

The Challenge of Change:

Improving services for women involved in prostitution and substance use

A report by DrugScope and AVA



Funded by The Pilgrim Trust



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Note on terminology

There remain ongoing debates around terminology in relation to prostitution. The term 'sex worker' is aligned with a view that selling sex should be recognised as a job like any other; however, this is not a view that reflects the narratives of the women interviewed for this research. All but one of the women interviewed for this research described experiences of violence in the course of their 'work', alongside experiences of drug dependency, poverty and homelessness. The term 'sex worker' implies a level of agency and choice that was not described by the majority of women we spoke to. At the same time, the term 'prostitute' is historically laden with institutional and cultural discriminations against women who sell sex, and defines and labels them by that act.

In research interviews, we asked women for their preferred terminology and used that terminology throughout interviews. For the purpose of this briefing, we have used 'women involved in prostitution' as a term that does not define women by the act of selling sex, but also recognises that selling sex is not a job like any other. The term reflects an understanding of prostitution as a form of violence against women and girls, and is in line with, for instance, the Mayor of London's violence against women and girls strategy, *The Way Forward*.

Overview and key findings¹

Women involved in street-based prostitution who misuse drugs and/or alcohol are one of the most marginalised and stigmatised groups in our society. However, they are rarely discussed in these terms, and too often they are absent from policy and practice addressing the needs of the most vulnerable. At a time when 'sex work' can be normalised, and even glamourised, the reality is that women involved in prostitution often use drugs and/or alcohol to cope with selling sex (and the violence and abuse in their lives) and often sell sex to support addiction. It is a vicious circle.

The focus of this research study has been on policy and practice to address the drug and alcohol treatment needs of women involved in street-based prostitution. Tackling substance misuse is fundamental to reducing harm and supporting women to exit prostitution. So, what kinds of interventions work best? How widely are they available? And, critically, what do the women themselves say about their expectations and experiences of services?

We found that while there are good services and positive stories, there remains a lot to be done. Many women involved in prostitution see no alternative; no other viable future for themselves; and no support for 'recovery', or prospect of 'a normal life'.

Currently, appropriate support that addresses substance misuse in the context of 'sex work' can be difficult to access. With evidence that a significant proportion of women seeking help for drug and alcohol problems (and many others who are not accessing help) have been involved in prostitution in some form, this is the 'challenge of change' identified in the report's title. Many of the women we spoke to recognise and accept this challenge on a personal level, but need more and better support from policy makers, planners and commissioners, and from services on the ground. We hope that the report's recommendations provide a framework to enable us all to rise to this challenge and respond to the needs of a marginalised, stigmatised and traumatised group.

Key findings:

- Drug use and prostitution are reinforcing. For many women, drugs are the reason they become involved in prostitution, and all the women interviewed for our research reported working on the streets to get money for drugs. Alcohol use was also identified as an issue for a number of the women, although not generally as driving their involvement in prostitution.
- Women involved in street-based prostitution and substance use experience considerable harms, including mental and physical health problems, and violence and assault. Many feel the impact of 'double stigma' as a result of using drugs and involvement in prostitution.
- This group commands little attention within national policies, and guidance is rarely provided on addressing substance misuse problems among women and prostitution together.
- Women involved in prostitution and substance use have complex, entrenched problems and the process of change and recovery is likely to take a long time. The availability of a range of support, from harm reduction and treatment services to services to help them exit prostitution and support their ongoing recovery, is therefore crucial.

¹ It is important to highlight two caveats. Firstly, this project has focused on women involved in street-based prostitution; issues and problems may be different for other kinds of prostitution, although we would envisage that there would be significant overlaps. Secondly, it has centred on women involved in prostitution. It is important, too, to note the involvement of men in prostitution, and the exchange of sex for drugs in this context – this is an area that requires attention and research.

- Women may face a range of barriers to accessing support. Organisational barriers include: lack of flexibility in some services; issues in relationships with keyworkers, including stigmatising attitudes and disparities in gender and age; an absence of support for wider issues, including housing and employment; and a lack of ongoing support and aftercare.
- Positive interventions identified include: increased service accessibility through evening opening hours, mobile outreach services and childcare provision; women-only provision; support from 'real' peers; enhancement of standard programmes; and support that helps women to address their range of needs, and move on.
- While current provision includes services that are working to address the particular needs of women involved in prostitution and substance use, it is also clear that their specific problems are often not recognised or catered for.

Policy recommendations:

1. A range of services should be available to women involved in prostitution and substance use, from needle exchanges and treatment to housing and employment support. More work is also needed to map out recovery pathways that address the particular issues experienced by this group.
2. The development of tailored support for this group of women should be considered – by policy makers, commissioners, funders and service providers – as a key priority within the emerging 'multiple needs' agenda.
3. The specific needs of these women should be considered in local Health and Wellbeing Boards' needs assessments and strategies, and Police and Crime Commissioners' plans. Additionally, all local authorities should develop a violence against women and girls (VAWG) strategy that recognises the needs of this group.
4. Effective mentoring often depends on matching service users with 'real' peers, i.e. those with similar histories and experiences. The gender of peers is important too, as is the provision of appropriate training and support to work with this highly vulnerable group.
5. There is a real need for further research into men who exploit women through prostitution, and how services can identify, target and engage with this group to address and change their behaviour.

Good practice recommendations for services:

1. Measures to improve the accessibility of services for women involved in prostitution and substance use include: evening and weekend opening hours, mobile outreach services, childcare provision, drop-in support, and a flexible approach to missed appointments.
2. The enhancement of standard drug and alcohol treatment programmes is an effective approach with this group of women.
3. Given their experiences of physical and/or sexual violence, women-only provision is crucial, as is access to domestic and sexual violence support.
4. Services can address the stigma experienced by this group of women through thorough training for and development of staff. Robust assurances about confidentiality can help to counter reluctance to disclose involvement in prostitution, as can literature/advertising that make it clear that prostitution is an issue services address.
5. Alongside harm reduction and treatment services, wider support should be available, including with housing and employment. There is also a need for ongoing aftercare for those who are substance-free and no longer involved in prostitution.

Introduction

A number of research studies and policy papers have highlighted the relationship between involvement in street-based prostitution and problem drug use, and the barriers that can prevent women involved in prostitution from accessing services to change their lives and achieve recovery. Nevertheless, there has been little research that has documented in detail the problems faced by this particular group of women, the extent and nature of current service provision and the adequacy of coverage.

Through a wide-ranging study – including an evidence review, interviews with women with a history of substance use problems and prostitution, an online survey of services and observational site visits² – this project has sought to fill this gap and provide a platform for the further development of services to meet the needs of this particularly marginalised group, who may fall into the gaps between services. This policy briefing provides a summary of the research findings, and makes strategic and policy recommendations to improve interventions and outcomes for women involved in street-based prostitution and substance use, as well as good practice recommendations for services.

A hidden group experiencing substantial harms

While there are no good estimates of the number of women involved in street-based prostitution and substance use, the information that is available indicates this is a group of significant size. Moreover, research points clearly to the reinforcing nature of drug use and prostitution, and to the substantial harms experienced by these women.

The stigma associated with both drug use and prostitution means that this is a largely hidden group of women. However, while few large scale surveys collect information to allow estimates of prevalence to be generated, the Drug Treatment Outcomes Research Study (2007) found that 10% of women commencing drug treatment said they had exchanged sex for money, drugs or something else in the past four weeks. While this may encompass more than what might be strictly defined as street-based prostitution, it does indicate that the group is likely to be sizeable.

Our research emphasised the reinforcing nature of drug use and prostitution. All the women interviewed during the course of the study reported working on the streets to obtain money for drugs – with some describing the amount of drugs they used depending on how much they earned from selling sex – and many made it clear that this was the reason that they became involved in prostitution. While others indicated that they became involved for other reasons, they also illustrated the way prostitution can exacerbate drug use, and vice versa:

“... once you’re out there and you’re doing what you’re doing ... You need drugs to stay sane, but to pay for the drugs you need to carry on committing those offences, so to speak.”

The research also pointed to the substantial harms experienced by women involved in prostitution and substance use, such as mental health problems, including resulting from trauma such as past physical and sexual abuse; poor physical health; sexual health risks, including sexually transmitted infections and HIV transmission, with those who are injecting drugs having a dual risk for HIV; and very low self-esteem, often as a result of the stigma they experience. The words used by the women interviewed to describe how they felt about themselves included ‘ashamed’, ‘guilty’, ‘dirty’, and ‘worthless’, with one woman saying she felt she was “in the gutter and deserved to be there”. Another explained:

² The main components of the research were: an evidence review, conducted by the University of Greenwich; a review of current policy; interviews with women with a history of substance use problems and prostitution (n=19) in two geographical areas (West Midlands and Yorkshire and the Humber), conducted by peer interviewers; an online survey of services (n=64), with the majority of respondents based in substance misuse services (n=46), and responses also received from sex work or exiting prostitution projects (n=12), women’s community projects (n=2) and four other related services; and observational sites visits to six services in the two areas where the peer interviews were conducted, which included interviews with staff and service users.

"I lack confidence, I feel like sometimes everybody can tell that I'm on drugs and that I might be selling myself. No self-esteem, I feel worthless. I'm out there doing something society frowns upon. I've got a lot of shame and guilt that I'm doing it."

While many people with drug problems have similar issues, the additional stigma from engaging in prostitution appeared to weigh even more heavily on them; most women had told their families about their drug use, but many were concealing their prostitution.

Violence was also a particular issue for most of the interviewees. In some cases this included violence from a partner; more often it involved violence from a customer or 'punter', such as being threatened, "smacked about", or raped. In some cases, the violence was extreme. One woman reported:

"I've been raped, I've been beaten up, fucking sodomised, punched the fuck out of, tied up, stripped in the car and thrown out in the middle of the fucking fields and having to walk home and knocking on someone's door because you can't just walk home. How humiliating can it get? Once that fucking happens you don't forget."

Neglected within the national policy context

Very little attention is currently devoted to women involved in prostitution and substance use in national policy documents, including the 2010 Drug Strategy, and those focusing on multiple needs and women involved with the criminal justice system. Where strategies do mention substance misuse problems among women or involvement in prostitution, there is rarely any consideration of addressing these issues together.

Women involved in prostitution and substance use command little attention within national policies. The 2006 Prostitution Strategy, published under the last government, briefly highlights that "this is a particularly vulnerable group of problematic drug users due to their need to finance their drug use, and often that of their partners, through prostitution", and suggests that the first step must be "to set them free from the drug addiction that constantly forces them back onto the street". The 2011 'Review of effective practice in responding to prostitution', published by the Home Office, also notes that "support aimed at overcoming alcohol and drug abuse should recognise the complexities of these issues in relation to people involved in prostitution". The 2010 Drug Strategy, however, contains no mention of the words 'prostitution' or 'sex work', or even 'woman', 'women', or 'girl'. The 2012 Alcohol Strategy, which takes a 'public health' approach, is similarly reticent about this group of women.

Policies within the current government's strategy for tackling violence against women and girls include a 12-month national 'Ugly Mugs' pilot scheme, and research, carried out through embassies, on international best practice in relation to tactics to reduce harm and abuse of women involved in prostitution. The 2011 Human Trafficking Strategy mentions women trafficked for prostitution, but makes no reference to substance use issues. The national Troubled Families programme is also likely to cover some women who will be involved in substance misuse and prostitution, but there are few mentions of these women in the accompanying documentation for the programme.

It might be expected that women with substance addictions who are involved in prostitution will often become involved in the criminal justice system, and there are a range of other policy and guidance documents in this area in which they might be considered. The Corston Report (2007) emphasised the importance of coordination at a strategic level of resettlement pathways for prisoners, including the drugs and alcohol pathway, and the pathway for women who have been involved in prostitution – which it also recommended should be "mandatory in every regional resettlement plan for women". It recommended, too, a national network of 'one-stop-shops' for women who offend or at are risk of offending, to ensure the provision of holistic, community-based responses to women's multiple needs, a development which 'Breaking the cycle' (2010), the coalition Government's first detailed statement of plans for criminal justice reform, set out its support for. However, 'Breaking the cycle' and subsequent policy documents – including 'Punishment and reform: Effective community sentences' (2012), 'Transforming

rehabilitation: A revolution in the way we manage offenders’, and even ‘Strategic objectives for female offenders’ (2013) – have remained silent on the links between substance use and prostitution.

Where drug and alcohol problems among women or involvement in prostitution are mentioned by national strategies, guidance is seldom provided on addressing the issues together. There is very little, then, on service provision for this group of women, who have particularly complex and entrenched problems, and who struggle to overcome these.

Barriers to accessing support and positive interventions

Women involved in street-based prostitution and substance use face a number of barriers that can prevent them from getting the right support. However, our research also identified positive interventions that are accessible to this group of women, and meet their range of needs. It is crucial that a broad spectrum of support is available, from harm reduction services to wider support, including help with housing and employment. Many of the women interviewed during the research spoke of their desire for longer-term change, including being substance free, having a job and a nice home, and being with and providing for their children



Many of the women interviewed during the research had been accessing services on and off for a number of years, ranging from harm reduction services such as needle exchanges, as well as those providing free contraceptives and sexual health checks, to more structured treatment provision and wider social support. Although they gave a range of reasons for accessing services, in most cases, there was a feeling that they had had enough, either because of health issues, a specific incident, or because they felt, quite simply, that they could not go on in the

same way. While many interviewees gave accounts of positive experiences within services (see below), they also highlighted a range of barriers to accessing the support they needed, many of which echoed those identified in other sections of the research.

Barriers to service use and negative experiences

Barriers to services can be individual or organisational. Individual barriers can include **low self-esteem**, which can impact on an individual’s belief that it is possible to change. As one woman replied when asked about the issues that make it difficult to stop their drug use:

“Guilt, shame, my lifestyle – how overwhelming it is to change. There’s such a lot I need to change.”

This can affect women’s motivation levels; additionally, since drugs can be a habitual way of coping with stress, the tendency to relapse is strong.

Many women are also trying to change their lives **while still living in the same environment and mixing with the same people** – for example, they may be living in a hostel with other women who are still using drugs or are involved in prostitution. More than half the women interviewed mentioned this as a barrier to change, whether it

related to dealers, or partners, friends and acquaintances encouraging them to continue using drugs, to clients or previous clients, or to the need for cash encouraging them to continue working. Moreover, while remaining within these networks can result in considerable harms to them, women may also fear the loss of what is often the only social support they have.

Organisational barriers are wide-ranging. They include **hours of opening**: the hours and days of operation of many services make it difficult for women to gain access to them since they don't suit the women's work schedules, and several interviewees also raised the need for 24-hour access to support when they were struggling not to lapse or relapse. Some felt that, when they accessed drug treatment, **the time taken to obtain a prescription was too long**, which encouraged drop out as motivation waned. The **inflexibility of some services**, particularly when dealing with missed appointments, was also raised. Many women recognised that they could be difficult to help, but lack of flexibility can mean losing the support they need – one interviewee reported that she had tried to access drug treatment, but was thrown off her methadone script when she missed her first appointment because “I had to go to [town] to see my daughter and forgot to phone. It's as easy as that.”

Several women talked about the need for services to have some **provision for childcare** or to take account of the needs of women with childcare responsibilities when making appointments. **Geographical location of services** can also be problematic. There is a trade-off between being accessible to the women by being located near where they work so they can access help easily and, when they are in the process of recovery, having to go back there and the risk of being drawn back into old habits.

One of the most significant issues for women accessing services is the relationship with their keyworker. **Consistency of keyworker** is crucial to help foster trust, and aid engagement with and retention in services. For this group of women, who have very negative self-perceptions, it is particularly difficult to discuss issues which they are deeply ashamed about. Many feel the effects of ‘double stigma’ as a result of using drugs and being involved in prostitution, and it takes time for them to develop the trust necessary to open up. However, several interviewees mentioned that they had experienced frequent changes in key worker, which is likely to work against this. **Stigmatising staff attitudes** can also act as a significant barrier to effective treatment. Many of the interviewees chose not to disclose their involvement in prostitution to the drug services they were accessing; however, several that did reported feeling ‘judged’ or ‘looked down on’. While some of this may be a perception based on the low self-esteem that many of the women have, it is damaging, nevertheless, to the therapeutic relationship.

Several of the women interviewed reported particular problems with having a male keyworker, which is unsurprising given the experiences of abuse from both partners and clients that most have experienced. Another issue raised was having a key worker much younger than themselves:

“...especially now that I've got a bit older and I'm sitting with someone who might be ten years below me and they've just come out of college and everything, that it feels like I'm being judged or looked down on.”

It is important to note that some women had experience of excellent support from keyworkers. However, issues such as a **disparity in gender and age** are likely to make it more difficult for any keyworker to establish a good therapeutic relationship with women who have such complex and entrenched problems, and who will require a high level of ongoing support.

Many of the women interviewed spoke of wanting to be substance free, having a job and a nice home, and being with and providing for their children. However, many also pointed to a lack of support from services in addressing their range of needs, and helping them to make significant changes in their lives. **For some, there was a perceived absence of any support beyond a script:**

“Well I suppose they gave me a script which was helpful, but really they didn't have a look at why I was using, and still to this day I feel like the script is the easy solution. They're not too bothered about getting you to move on.”

In addition to the lack of wider support to help them to move on, a **gap in ongoing support and aftercare** to enable them maintain a substance-free lifestyle and stay off the streets was also identified. Given the longstanding and entrenched nature of most of the women's problems, this is a major issue.

The importance of a **range of services** being available to women involved in prostitution and substance use is clear; this includes harm reduction services and provision for improvement in living conditions while women continue to be involved in prostitution and substance use, to services to help them exit and treatment – both community-based and residential – to help them recover from their substance use problems.

Anna³

Anna uses heroin and crack. She was using drugs for a long time before she became involved in prostitution, and didn't see her substance use as a causal factor. However, she explained that now, she works every day, in order to pay for her drugs.

She stopped using about 18 months ago, for just over a year, but then relapsed. She has a daughter, who isn't currently in her care, and she is the main reason that Anna wants to stop using drugs altogether. Anna said that although her family knows about her drug use, she hasn't told them about her involvement in prostitution: "My mother will never know what I do". She also described how she frequently feels frightened while working; on one occasion, she was raped.

Anna has attended a service for women involved in street-based prostitution and a drug service. She explained that, for her, one of the biggest barriers to help has been the length of time it takes to get onto a script. She also explained that, alongside a script, a wider range of support is needed, as well as ongoing aftercare to help women to remain drug-free.

Positive experiences of services and effective interventions

The research also explored effective interventions and positive experiences, many of which are the flip-side of the barriers and problems identified. Measures that increase the accessibility of services – including **evening opening hours, mobile outreach services, childcare provision and telephone support** – were all recognised as important.

The need for **women-only provision** – or, if this is not possible, women-only groups – was also identified. The coordinator of a women's group at a peer recovery project visited during the research explained her views on the limitation of mixed gender groups for peer support:

"[They are] sharing things like about partners and kids, things which they won't share in front of men because men tend to take over, men's opinions, so if you try and get an opinion and it's something involving a man in a group that's all men, you're not going to get an honest opinion."

Women-only provision also has a role in promoting women's safety in treatment. The women's group coordinator highlighted experiences of abuse within mixed support groups:

"Some men are not there to get well, they are there because they want a new relationship and if you say something that makes you a bit vulnerable – I'm past that now, I can see what people are doing, but some people are not. When I first went in there, it was much easier for men to prey on me, because you want that attention ... and you're particularly vulnerable."

³ All names have been changed to protect the identities of the women interviewed

The women who were interviewed were asked directly if they considered it important that service staff were people who were able to relate to their situation – that is, who were their **peers, with experience of using substances and involvement in prostitution**. Most women said they thought this was important, because “... *how can people give you advice if they haven't lived that life?*” One interviewee also highlighted the role peer support could play in addressing the double stigma felt by some women as a result of using drugs and being involved in prostitution. As noted earlier, feelings of shame can prevent women from disclosing involvement in prostitution to keyworkers, as well as to family members, which can cut them off from crucial support. Peers may be perceived as easier to talk to:

“I think if someone's been there they know what I'm talking about and are not judging me and to be honest I can't bullshit them.”

Peer support was also pointed to as providing a positive example, and so motivation and encouragement that lasting change is possible. However, **support from non-peers** can be appropriate, too, provided that it is non-judgmental, and takes a sensitive approach:

“It doesn't only have to be [someone with lived experience], but I think someone who has empathy and understanding for what you're going through helps more than anything.”

There is strong evidence for the **enhancement or tailoring of standard programmes** as an effective approach with this group, and the importance of **integration of provision** or strong case management to address the multiple needs of women involved in prostitution and substance use is also clear. Most of the women interviewed favoured an integrated approach, with some explaining that it would be easier and more efficient, and would save having to go over the same ground with different people in separate services. A further advantage was seen to be the potential to develop a trusted relationship with one or just a few workers, rather than receiving support from a range of people. While some women felt that services should be kept separate, this does not preclude **close working** to facilitate access to treatment.

As highlighted earlier, the availability of a range of services to women involved in prostitution and substance use is important, from harm reduction and treatment services through to exit-focused programmes. Our research also indicated that, as well as leading to reduced substance use, involvement in prostitution and risky behaviours, access to harm reduction outreach services can increase access to treatment services.

Sarah

Sarah is in her mid-30s. She started using heroin when she was 19, and crack when she was 21. She became involved with prostitution at the age of 23, and now works two or three times a week, primarily to pay for her drugs.

She started receiving support from a service for women involved in street-based prostitution when she met one of their outreach workers, and subsequently started to engage with a drug treatment service alongside this. While she identified positive aspects to both services, she explained that “I do think the two should go hand in hand though because it's always there, if you want drugs you go down and get the money. It's always a way to get money.”

Sarah described her self-esteem as being “on the floor”. She described how her partner, who also uses drugs, has “manipulated and scared me into going down and working the beat”, and that he had used “scare tactics to get the money off me when I'd got the money”. She explained that she wanted things to change: “I'd like to travel, and I'd like a full time job, and to be respected. Just a normal life really.” However, she felt the support she is currently receiving is unlikely to help her to do this: “All they seem to give you is 10 minutes of an appointment, see what you're using, take a sample test and then give you a script and then ask you to come back in two weeks. That's about all the support you get.”

Current provision of services

Our survey of current provision indicated that, while there are services that are working to address the particular needs of this group of women, the specific problems faced by women involved in street-based prostitution and substance use are not always well recognised or catered for. Areas that remain underdeveloped include the enhancement or tailoring of standard programmes, domestic and sexual violence support, provision of peer support by 'real' peers, and addressing women's wider needs to support longer-term change.

The majority of respondents to the online survey of services conducted for the research told us that they took proactive steps to ensure their accessibility to women involved in prostitution and substance use. However, when those services were asked about the specific steps they take, positive responses were low. For instance:

- Just over half of services (52%) had **evening opening hours**
- Just over half of services (52%) had an **outreach van or similar**
- Less than half of services (42%) provided **women-only sessions or times**
- Less than a third (28%) provided **specific sessions or times for women involved in prostitution**

Additional measures to ensure the accessibility of services did not always appear to be in place:

- Just over a third of services (38%) said they were located **near to the area used for soliciting**
- Less than a third of services (30%) reported that they undertook **outreach in prisons**
- Less than a third of services (28%) said that they provided **support around children/pregnancy**

Tailoring of standard programmes

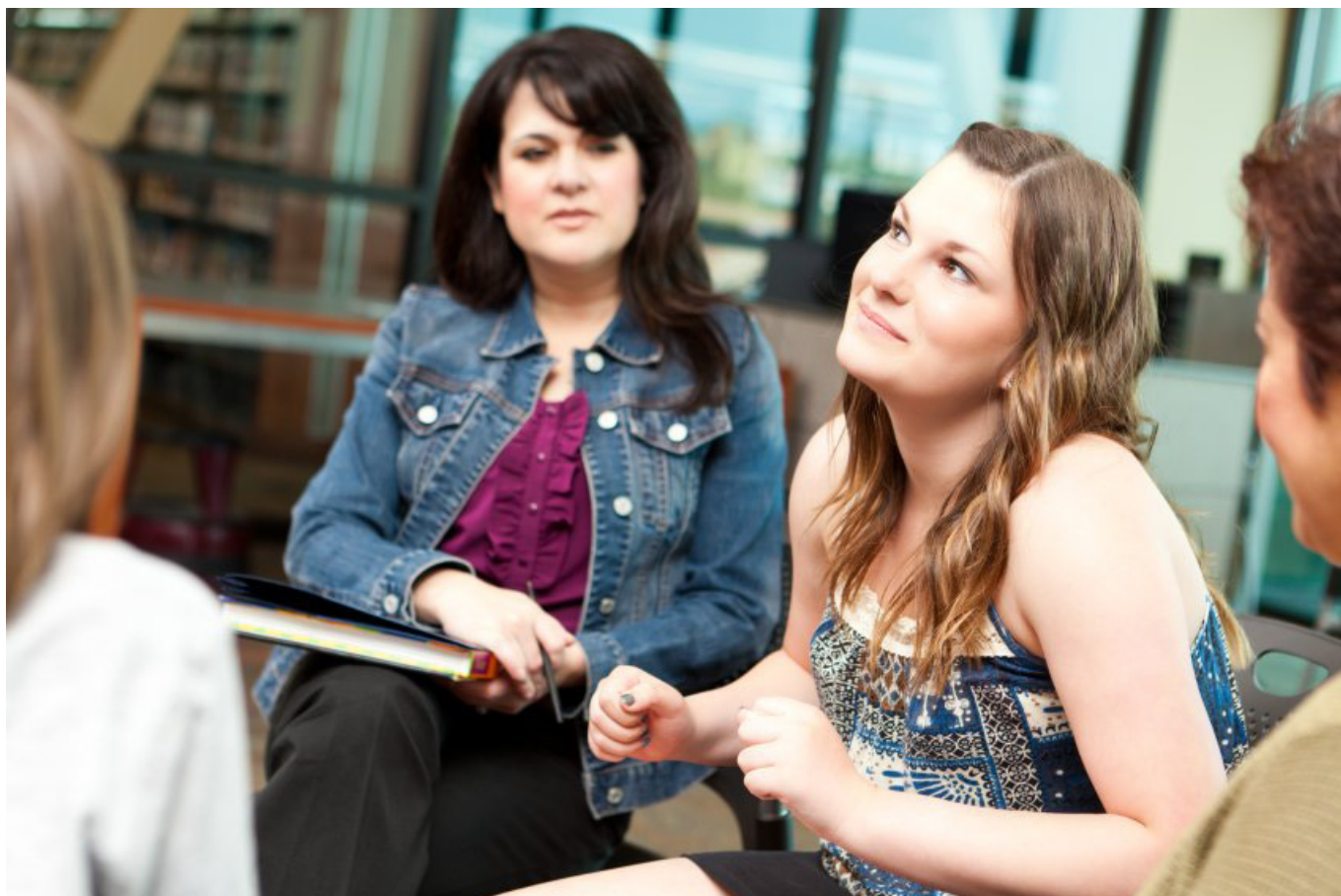
While robust evidence points to the effectiveness of tailoring standard interventions for this group of women, many of the services surveyed didn't take this approach. Under a third of substance misuse services (28%) reported that they provided advice and information around prostitution within their services, and just 30% said they provided harm reduction advice related to prostitution.

This contrasts with relatively high levels of support around substance misuse available within sex work, exiting and women's community projects. Almost all of these projects said they provided advice and information around substance use, and around harm reduction related to substance use, in-house. Across the range of projects surveyed, however, a relatively low proportion provided in-house services such as free contraceptives (56%), and just over a third (38%) offered STI screening. The need for quick access to drug treatment, as raised in the qualitative interviews, can be seen to be addressed by some services, although across the survey, under half (45%) said they offered substitute prescribing in-house.

Positively, drop-in or open access support was available in more than two-thirds (69%) of services. Again, however it was more prevalent in sex work, exiting and women's community projects.

Domestic and sexual violence support

A high proportion of the women interviewed identified experiences of violence and abuse, and, in line with this, many of the services surveyed drew links between women's involvement in prostitution and substance use and experiences of violence: nearly 90% of providers believed that their clients who sell sex are often doing so to fund a partner's drug habit, and two-thirds believed that women are coerced or forced to sell sex for drugs. One of the services visited highlighted the relationship between domestic violence and substance misuse amongst their clients, and how this can impact on treatment:



Worker #1: We have loads of guys trying to get in this door. And the reason that there's posters on the glass bits is because they pull up the chair and they will try and look through, they will and see everything that's going on and control it ... there's a lot of men that can't stand the women coming in here. So they'll encourage it to some degree because they want them to have some methadone that they can share with them or swap with them or whatever, but if it's out of their control they're really like ...

Worker #2: And they don't want the girls to get stronger to the point where [they say] 'Well actually, I can make my own choices.' So there's quite a lot of balancing.

In spite of these acknowledged links, while all the services surveyed said they provided access to domestic and sexual violence services by working in partnership with another organisation, by referral or by signposting, just 16% of providers had domestic violence services available in-house, and only 13% had sexual violence services available in-house. These were almost all sex work, exiting or women's community projects; only one substance misuse service provided domestic and sexual violence services in-house.

Peer support

While some expressed reservations, the majority of providers were generally positive about peer support for this client group. Some pointed to the benefits noted earlier, including the provision of a positive example and motivation and encouragement to change through this. The role of peer support in cutting through the double stigma felt by many women was also highlighted:

"Peer support brings commonality, so the immense shame many women feel is broken down a bit because it's shared amongst peers. Women can bring their experiences and feel valued, and accepted and not alone."

Peer support was widely available amongst the providers surveyed, and 41% of providers who responded to this question in the survey reported women-only peer support as available, including a number of services where one-to-one support that was specific to women involved in prostitution was provided. However, substance misuse services were less likely than other services to have women-only peer support available.

Wider support and help to move on

Many of the women interviewed during the research spoke about wanting to change their situation, and to lead 'normal' lives. One woman explained her aspirations for the future:

"I'd love to be clean. I'd like to have a job but I've got no qualifications. I'd like to provide a nice house for my son. Holidays. You know, he's missed out on basic things other kids have. You know, I'd like to take him abroad. We've only had weekends and a few days in a caravan. So yeah. Things like that. Things that people would say is normal everyday lives."

Many of the services surveyed appeared to respond to this by providing support addressing women's wider needs, and aimed at longer-term change – the majority, for instance, reported providing some assistance with housing. However, only 2% of respondents said they provided the service in-house. The most common arrangement was to provide a referral to another organisation, with just under half (49%) of services doing this. Around a fifth said they signposted clients to other organisations.

More services reported providing education and employment support in-house, with just over one in 10 (12%) offering this. The majority, however, did not: just over a third (36%) provided referrals to other organisations, and just under a fifth (17%) said they signposted people to another organisation.

While solid partnership working can help people to access the range of help they need, one of the services we visited explained the distinct benefits of their 'one-stop-shop' approach to providing support:

Worker #1: We've got tenancy support, so they can sign up for tenancy support to maintain their tenancies; we have Jobcentre Plus – their funding's been pulled, but they were coming in and offering benefit advice; we have peer mentoring groups and service user stuff ...

Worker #2: We'll have any [service provider] who'll come, basically. If we try to start booking appointments off-site, they don't go. So the more people we can have here to say look, this is alright, this is what you wanna be doing, then the idea is that they will go out by the time they get a little bit more stable and whatever.

Karen

Karen started using crack cocaine aged 15, and became involved in prostitution at the same age. She described how, before she stopped working, "I hated myself ... getting in the bath at night I'd scrub myself silly, it's just the way it makes you feel. It just got to the point where I was scrubbing my skin so much it was making my skin sore". Karen explained that she had experienced "quite a few incidents with punters", including being "stabbed with scissors by some guy". She was also raped.

Karen started engaging with services after developing severe breathing problems as a result of her crack use. She received one-to-one support from a service that helped her with a range of issues, including her drug use. They also helped her to access regular health checks, provided support during a rape case, and helped her to access housing.

Karen is now in her-mid 20s. She stopped working four years ago, and stopped using drugs two years ago. She now has a full-time job, has recently married and is trying for a baby.

Conclusions and recommendations

Conclusions:

- Although there are no estimates of the number of women who may be involved in both street-based prostitution and substance misuse, the finding from the Drug Treatment Outcomes Research Study (2007) that 10% of new treatment entrants in England reported having exchanged sex for money, drugs or something else suggests that the size of this group is significant.
- Drug use and prostitution are reinforcing. All the women interviewed reported working on the streets to get money for drugs, and for many women, drugs are the reason they become involved in prostitution. Involvement in prostitution can exacerbate drug use and vice versa. Alcohol use was also identified as an issue for a number of the women, although not generally as driving their involvement in prostitution.
- Women involved in street-based prostitution and substance use experience considerable harms. These include mental and physical health problems, violence and assault, sexual health risks, and low self-esteem. Many women feel the impact of 'double stigma' as a result of using drugs and involvement in prostitution.
- This group commands very little attention within national policies. Where strategies do mention either substance misuse problems among women or prostitution, guidance is rarely provided on addressing the issues together.
- Women involved in prostitution and substance use have complex, entrenched problems and the process of change and recovery is likely to take a long time. It is important, therefore, to ensure the availability of a range of support, from harm reduction and treatment services to services to help them exit prostitution and support their ongoing recovery.
- Women may face a range of barriers to accessing support, including those that are individual, as well as organisational barriers. Organisational barriers include: service hours of opening; lack of flexibility in some services, with particular reference to missed appointments; lack of childcare provision; issues in relationships with keyworkers, including lack of consistency, stigmatising attitudes and disparities in gender and age; an absence of support to address wider issues, including housing and employment; and a lack of ongoing support and aftercare.
- Positive interventions identified by the research include: increased accessibility of services through evening opening hours, mobile outreach services, childcare provision and telephone support; women-only provision, or where this is not possible, women-only groups; support from 'real' peers with experience of using substances and involvement in prostitution; support from non-peers that is non-judgmental and takes an empathetic approach; enhancement of standard drug and alcohol treatment programmes; and support that helps women to address their range of needs, and move on.
- While current provision includes services that are working to address the particular needs of women involved in prostitution and substance use, it is also clear that their specific problems are often not recognised or catered for.

Policy recommendations:

1. The Drug Strategy sets out the Government's ambition for recovery-orientated drug and alcohol treatment, but there has been limited work to date to consider what recovery might mean and require for specific groups, including women involved in prostitution. In line with the 2010 Drug Strategy's recognition of recovery as "an individual, person-centred journey", **a range of services should be available to women involved in prostitution and substance use, from needle exchanges and treatment to housing and employment support. More work is also needed to map out recovery pathways** that address the particular issues experienced by this exceptionally vulnerable group, and the tendency to 'write them off' in the wider recovery narrative. Services also need to address alcohol problems in assessing and responding to the needs of women involved in prostitution.
2. Women with substance misuse problems who are involved in prostitution have multiple needs and disadvantages, and this can prevent them from accessing appropriate services. In the current terminology they are a group with 'complex' or 'multiple needs', and this is a barrier to accessing support. **The development of tailored support for this group should be considered – by policy makers, commissioners, funders and service providers – as a key priority within the emerging 'multiple needs' agenda.**
3. Many decisions about service development will now be made within local authorities. **The specific needs of women involved in prostitution and substance use should, for example, be considered in Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) produced by local Health and Wellbeing Boards.** Additionally, all local authorities should develop a violence against women and girls (VAWG) strategy that recognises the needs of this group. Police and Crime Commissioners should also recognise the needs of this group in the development and implementation of their Police and Crime Plans.
4. Peer support is of particular importance to this group, who may feel the impact of the 'double stigma' of using drugs and being involved in prostitution. One size does not fit all: **effective mentoring will often depend on matching service users with 'real' peers, i.e. those with similar histories and experiences. The gender of peers is often and obviously important too, and they need appropriate training and support** to work with a highly vulnerable group who may be disclosing extremely personal and sensitive information.
5. **There is a real need for further research into men who exploit women through prostitution, and how services can identify, target and engage with this group to address and change their behaviour,** potentially linking to the development of interventions for domestic violence perpetrators.

Good practice recommendations for services:

1. Services can help to ensure their accessibility for women involved in prostitution and substance use through a range of measures, including **evening and weekend opening hours, mobile outreach services, childcare provision or support with childcare arrangements, drop-in or open access support, and a flexible approach to missed appointments.**
2. Our research suggests that the **enhancement of standard drug and alcohol treatment programmes is an effective approach with this group of women.** Services can meet their needs by tailoring approaches to the particular problems and issues faced by women involved in prostitution and substance use.
3. Many women involved in prostitution and substance use have experienced physical and/or sexual violence from partners or clients, or both. **Women-only provision – or, where this is not possible, women-only groups or spaces – is therefore crucial, as is access to domestic and sexual violence support.**

4. Stigma is a significant issue for this group. Services can address this by ensuring **full and thorough training for and development of staff to ensure understanding of the specific needs of women involved in prostitution**, as well as a non-judgmental and empathetic approach. Stigma may also prevent disclosure about involvement in prostitution to keyworkers in the first place, and **robust assurances about confidentiality can help to counter this. Literature and advertising that make it clear that prostitution is an issue services address** can also act as a useful tool in encouraging engagement and disclosure.
5. Many women involved in prostitution and substance use want to make longer-term changes in their lives. A key message is that while women require support to reduce risks and manage addiction, they also aspire to 'recovery'. **Alongside harm reduction and treatment services, services should ensure that wider support is available, including with housing and employment. There is also a need for ongoing aftercare** for those who are substance-free and no longer involved in prostitution.

About DrugScope and AVA

DrugScope is the national membership organisation for the drug and alcohol field and the UK's leading independent centre of expertise on drugs and drug use. We represent around 450 member organisations involved in drug and alcohol treatment and supporting recovery, young people's services, drug education, criminal justice and related services, such as mental health and homelessness. DrugScope is a registered charity (number: 255030). Further information is available at <http://www.drugscope.org.uk>

AVA (Against Violence and Abuse) is a national second tier service working to end all forms of violence against women and girls. The key aims of AVA are: to challenge, enable, encourage and support all agencies and communities to contribute to achieving our vision of a world free from violence against women and girls; to offer a range of high quality and expert services to facilitate specialist and generic agencies to contribute towards our vision; and to identify and fill gaps in the field, find innovative solutions to current and emerging situations and inspire an effective strategic approach to reducing and preventing violence against women and girls. Further information is available at <http://www.avaproject.org.uk/>

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