-medication. She told her psychiatric nurse that she was using substances to manage how she was feeling because her medications weren't helping, and that she felt unsafe combining her medication with the substances she was taking but she felt like it was all she could do to cope until her medications were adjusted. Her nurse denied her a medication review until she 'sorted her substance use out.'

Tina put in a complaint, highlighting that it should be her right to have a medication review, and she was assured she would get a new psychiatric nurse. However, this did not happen.

Services are often also limited in the number of sessions they can offer individuals due to funding and capacity limits. However, as one of our caseworkers highlighted, "with the people we support, it can take five or six weeks just to build up that little bit of trust for them to open up, never mind have therapy sessions – so to only offer five or six sessions, it's not going to do them any help."

Stigma and discrimination regarding dual diagnosis can also prevent people from getting a foot in the door to access support. A woman supported by the ASE Partnership was referred to a specialist Drug and Alcohol service, but due to her existing mental health needs she was denied support. Communication from the service to her ASE Partnership caseworker outlined that they believed "the complex processes used would be difficult for her to follow and she would struggle to retain the information."

It is vital that services are made available to the people who need them, rather than labelling them 'too complex' to support. For individuals facing multiple complex unmet needs, a joined-up multi-agency approach is needed.

The government's 10 Year Health Plan[4] outlines a commitment to reform the National Quality Board, and task it with developing a new quality strategy by March 2026, and a series of Modern Service Frameworks, including one focussed on mental health. We recommend that this strategy and mental health service framework address care inequity for those experiencing dual diagnosis. The guidance for good practice is already available in NICE guidelines, this needs to be reinforced in the upcoming Modern Service Frameworks and Quality Strategy.

The Health Plan also outlines a commitment to reform the Care Quality Commission (CQC) towards a more data-led regulatory model. In line with this plan, we recommend that the CQC lead a national data collection on the rates of denied mental health care due to existing substance use to identify the scale of the issue.

# Housing

Housing, refuges and emergency temporary accommodations are not accessible for many women facing multiple complex unmet needs, particularly women who have experienced sexual exploitation and use substances.

Our research highlighted that many women are turned away from housing services due to their substance use and trauma responses. This is, again, covered under NICE guidelines which state "do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance misuse,"[5] yet we know this is not regularly being followed. For many victim/survivors, this can push them back into the home of a perpetrator so that they have somewhere to stay.

Under the Domestic Abuse Act 2021, there is statutory guidance for safe accommodation services and pathways for survivors of domestic abuse. This does not extend to survivors of ASE. We have found that the lack of statutory guidance and limited understanding of ASE has led to a higher threshold for evidence being required for survivors to access safe accommodation.

[4] Secretary of State for Health and Social Care (July 2025): *Fit for the Future: The 10 Year Health Plan for England.* https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf

[5] National Institute for Health and Care Excellence [NICE] (2016). *Coexisting severe mental illness and substance misuse: community health and social care services* [NG58] . https://www.nice.org.uk/guidance/ng58/chapter/Recommendations

Survivors of ASE should be entitled to the same housing provisions and pathways as survivors of domestic abuse. To ensure a multi-agency approach is taken to supporting survivors, we urge integrated care systems (ICSs) to create clear referral pathways between mental health, substance use, and housing services.

For victim/survivors facing complex trauma and comorbidities we recommend the implementation of housing first principles by housing providers. Particularly, housing not being conditional on stopping the use of substances, support not being conditional on engagement and compliance, and housing not being conditional on the acceptance of support and compliance.

For many women who have been given refuge or temporary accommodation, their substance use has increased in severity and/or frequency due to the environments they are placed in. Other people in the accommodation may encourage the use of or supply substances, making recovery extremely difficult. For more information on how victim/survivors of ASE face barriers to accessing housing, please follow this link. As highlighted in our previous research, accommodation offered to survivors of ASE can be unsafe, sometimes putting them in close proximity to people who harm. When survivors have declined unsafe accommodation they are labelled 'intentionally homeless,' which can further perpetuate the cycle of returning to perpetrators of exploitation, and increased substance use to cope.

## Substance Use Recovery Services

Our caseworkers identified significant gaps in substance use recovery services which prevent them from adequately supporting women facing multiple complex unmet needs. A key issue being the time and location gaps between detox and rehabilitation services offered to the women we support.

Women are having to wait weeks between going through detox before gaining a space at a rehabilitation service, and our caseworkers identified that these “waiting times become the opportunity for relapsing.” Where significant travel is required to access rehabilitation services, cost of travel can also act as a barrier to gaining the support they need. Due to capacity limitations, particularly for third sector substance use recovery services, frequency of communication and appointments are often limited, sometimes only offering appointments once a month.

ASE victim/survivor’s lives are often turbulent and this can lead to missed appointments or lack of communication. One woman supported by the ASE Partnership had her case closed by a substance use recovery service due to one missed appointment and one missed phone call.

Many services offer mixed-gender support. While we recognise that this may work best for some people, for the women we support this has sometimes led to their perpetrators being at the same recovery service as them. We also recognise that not all cases of sexual exploitation fit into this binary of men causing harm and women being victim/survivors, however, this is the most common situation we come across. We have found that where services offer one day a week for single-gender service provision, or offer co-location support with different locations or entrances for different genders, this has been better for the women we support.

A ‘one-size-fits-all’ approach to recovery is not suitable for the women we support. For many victim/survivors, substances are used as a coping mechanism to deal with significant trauma and therefore recovery may look different for them. We advocate for recovery services to allow those accessing their services to have a voice in their recovery, and define what recovery means to them. This often means more of a focus on harm reduction rather than sobriety or abstinence. This requires flexibility and a truly person-led approach to care.

# Conclusion

The current system has failed to support women who have experienced sexual exploitation. They are left trapped in a cycle of trauma, substance use, child removal and further exploitation. Rather than being offered a pathway to recovery, many women feel as though they are being set up to fail. We therefore must listen to the voices of lived experience, offer truly person-centred approaches to support, and address root causes of exploitation. Without meaningful early intervention and system reform this cycle will continue.

# Contact Us

## *ASE Partnership*

ASEP@changing-lives.org.uk

Email