The Challenge of Change: Improving services for women involved in prostitution and substance use

A report by DrugScope and AVA

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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 report, 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*.

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Overview and key findings[1]

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

[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.

services to help them exit prostitution and support their ongoing recovery, is therefore crucial.

- 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.

1 Introduction

1.1 Background to the project

A number of research studies and policy papers have highlighted the relationship between 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 nature of the problems faced by this particular group, the extent and nature of current provision and the adequacy of coverage. This wide-ranging study seeks 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.

The stigma associated with both drug use and prostitution means that this will be a largely hidden group of women and there are no good estimates of the number of people affected in this way. Because of the sensitive nature of the issues, few large scale surveys collect information to allow estimates of prevalence to be generated. However, the Drug Treatment Outcomes Research Study (DTORS) found that 10% of women commencing drug treatment said that they had exchanged sex for money, drugs or something else in the past four weeks (Jones et al, 2007). 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 quite sizeable.

1.2 Aims of project

The purpose of this project was to:

- highlight the complex needs of women involved in prostitution in addressing their substance misuse problems;
- examine the relationship between sexual exploitation, sexual violence and drug and alcohol use (including involvement in drug supply);
- map and explore the diversity of drug and alcohol support needs for women involved in different ways with the sex industry;
- compare the experiences of women involved in prostitution and substance use in 'sex work'-only services with those using mainstream drug and alcohol services;
- develop best practice recommendations for both sex work projects and drug and alcohol services;
- identify strategic and policy recommendations that could improve interventions and outcomes for women involved in prostitution and substance use.

1.3 Project components

The project used a range of research methods to gather an overview of the issues experienced and also to provide a more in-depth perspective on these. The main components of the research were:

- A rapid evidence review, conducted by the University of Greenwich.
- A review of current UK policy, strategy and guidance documents.

- Interviews with women with a history of substance use problems and involvement in prostitution in two geographical areas (n=19). The interviews were conducted by two peer interviewers and took place in two different geographical areas, West Midlands and Yorkshire and the Humber.

- An online survey of services (n=64). Telephone interviews were also conducted with four survey respondents who agreed to participate in further interview, including two in the cities where peer interviews were conducted, and two in other cities.

- Observational site visits to six services in the two areas where the peer interviews were conducted, which included interviews with staff and service users.

1.4 Current policy context

Before considering the findings of the research it is worth considering the extent to which the needs of this group of women are addressed within current policy and guidance. The wide range of problems confronted by women involved in prostitution and substance misuse means that they could be included in a wide range of different strategies. The two of most direct relevance would be the Prostitution Strategy and the Drug Strategy.

Published under the last government, the Prostitution Strategy (Home Office, 2006) briefly mentions those women involved in prostitution who have problems with substance misuse and addiction. It 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' (2011a), 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.' However, the 2010 Drug Strategy (Home Office, 2010) 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 (Home Office, 2012).

Policies within the current government's strategy for tackling violence against women and girls (Home Office, 2013) 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 (Home Office, 2011b) 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 potentially relevant policy and guidance documents relating to the criminal justice system 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 are at risk of offending, to ensure the provision of holistic, community-based responses to women's multiple needs, a development which 'Breaking the cycle' (Ministry of Justice, 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' (Ministry of

Justice, 2012), 'Transforming rehabilitation: A revolution in the way we manage offenders' (Ministry of Justice, 2013b), and even 'Strategic objectives for female offenders' (Ministry of Justice, 2013a) – are silent on the links between substance use and prostitution.

Overall, it is clear that there is very little in any of the strategies that provides guidance on service provision for this group of women with particularly complex and entrenched problems. Where there is reference to either substance misuse problems among women or involvement in prostitution, there is rarely any consideration of addressing the issues together.

2 Evidence review summary

Overview
The studies reviewed for the evidence assessment highlighted that a high proportion of women involved in street-based prostitution have substance use problems; similarly, a high proportion of women in drug treatment are or have been involved in prostitution. Drug use and prostitution can be said to be mutually reinforcing.

Women who have substance use problems and are involved in prostitution have high rates of mental health problems, and poor physical health. Risks for these women include assault, sexual health risks, and arrest and incarceration. Stigma also has a significant negative impact on self-esteem and mental health.

Four broad types of support need have been identified for women involved in street-based prostitution: basic physical needs; mental/emotional needs; healthcare needs; and longer term needs. A range of services should be available, from harm reduction services to services to help women exit prostitution and recover from their substance use problems.

Barriers to service use can be individual or organisational. Organisational barriers include service hours of operation, issues around trust in and consistency of keyworker, and geographic location of services. Factors identified as important for services for women involved in prostitution and substance use include outreach services and use of peers, women-only provision and childcare provision; enhancement of standard programmes to make them more specific to the needs of this group; and integration of provision or strong case management to deal with the full range of issues experienced by women.

This review focused on interventions for women involved in prostitution who also have substance use problems and was a rapid evidence assessment, rather than a systematic review, limited to studies in English published within the period 1997-2012. Five databases (Medline, PsycINFO, CINAHL, ISI Web of Science and Scopus) were searched, using variations of the following search: Prostitution AND substance abuse) AND (access OR harm reduction OR treatment OR talking therapy. This was supplemented by a Google Scholar search. 1,167 possibly relevant papers were identified; after scrutiny of the abstracts and removal of duplicates, these were reduced to 65. These papers were then accessed by researchers from the Centre for Applied Social Research at the University of Greenwich, who used a template to summarise their content and pull out key relevant findings.

It is important to note that the papers identified often had limited information on the specific target group for this study, and the bulk of them came from North America. Most focused on adults (probably because of the ethical issues that would be raised in working with women involved in prostitution under the age of 18) and on street-based prostitution. These factors should be borne in mind when considering the generalisability of the findings.

This chapter picks out the principal findings from the evidence review. The full evidence review is available here.

2.1 Extent and nature of the association between substance use and involvement in prostitution and associated harms

Key findings:
- A high proportion of women involved in street-based prostitution in these studies have substance use problems, in particular opiate use, but also frequently injecting and polydrug use, and high risk patterns of drug use.

- Similarly, studies of women in drug treatment find a high proportion are or have been involved in prostitution.
- Drug use and involvement in prostitution are mutually reinforcing. A Canadian study found an independent positive relationship between the amount spent on drugs and the amount earned from prostitution.
- Women who have substance use problems and are involved in prostitution have high rates of mental health problems and poor physical health.
- They often have other pre-existing vulnerabilities, e.g. prior sexual abuse, low educational attainment, poverty, leaving home at a young age, and homelessness. This increases the complexity of providing services for them.
- Risks associated with substance use combined with prostitution include assault, and also arrest and incarceration. There are sexual health risks, including sexually transmitted infections (STI) and HIV transmission, and those who inject drugs have a dual risk for HIV. Stigma also has a significant negative impact on self-esteem and mental health.
- A number of studies indicate that women with substance use problems involved in prostitution do not do well in traditional treatment services, often continuing to use drugs while on substitute medication.
- Women involved in prostitution are often high users of health services, commonly emergency rooms and GPs, and a number of studies suggest that they are less likely to discuss their prostitution in primary care settings than in substance misuse services.
- The one study that looked at underage women involved in prostitution (in the US and Mexico) found a number of differences in both reasons for beginning to use drugs or involvement in prostitution and risk behaviours among those who started 'sex working' as minors compared to their adult counterparts. The study argues that women who become involved in prostitution as adolescents are a vulnerable population who experience multiple, accumulating risks as youths and adults, including violence, forced and unsafe substance use, and unprotected sex.
- Alongside harms to the individual, there are also community harms. Public nuisance is introduced by sex markets that are obvious rather than discrete.
- There are different types of prostitution. A study in Bristol found those involved in parlour-based prostitution had lower rates of problematic drug use, better health, more stable backgrounds and better engagement with health services than women involved in street-based prostitution. A study in the US of attendees at a needle exchange distinguished between low and high frequency involvement in prostitution. The former tended to be associated with lower drug use rates and more stable living conditions and employment.

Association between substance use and involvement in prostitution

A consultation in Liverpool about the establishment of a managed zone for prostitution consulted a range of organisations and individuals, including a sample of 50 women involved in prostitution (Bellis et al, 2007). Over 85% of these women (who were aged predominantly between 26 and 35 years) had used heroin in the past four weeks, and three quarters had used crack cocaine. A significant number were involved with health services: two thirds were involved with drug treatment, just over 60% with GPs, and almost three quarters with outreach workers for 'sex work' projects. However, women were much less likely to disclose their involvement in prostitution to their GPs. Almost half had been arrested for prostitution, soliciting or similar, while over two thirds had been sexually assaulted while working.

A study among people entering treatment for substance misuse in the US showed just over half (51%) of women and 11% of men had a history of prostitution (Bernette et al, 2008). Factors associated with a history of prostitution were: mental health problems and service use, suicidal behaviour and physical health problems among men, and use of emergency care and hepatitis services among women. A separate study of cocaine-dependent

individuals in treatment in St Louis, USA, found very similar rates of involvement in prostitution, with 52% of women and 9% of men having traded sex for drugs or money at least once and 45% and 7% respectively having done so three or more times (Cavazos-Rehg et al, 2009).

An Australian study of women involved in street-based prostitution (Roxburgh et al, 2008) found very high rates of drug use (83% heroin, but also cocaine, methamphetamine, cannabis and alcohol) and injecting, as well as risky use behaviours. They also found very high levels of mental health problems (e.g. 54% severe depressive symptoms), including suicidal thoughts (74%) and attempts (42%). The age of first drug use was quite young (mean = 15) and 61% had left home before they were 16. Concerns were voiced among the women in the study, who worried about health professionals understanding them and their involvement in prostitution. Although a large proportion of the women were engaged in drug treatment, many of them continued 'heavy' patterns of illicit drug use. The study notes that further research, identifying potential barriers to treatment for this group, is warranted in order to develop relevant programmes that would encourage attendance and sustained engagement. It also points to the role of outreach workers as crucial in promoting and providing referral information on available drug treatment programmes.

A study in Canada (Deering et al, 2011b) among women (including trans-gendered) involved in street-based prostitution found that there was an independent positive relationship between the amount spent on drugs and the amount the women earned through prostitution. A similar relationship was found between the amount spent on heroin injecting and income through prostitution, suggesting heroin injectors may be particularly economically vulnerable because of its comparatively high cost, which may lead them to engage in higher risk prostitution. Opiate substitution therapies can reduce the average amount of money spent on drugs, indicating, the study notes, that this could be an important intervention to reduce harm to vulnerable women who engage in prostitution to sustain heroin use. It also highlights that improving access to and utilisation of addictions treatment for women involved in prostitution could reduce their dependence on earnings through prostitution to support drug use.

Risks and harms associated with involvement in prostitution and substance use
Risks to women involved in prostitution identified in the studies include violence, including domestic violence; sexual health risks, e.g. STIs, HIV and Hepatitis – drug-users involved in prostitution have a dual risk for HIV from injecting drugs and from unprotected sex (El-Bassel et al, 2012); and prosecution and incarceration. Stigma and negative effects on self-esteem or mental health are said to arise from all types of prostitution.

In an international review, Cusik (2010) describes how addiction is frequently associated with involvement in prostitution, and generally discussed in terms of negative consequences for women's health and safety when working, or the risk of becoming trapped by the mutually reinforcing aspects of certain behaviours or substances. The harms experienced may depend on the type of sex market in which the individual operates, as do the opportunities to control them. Women involved in prostitution who appear to be drug users are most often denied work in indoor and co-operative 'sex work' establishments. The open, street-based and low status sex markets thus become the only ones accessible to these women. Women involved in prostitution may have pre-existing vulnerabilities, for instance, prior sexual abuse, low educational attainment, and poverty, which may respond to more generic programmes. Some harms can be reduced for women involved in prostitution through programmes that specifically address the conditions under which they work.

A study in the US and Mexico looking at the impact of underage sex work (Goldenburg et al, 2012) found a number of differences in both reasons for beginning to use drugs or

becoming involved in prostitution and risk behaviours among those who started 'sex working' as minors compared to their adult counterparts. They argue that women who become involved in prostitution as adolescents are a vulnerable population who experience multiple, accumulating risks as youths and adults, including violence, forced and unsafe substance use, and unprotected sex. It highlights that since vulnerable populations often experience fewer opportunities than groups with more resources to derive benefits from population-based interventions, targeted interventions for vulnerable youth and younger women are needed.

In a study in Canada, Mehrabadi et al (2008) found women recently involved in prostitution were more likely to report ever having injected drugs, recent (in the last six months) daily use of non-injection crack, injection cocaine use, injection opiate use, and injection speedball use. Women involved in prostitution were more likely to report daily use of the needle exchange site in the past six months, and to report runs or binges with injection drugs over the same period. However, in terms of condom use and sexual experiences, there was no evidence to suggest unsafe sex with casual or regular partners, or ever being pregnant was associated with recent involvement in prostitution.

An Australian study that recruited injecting drug users through needle exchanges (Roxburgh et al, 2005) examined whether regular injecting drug users who were currently involved in prostitution were at greater risk for adverse outcomes (such as homelessness and poor mental health), were more likely to engage in risky behaviours (needle sharing, criminal activity), and had different drug use patterns than injecting drug users who were not engaged in prostitution. There were more similarities than differences, and the researchers suggest that a larger study is needed to clarify if those involved in prostitution are heavier drug users.

A study in South Africa (Wechsburg et al, 2009) found women involved in prostitution had higher rates of substance use, familial substance use and physical abuse that a comparator group of women not involved in 'sex work'.

Alongside harms to the individual, there are also community harms. Public nuisance is introduced by sex markets that are obvious rather than discrete. These are often busy places, populated by the general public, as well as the clients of women involved in prostitution, drug dealers, drug purchasers and vigilantes with a mission to halt sex markets.

Variations across different types of prostitution

It is important to recognise the diversity of patterns of prostitution. A US study of attendees at needle exchanges differentiated between low frequency and high frequency involvement in prostitution. Those identified as having 'low frequency' involvement were more likely to primarily live in their own home/apartment, and have a job and a legitimate source of income. They also had lower drug use rates, although they still engaged in risky sexual behaviours, perhaps more than those identified as having 'high frequency' involvement (Braine et al, 2006).

A study in Bristol (Jeal and Salisbury, 2007) compared women involved in parlour-based prostitution with those involved in street-based prostitution. Those who were parlour-based disclosed originating from a variety of countries including Lithuania, Ukraine, Albania, Russia, Poland and Kenya, but most were from the UK. None of the women involved in street-based prostitution were from outside the UK. Those in parlours appeared to have had a more stable childhood, had a more stable current home environment and fewer chronic health problems than those working on the streets. In comparison with women involved in street-based prostitution, those working in parlours were less likely to report chronic and acute illnesses, and more likely to be registered with a GP. They were more likely than

women working on the streets to have been screened for STIs in the previous year and more likely to use contraception in addition to condoms. They were less likely to be overdue for cervical screening, and more of those booked for antenatal care in the first trimester attended all follow-up appointments.

Fewer of the women working in parlours used heroin, crack cocaine or injected drugs. Women working in parlours were less likely to be using drugs and spent less money per week on drugs; they were also less likely to be sharing injecting equipment than women involved in street-based prostitution. Women based in parlours had been older when they started selling sex (mean = 23.1 years, versus 20.8 years) compared with women working on the streets. Those in parlours were more likely to want money for living expenses and were much less likely to be driven into prostitution by the need to fund a drug habit. They were also less likely to have experienced violence or been groomed to force them to sell sex. Women working in parlours were more likely to be involved in prostitution to accommodate the childcare and financial burdens of being a single parent.

When asked to suggest an appropriate service for their population, a few suggestions were common to both groups. These were: a service location near their place of work, female health professionals, condom provision and counselling. Significantly more women working in parlours suggested improvement in the existing STI clinic service, a service that also included Hepatitis B vaccination, contraception and health education, and was separate from services for their general health. Women involved in street-based prostitution wanted a health service for all aspects of health and basic living needs, which the study notes reflects the relative social stability of those working in parlours compared with the absence of even basic needs such as food and drink in the lives of those working on the streets. Women involved in parlour-based prostitution were also significantly more likely to want input from agencies for career support and financial advice than those involved in street-based prostitution. The two groups had very different health experiences, risk-taking behaviour and use of services.

2.2 Service needs and barriers to use

Key findings:

- Four broad types of support need have been identified for women involved in street-based prostitution:
  - Basic physical needs (e.g. food, clothing, sanitary products, shelter)
  - Mental/emotional needs (e.g. friendship, counselling, domestic violence protection)
  - Healthcare needs (e.g. drug treatment, reproductive care, HIV/STI care, general medical care)
  - Longer term needs (e.g. mailing address, ID, social security number, housing, employment.
- A range of services should be available, from 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 prostitution and recover from their substance use problems. The need for integrated services is also clear.
- Some barriers to service use relate to involvement in prostitution and some to substance use, but they are often similar. Some barriers are individual and some are organisational.
- The social networks of women who use drugs and are involved in prostitution may centre around drug users and others involved in prostitution, making it difficult for them to disengage as they fear the loss of social support. Similarly, prostitution may provide economic stability for women who have no alternative economic opportunities. Other barriers can include fear of services and the potential consequences of engagement.
- Service/organisational barriers include: hours of operation, long waiting lists and problems with telephone systems. There can also be issues around trust in and

consistency of keyworker. Geographic location of services and the location of policing as barriers also need consideration.
- Barriers can be mutually reinforcing, e.g. lack of access to hygiene facilities and products may make employment less likely. Housing, or lack thereof, is a particular issue which often interferes with support provision and exacerbates other issues.
- Stigma is a significant problem for women involved in prostitution and substance use.

Service needs

A study in Miami, Florida (Kurtz et al, 2005), which looked at service needs and barriers to access for women involved in street-based prostitution, identified needs of four broad types based on interviews with 586 women and focus groups with 25 women:

- Basic physical needs (e.g. food, clothing, sanitary products, shelter)
- Mental/emotional needs (e.g. friendship, counselling, domestic violence protection)
- Healthcare needs (e.g. drug treatment, reproductive care, HIV/STI care, general medical care)
- Longer term needs (e.g. mailing address, ID, social security number, housing, employment)

A review of the impact of sexual exploitation of women (Taylor, 2011) highlights the strong relationship of a history of sexual abuse with substance misuse, mental health problems and prostitution, and the need for multi-faceted services that address all these issues at the same time. The need to recognise the potential impact of intimate partner violence on service engagement is also highlighted. The review points out that women entering into substance misuse treatment 'may be coping with the underlying issues of childhood sexual assault or sexual trauma after childhood. As a result of the sexual victimization, additional correlates have been identified as culprits in hindering women's psychological, physiological, and social development. The aftermath of sexual assault continues to affect these women across the life domains. Effective treatment is needed to address the mental health and substance use issues sexual assault victims face on a daily basis. Medical treatment is needed by those women who have contracted HIV or other sexually transmitted diseases as a result of sexual victimization or engaging in associated behaviours such as prostitution. In addition, services are paramount in assisting these women to escape the injustices of domestic and intimate partner violence' (p.5).

An evaluation of a trauma-oriented treatment programme in Arizona for women who have been involved in prostitution (Ward, 2009) concluded that it is essential for service providers to recognise that these women display significant levels of trauma symptoms that need to be addressed as part of their treatment. It can also be important to consider the stage at which women involved in prostitution and substance misuse are, as in their readiness to change, when considering the type of support they might need. Baker et al (2010) identified five main stages from immersion, through awareness, then deliberate preparation, then initial exit which may be followed by re-entry, before final exit is achieved.

Barriers to service use - individual

Barriers to service use can be broadly categorised as individual or organisational. A small study in the US of 12 women involved in an intervention programme for women involved in street-based prostitution (Murphy, 2010) – which identified that all had been addicted to drugs and 10 were currently using them – found that these women lacked the usual forms of social support, in terms of family and community, and so they turned to one another for support and encouragement. Social support among the women was also linked into their drug behaviour. Thus, it could be difficult for women to disengage from drug use and prostitution given that they comprised a strong component of their personal lives.

Most of the women involved in the study had a regular clientele; involvement in prostitution provided the women with some form of economic stability that they otherwise may not have had. The study highlights that women need to re-establish themselves in a community where addiction and prostitution are not part of the culture. It is hypothesised that remaining in prostitution becomes a vicious cycle of drug use to decrease the 'pain' of prostitution and the actual behaviour of prostitution in order to sustain the drug habit. In addition, despite the fact that the social network itself perpetuates negative outcomes, the women engage with one another and may fear the loss of the only social support that they may have; thus, they continue to be involved in prostitution.

A study of out-of-treatment cocaine users in St Louis, Missouri (Striley et al, 2008) found that 48% of women in the study reported selling sex. Women (all, not just those involved in prostitution) who had not sought treatment reported significantly more fear of going to hospital than men, more fear of the treatment they would receive, and more fear of what others would say or think. Most medical care received occurred in clinics or emergency departments.

Barriers to service use - organisational

A study in Quebec of women involved in prostitution who operated in a range of settings (mainly indoors rather than street-based) investigated their health service use (Nquyen et al, 2008). Finding that the most frequent reason given for consulting health services was drug addiction, the study also found that the hours and days of operation of most health services made it hard for women involved in prostitution to gain access to them since they did not suit their work schedules. Several of the women involved in the study mentioned having faced unbearably long waiting periods in hospital emergency services and leaving after several hours without obtaining care. Some respondents mentioned that mental health services were not readily accessible, or they highlighted long waiting lists to consult a psychologist. Others noted problems encountered with telephone systems when attempting to gain access to services.

The findings of a study considering the role of violence and policing in an area as a barrier to health services and needle exchange use among substance-using women involved in street-based prostitution in Vancouver (Shannon et al, 2008) indicate that geographical location of services may need to be considered, taking into account service users' fears of particular locations. The study also suggests that there is a need for more extensive analyses of the role of specific environmental–structural factors that mediate harm reduction and prevention efforts among women in 'survival sex work' at the individual level.

A study of health service access by women involved in prostitution in Vancouver (Shannon et al, 2005) showed a high uptake of primary care and emergency room services, probably reflecting generally poor health status, highly unstable lifestyle patterns, high rates of addiction, inaccessible clinic hours during evenings, and a lack of women-specific services. In addition, women reported a high level of contact with frontline workers and use of harm reduction initiatives, attesting to a much higher uptake of low-threshold and more easily accessible services among this group.

A small qualitative study in Glasgow sought to identify barriers to effective drug treatment for women involved in street-based prostitution (Smith and Marshall, 2007). All the women interviewed were injecting opiate users and most used other substances as well. All cited heroin addiction as instigating their initial engagement in prostitution and the amount they worked was related to the extent of their use. Alongside an impoverished sense of self-worth, exacerbated by the stigma they experienced, organisational barriers to effective treatment that emerged from the interviews included: lack of trust and consistency (a change in support worker during treatment is damaging and often leads to disengagement);

absence of a comprehensive treatment package (this includes dealing with psychological and other problems, not just substance use); discrepancy between 'readiness for treatment' and availability of services; and lack of provision for opiate-addicted couples (as some women are involved in prostitution to support both their own and their partners' habit). The study concludes that trust and consistency of keyworker is necessary to ensure clients feel secure in treatment, and aids retention, noting that the vulnerable nature of this population makes continued support from a keyworker vital.

Barriers as mutually reinforcing

Kurtz et al (2005) highlight that barriers can intersect in ways that often make problems self-perpetuating for women involved in street-based prostitution. For instance:

- Lack of access to water, showers, and hygiene products increases the likelihood that a woman will be refused help or employment.
- The inability to find shelter at hours of the day compatible with their lives leaves women on the street, and at increased vulnerability to violence, heavier drug use, and loss of self-esteem. Some women said they smoked crack all night on the streets so they would not risk being raped while asleep.
- Living on the street increases drug seeking and use, making women less able to make the decisions necessary to find help.
- Life on the streets hardens many women, leading them to expect social disdain, discrimination, and marginalisation, so that they assume no one truly cares even when social service providers do offer assistance.
- Drug use and street life foster the loss of social and communication skills, impatience, fear of authority figures, and a loss of sense of social time. Women often arrive late or on the wrong day for appointments and/or they are not willing to wait in line for service.
- A lack of legal identity, address, and/or status cause women to be ineligible for most employment, and also to fear arrest on loitering, solicitation, and drug possession charges when going for help. Women said this was of particular concern when seeking healthcare.

The study also suggests that social service and healthcare staff members (including administrative, reception, and secretarial staff) would benefit from training designed to increase their sensitivity to the needs, fears, social disconnectedness, and secretiveness of many women involved in street-based prostitution. It notes, too, that there are some structural barriers to services for women involved in prostitution that would be difficult or impossible to eliminate in the context of high levels of homelessness. The study argues that there is a need to find effective ways to increase women's empowerment and reduce their marginalisation to the extent that they can successfully navigate the complex web of social service and healthcare entities that exists in every community. Such efforts might include providing an intermediate level of case management, perhaps including women previously involved in prostitution and substance use in key support roles, to keep clients engaged and on a path toward making consistent, if small, steps to getting care and treatment.

Housing is a particular issue that often interferes with support provision and exacerbates other issues. McClean et al (2006) studied a sample of 148 female detainees in Baltimore City Detention Center. They found that almost half of these detainees reported a perceived lack of stable housing availability upon release. Familial support and a monthly income of $400–799 were significantly positively associated with perceived housing stability upon release; wanting a support group for issues surrounding involvement in prostitution was significantly negatively associated with perceived housing stability upon release. The study suggests that interventions should emphasise access to housing, economic opportunity and family reunification. It argues that special attention is warranted to those who have been

involved in prostitution, who may be marginalised from family and service-based support networks.

The impact of stigma
Lazarus et al (2012) consider 'occupational stigma as a primary barrier to healthcare for street-based sex workers in Canada'. In multivariable analysis, adjusting for sociodemographic, interpersonal and work environment risks, occupational 'sex work' stigma remained independently associated with an elevated likelihood of experiencing barriers to health access. The study concludes that there is a need for policy and societal shifts in views of 'sex work' as a legitimate occupation, combined with improved access to innovative, accessible and non-judgmental healthcare delivery models for women involved in street-based prostitution that include the direct involvement of these women in their development and implementation.

A study of the stigmatisation of women involved in prostitution and drug use in Ireland (Whitaker et al, 2011) highlights the way stigmatising staff attitudes and casual use of words such as 'clean' and 'dirty' can provide barriers to effective treatment. It also notes the additional stigma of prostitution, seen as 'worse' than drug use. Nevertheless, it argues that women involved in prostitution can still have agency and implement harm reduction strategies.

2.3 Positive interventions and good practice

Key findings:

- Factors identified as important for services for women involved in prostitution and substance use include:
  - Outreach services
  - Use of peers
  - Women-only provision
  - Childcare provision
  - Non-judgmental approach
  - Enhancement or tailoring of standard programmes to make them more specific to the needs of this group (greater intensity and specific content)
  - Integration of provision or strong case management to deal with the full range of issues experienced by women
- As highlighted earlier, there is a need for a range of services, from harm reduction services through to exit-focused programmes.
- As well as leading to reduced substance use, involvement in prostitution and risky behaviours, access to harm reduction outreach services can increase access to conventional addiction services.

Use of peers and outreach services
A small evaluation of a pilot of a peer-driven intervention to increase access and adherence to anti-retroviral therapy among street-entrenched HIV-positive women in Vancouver, most of whom used drugs, suggested the approach might have value, in particular for higher risk women (Deering et al, 2009).

Deering et al (2011a) used a prospective cohort approach to look at factors associated with the use of a peer-led mobile outreach programme in Vancouver. High risk women, including those servicing a higher weekly client volume and those soliciting clients in deserted, isolated settings were more likely to use the programme. Women who used the peer-led mobile outreach were more likely to use inpatient addiction treatment, even after adjusting for drug use, environmental–structural factors, and outpatient drug treatment. At the same time, younger women involved in prostitution were significantly less likely than older women

to access the outreach service, suggesting that continued barriers to services exist for this population.

Another study (Janssen et al, 2009) describes and evaluates the same project, which it names as the Mobile Access Project (MAP) service. Staffed by a driver and two peer support workers, the MAP van circulates through Vancouver's Downtown Eastside and surrounding areas every night from 10.30 p.m. to 5.30 a.m., stopping roughly every six blocks and spending about 15 minutes per stop. The route follows many of the 'strolls' frequented by women involved in prostitution. The majority of women surveyed used van services once (44.8%) or twice (20.9%) each night. The remainder of the women reported accessing the van twice weekly (17.9%), once weekly (11.9%), or less frequently (3%). Log books indicated that MAP was rapidly adopted. The average number of monthly contacts increased from 963 in 2004 – when it first started operating – to 1,269 in 2005 and 1,496 in 2006.

Over 90% of MAP clients reported that the van made them feel safer on the street. In addition, 16% of surveyed clients recalled a specific incident in which the van's presence protected them from a physical assault and 10% recalled an incident when its presence had prevented a sexual assault. The mean number of condom packs distributed per month rose from 531 in 2004 to 1,074 in 2005, and to 1,432 in 2006, and the number of clean needles dispensed per month almost tripled during the MAP's first three years of operation. The study notes that a key reason for the success of the needle programme may be that women can access the van without leaving the corner they are working on for more than a few minutes; another reason may be the social support provided by peers who staff the MAP van. The researchers conclude that MAP is promising as a relatively low-cost method of meeting the immediate needs of women involved in street-based prostitution, including shelter from imminent danger, first aid, condoms and clean needles, information about predators, and access to health and other community services. They also argue that it demonstrates the value of using peer support for this particularly vulnerable group of women.

Nuttbrock et al (2004) conducted a randomised controlled trial (RCT) of enhanced outreach provision compared with the existing outreach programme to increase treatment engagement among women involved in prostitution. The control treatment, the Off-The-Streets Mobile Unit (OTSMU), delivers services in New York City at various sites where women involved in prostitution congregate and drug activity is common. The OTSMU provides amenities (bathroom facilities, a bag lunch, and a warm and friendly environment), HIV prevention (condoms and literature), brief onsite counselling, and referrals for medical, psychiatric, and substance misuse treatment. The experimental intervention entailed an additional mobile unit, the Treatment Linkage Van, which operated in tandem with the OTSMU van, and featured three programme enhancements designed to increase the number of successful referrals to substance misuse treatment: a weekly scheduling of counselling for a minimum of six weeks; onsite substance misuse counselling conducted by an experienced treatment specialist (rather than a counsellor in collaboration with an office-based social worker); and direct access to a range of programmes designed specifically for women, including substance misuse treatment. The study notes that, contrary to expectation, the experimental intervention did not result in an additional number women entering substance misuse treatment, and argues that the existence of a basic model of street outreach, not the intensity of this outreach, appears to be critical.

An evaluation of an outreach-based programme using a risk-reduction approach to provide drug treatment to women involved in prostitution in the US proved able to reduce drug use, improve accommodation status and reduce the number of nights spent in jail despite the fact that those enrolled had a multiplicity of factors identified as barriers to treatment. The day programme offered meals, HIV and drug use risk reduction education sessions, group

discussions and one-to-one counselling. Greater service use intensity was associated with better outcomes (Bowser et al, 2008).

Women-only provision and childcare
A literature review of programme factors that improve retention and outcomes from substance misuse treatment for women generally (Sun, 2006) identified the following suggestions for best practice when developing services for women with substance use problems:

- Women-only programmes are still scarce and policymakers must make these more available to women.
- Women-only groups should be made available as an option if a programme is unable to take only women.
- Optimal treatment for women includes childcare and other services being available onsite.

It also highlights that practitioners must emphasise a non-judgmental and non-confrontational approach in working with women, and should provide women with individual counselling in addition to group counselling. Additionally, it argues that when referring a woman, particularly one with few resources and heightened environmental stress, practitioners should keep in mind that a residential programme is likely to have a more solid and long-lasting effect on her recovery.

Tailoring or enhancement of standard programmes
Sherman et al (2006) report on a pilot social enterprise HIV prevention intervention study (JEWEL) upon sexual and drug-related risk behaviours among women drug users involved in prostitution in Baltimore. Social enterprise was the broader framework of the study in that it was designed to address environmental barriers to prevention such as lack of access to sustainable and licit income. The intervention was comprised of six two-hour sessions that taught HIV prevention risk reduction and the making, marketing and selling of jewellery. The pilot study had three primary aims: to assess the feasibility of training drug using women how to make, market, and sell beaded jewellery; to enhance women's HIV transmission knowledge, provide risk, and critical thinking skills; and to enhance women's job self-efficacy by providing them with training in the making, marketing and selling of beaded jewellery. In total, 54 women participated in six cohorts of the six-session intervention, and 50 women were eligible for follow-up. Through the creation of an economically enabling environment in combination with enhancing women's HIV risk reduction skills, the study found that participants reduced selected sexual and drug-related HIV risk behaviours. Specifically, women reported significantly lower rates of non-injecting (i.e. crack smoking) and injecting drug use, as well as a reduction in the number of all sexual partners and 'sexual trade partners'. Compared to the baseline survey, women also reported significantly lower rates of illegal sources of income at follow-up.

Suratt and Inciardi (2010) report on an RCT to assess the effectiveness of an HIV risk reduction programme tailored to meet the needs of women involved in prostitution in Miami. The study showed that participation in a tailored HIV risk-reduction intervention can be effective in reducing drug use and sexual risk behaviours as well as violent victimisation among this group of highly vulnerable women. Women in the 'Sex Worker Focused' (SWF) intervention were 1.6 times more likely than women in the standard intervention to decrease unprotected oral sex, and were 1.9 times more likely to report decreased sexual victimisation. Although the study notes that the precise reason for this pattern of effects is unclear, it argues that the significant six-month outcomes may indicate that the targeted message of the SWF intervention had a longer-term impact than the traditional message of the standard intervention; because the SWF intervention message was tailored in its

content, language, and style, it may have been perceived to be more salient by the target population.

A women-focused intervention to reduce HIV risk behaviours among women involved in prostitution (a mix of indoor and street-based) in Pretoria (Wechsburg et al, 2006) was compared with a standard intervention. It found increased rates of protected sex and decreased substance use as well as decreased violence, although violence remained a significant problem for the women. The women-focused intervention presented the same information as the standard intervention but, in addition, it addressed HIV/AIDS issues facing women in South Africa (as identified in focus groups). It included a more personalised assessment of each woman's drug and sexual risks that informed specific goals to help each woman negotiate risk-reduction by communicating the importance of condom use with sex partners. The women also learned violence prevention strategies such as staying sober to assess the situation, communication techniques in difficult situations, and ways to exit a volatile situation if need be. Women were also shown how to actively seek community resources.

Integration of provision

An evaluation of a primary care, GP-led treatment intervention for women involved in street-based prostitution who used heroin in Derby (Litchfield et al, 2010) involved 34 women. The 'targeted sex workers' clinic' was designed to provide a more intensive, 'one-stop shop' service for women involved in prostitution who used heroin, in order to offer them a range of medical, social, and drug treatment services including prescribed treatment for heroin addiction, contraception, and sexual health interventions. Referrals were invited from any source, but came particularly from a local street agency offering non-medical support and outreach to women involved in street-based prostitution

Once the women involved had started on a prescribed treatment programme for their heroin use (usually methadone maintenance), patients were able to access sexual health interventions and advice, as well as specialised keyworking and psychosocial interventions as required. Of 34 women who were involved in prostitution at the beginning of the study, only 11 (33%) reported being involved a year later. Of 30 urine samples, 26 (87%) were positive for heroin at the beginning of the intervention, compared with 21 out of 29 (72%) a year later.

The role of harm reduction services

A German RCT (Eiroa-Orosa et al, 2010) comparing heroin-assisted treatment (HAT) with methadone maintenance treatment (MMT) among hard-to-treat individuals reported that there was a higher rate of prostitution among the women than the men, and that it was an important source of income for them. While the women receiving HAT did not do significantly better than those on MMT in relation to the primary outcomes of health and drug use, they did demonstrate significantly greater reductions in prostitution, which had an impact on reduction in illicit drug use.

A literature review concerning 'sex work' harm reduction by Rekart (2005) identified a range of different types of intervention that have been shown to reduce harms, most of which had a positive impact on drug use alongside other harms. Interventions identified by the study include: education (peer education, outreach programmes, accessible and appropriate materials, 'sex worker' involvement); empowerment (self-esteem, individual control, safe sex, solidarity, personal safety, negotiating skills, refusal to clients, service access, acceptance by society); prevention (male and female condoms, lubricant, vaccines behavioural change, voluntary HIV counselling and testing, participation in research); care (accessible, acceptable, high- quality, integrated care; prevention-care synergy; prophylaxis; STIs, HIV/AIDS, and psychological care; social support); occupational control (exposures

and hazards, treatment for health and safety injuries and diseases, employer duties, worker rights). In terms of education, the review indicates that successful materials are simple, clear, consistent, non-judgmental, attractive, and culturally sensitive.

Reporting on data from the Sydney Medically Supervised Injecting Centre (MSIC), Kimber et al (2008) found that 16% of clients who received written referrals to drug treatment had confirmed drug treatment referral uptake. Factors associated independently with MSIC drug treatment referral uptake were daily injecting and involvement in prostitution in the month prior to registration. The local injecting drug user (IDU) and 'sex worker' primary healthcare and drug treatment service, KRC, accounted for more than half the cases of confirmed referral uptake. The study highlights that this corresponds with other evidence that those involved in street-based prostitution use and benefit from low-threshold health and social services, such as MSIC and KRC, which are in locations and have operating hours convenient to their work.

3 Qualitative study of women involved in prostitution and substance use

Overview
The qualitative interviews highlighted the mutually reinforcing nature of prostitution and substance use. All the women reported selling sex to support their drug use, and in many cases, drug use predated their involvement in prostitution. Prostitution can exacerbate drug use and vice versa.

Involvement in prostitution and substance use have a major impact on women's self-esteem, and the stigma of involvement in prostitution is felt even more keenly than that of drug use. Violence is a common experience for this group of women and can be extreme, with consequences for physical and mental health.

The women interviewed gave a range of reasons for accessing services, including a specific incident, or because they simply felt they could not go on in the same way. Support needs range from short term basic support, harm reduction and treatment need, to longer term support to help maintain progress and recovery. Housing was a particular concern for many of the women interviewed.

As in the evidence review, individual and organisational barriers to services were identified. Organisational barriers included service hours of operation, inflexible procedures and lack of childcare provision. Lack of consistency of keyworker, stigmatising staff attitudes and disparities in gender and age were also identified, as was a lack of wider support and aftercare. Positive aspects of services identified include outreach services, drop-in access and telephone support; provision of peer support; a non-judgmental and empathetic approach from staff; and integrated provision or strong case management to cater for all needs.

This section of the research involved semi-structured interviews with 19 women who had a history of involvement in prostitution and substance use in two regions of England, West Midlands and Yorkshire and the Humber. The interviews were conducted by specially trained peer interviewers, and a snowball sample was used; interviewees were recruited through services in the areas, and through the interviewers' own contacts. Interviewees were provided with an information sheet, and were asked to sign a consent form (see Appendices). Where consent was given, the interviews were recorded and then transcribed. Where consent to recording was refused, the interviewers' field notes were available. A detailed ethics protocol, based on the Integrated Research Application System, was developed and adhered to throughout the study.

3.1 Relationship between substance use and involvement in prostitution

Key findings:
- All the women interviewed had been involved in street-based prostitution and had a history of substance use problems, particularly opiates and crack. In most cases, these problems were longstanding.
- Substance misuse and involvement in prostitution are mutually reinforcing. All the women reported selling sex to support their drug use, and in many (but not all) cases, drug use predated their involvement in prostitution. Some women explained that they used drugs to cope with selling sex, and that selling sex increased the use of drugs.
- Street drug markets and the 'sex work' beats are often intertwined, amplifying these problems.
- Involvement in prostitution also provides an independent income and a social network.

The women who were interviewed varied in age, length of their drug using and time they had been involved in prostitution. For example, one of the women had been working on the street on and off for 30 years and smoked crack when she did so, whereas another younger woman was a user of cocaine and had been involved in prostitution for only six months. Most of the women, however, had been both using drugs and involved in prostitution for a long period of time and from a young age, although one of the interviewees was no longer doing so at the time of interview.

All of the women interviewed had been involved in street-based prostitution, although several reported having moved to working by phone, and in one or two cases from home. A fairly common pattern when reducing involvement in prostitution seemed to be to stop or cut back on going out on the street while engaging by phone with regular clients. The sample did not include any women working from parlours or clubs.

Most of the women were or had been users of heroin and crack, although other drugs mentioned were cannabis, cocaine, amphetamines and alcohol. Some were currently heavy, daily users of both crack and heroin - for example, one woman reported using two bags of heroin and two bags of crack cocaine a day. However, several of the interviewees were on methadone prescriptions or reported having reduced their drug use by themselves. All of those who were taking medication reported some substance use on top of their prescription, often crack and alcohol. However, generally they also reported having reduced the amount of 'sex work' they did as their illicit drug consumption had decreased.

The women in the sample all reported working on the streets to get money for their drugs and many made it clear that this was the reason that they became involved in prostitution, with some describing the amount of drugs they used depending on how much they earned from selling sex. Nevertheless, six of the women indicated that they became involved in prostitution for other reasons, even if they were using drugs at the time. One woman described how she started to engage in prostitution when she was made homeless and, without a job or welfare benefits, had to find £25 for a hostel bed. She clearly illustrated the way involvement in prostitution can exacerbate drug use and vice versa, saying:

> *… 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. [WM-7]*

Similarly, another woman whose involvement in prostitution was not initially related to drug use said that it became so as she always used drugs heavily after being with a client. Drug markets and women involved in street prostitution also tend to share the same geographical space, and several of the women described how dealers would seek them out, which made it very hard to avoid using. For example:

> *We come out and we'll get us a number … and we'll see a dealer and it'll be in our face and it's a vicious circle coming out here and that's all it is. [Y-7]*

> *… dealers hassling and ringing me all the time. Always seeing associates who want to score … [Y-10]*

However, although there was a strong relationship between substance use and involvement in prostitution, some of the women saw other reasons for working. For example, one woman said in response to the question about why she engaged in prostitution:

It's about the money, even when I'm not using drugs I still need to go out and buy stuff and a McDonalds or something ... It's just having something to show for at the end of the week. [Y-5]

She also pointed to the way it provided a social network for her:

… it's about getting out and doing something, about associating with people … [Y-5]

Another woman saw involvement in prostitution as a better alternative to crime to fund her drug use:

I've got a little boy see, and before that I got involved in fraud and deception, and then I was shoplifting, and I got into trouble and I had a chance of being sent down so I had to look at different ways of making money. [Y-4]

3.2 Impact of substance use problems and involvement in prostitution

Key findings:

- Involvement in prostitution and substance use have a major impact on women's self-esteem, with women feeling worthless, ashamed and guilty.
- The stigma of involvement in prostitution is felt even more keenly than that of drug use, and this exacerbates the social exclusion experienced by these women.
- Violence is a common experience and can be extreme, with consequences for physical and mental health.

A major consequence of their lifestyle for the women interviewed was the damage to their perception of themselves. The words they commonly used to describe how they felt about themselves were: ashamed, guilty, dirty, worthless, self-loathing. One woman explained that she felt she was 'in the gutter and deserved to be there' [WM-9]. Another said:

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. [Y-7]

Two of the women spoke of having gone beyond such feelings, one saying she feels 'numb' now and considers it 'just a way of life' [Y-5], and another that she viewed it as 'just a job' [Y-8]. Unsurprisingly, several of the women mentioned experiencing mental health problems, including depression, anxiety and feeling suicidal, alongside the physical health consequences of heavy drug and alcohol problems.

While many people with drug problems have similar issues, it was clear that the additional stigma from being involved in prostitution weighed even more heavily on them; while most women had told their families about their drug use, many were concealing their prostitution. This exacerbated the social exclusion that often accompanies problematic drug use, as it could lead to them cutting themselves off from family support. One woman explained:

… they don't know I do it, but they know I'm up to something – I've had to lie to them and say I'm doing a cleaning job and I can't get over to see them because they're in [town]. … I feel guilty. So I never get to see them. [Y-7]

Interviewees also reported difficulties with employment resulting from their substance misuse, as well as a lack of education and qualifications, and the impact of having a criminal record.

Violence was a particular issue for most of the women interviewed and in some instances was extreme. In some cases this included violence from a partner, but more often this involved violence from a customer or 'punter', such as rape, being 'smacked about' and threatened. 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. [Y-15]*

Such experiences will have a huge impact on the women's physical and mental health, and drugs and alcohol will often be used to counteract the effects.

3.3 Support needs and reasons for accessing services

Key findings:

- The women gave a range of reasons for accessing services but in most cases there was a feeling that they had had enough, either because of health issues, a specific incident, or because they simply felt they could not go on in the same way.
- Pregnancy or concern for their children was a reason for accessing services for about half of the women interviewed.
- Support needs are very varied, ranging from short term basic support, harm reduction and treatment need, to longer term support to help maintain progress and recovery.
- Housing was a particular concern for many of the women interviewed.
- In addition to drug treatment, many of the women have mental health issues for which they need ongoing support.
- To sustain longer-term change women need support to establish a new social circle and to access alternative activities, as well as education and support to obtain employment.

In the interviews, women were asked why they accessed services and in discussing this, their lifestyle and their experiences of services, they revealed a wide range of needs as well as the motivations for seeking to change.

In many cases the women talked of having reached a point where they realised they needed to change. Sometimes this was because their drug use and/or prostitution was having a major effect on their physical or mental health, for example:

> *I had problems with my breathing which was caused by the crack, it had caused me to have fluid in my lungs, and caused my breathing to be really bad. It got to the stage where I had to move out of the flat I was living in because I couldn't even get up one flight of stairs – they had to move me to one without stairs because my breathing was that bad. [WM-9]*

> *I saw someone from the [name] project who was in a car. They gave me a sandwich and left me a phone number and some condoms and then I was feeling really bad going down and doing prostitution and that's when I called them up feeling suicidal. That's when I asked for help. [Y-3]*

For others it seemed that there was no specific reason but rather they had got to a point where they felt they had had enough:

> *Sick of the drugs – same shit, different day. I'd had enough. [Y-8]*

> *Just wanted it to end, it wasn't where I belonged. [Y-9]*

Children played a part in the decision to access services for almost half of those interviewed. Two women said they had sought help when they had become pregnant and others accessed services because they wanted to be able to have access to their children or because they felt they owed it to them:

> *I'm getting too old now and I've got kids and that's what has changed [Y-5]*

Many of the women had been accessing services on and off for many years. These ranged from harm reduction services, such as needle exchanges and the provision of condoms and sexual health checks, to more structured treatment provision and wider social support to address a wide range of needs.

Services, and in particular sex work services, had addressed basic needs such as food and access to benefits. They also helped with a rape case for one woman and a domestic violence incident for another, helping her to access a safe house.

Housing is a major issue for this group of women and almost half of those interviewed mentioned either receiving or needing help with a housing issue, either short term or longer term. For example:

> *They've been fantastic. I'm really lucky to have had them around at some points or I wouldn't have a roof over my head some nights. [WM-7]*

The long term nature of the problem is illustrated by another interviewee who explained she wanted 'secure housing' because she was in constant fear of her children being taken away from her if she loses her house. This can also have an impact on access to treatment:

> *I've got a friend who wants me to go into rehab because of my drinking and I took it to extremes but I'm not sure it'd help because then I'll come back and I'd have to get a new place and everything. I'm just getting settled where I am and there are people I know and trust and I'm back in an area where I feel at home and feel safe again. I don't want to jeopardise that by going to a rehab and my landlord giving a place up to someone else because I'm not there. [WM-8]*

Another issue raised in many interviews was the importance of developing a new social circle and having meaningful activities. As one interviewee said:

> *… if I was still living with anyone who was using then I'd still be working, but I moved away from the area and I moved away from people I used to associate with, those I'd go out with, go work with, go buy drugs with - I cut everybody off and moved away. [WM-9]*

Some services were reported as having provided a drop-in centre which was valued by several of the survey participants as it provided an opportunity to socialise 'like normal people'. Having opportunities to socialise with new people was mentioned as being important for making changes to their lives; having been involved in substance use and prostitution for so many years, all of their acquaintances were in the same situation:

> *I haven't got a social life. I haven't got any friends apart from out here and I wouldn't call them friends, I'd call them acquaintances. When I've been at home for two weeks, no one will ring me but they'll come up to me when I'm down here. [Y-7]*

As well as people to socialise with, participants talked about the need to 'have other things in place, activities to do'. For example, in answer to what she would like to achieve in the long run, one of the participants replied:

> *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 … Education I mentioned because I've got no qualifications so how am I supposed to get a job. I've got a criminal record now so how is that going to impact on what I can do now or in the future? [Y-4]*

In addition to healthcare for the physical health problems associated with drug use and prostitution, the mental health problems discussed earlier clearly also need to be addressed. One interviewee felt she was not ready to give up alcohol fully as she gets panic attacks and problems with flashbacks relating to events in the past, which become worse if she doesn't drink. Others reported needing help for suicidal feelings and dealing with the aftermath of extreme violence or the impact of withdrawal from drug use:

> *I need help with the mental rehabilitation side of things. It's not just the getting clean, that's the difficult bit. That's difficult but in the scheme of things I've got clean billions of times and I've always gone back. It's about maintaining - the stability. [WM-7]*

3.4 Barriers to service use and negative experiences

Key findings:

- Individual barriers to accessing services include:
  - Self-esteem/belief that change is possible
  - Stigma attached to drug use and involvement in prostitution
  - The situation in which many of the women continue to live
- Organisational barriers include:
  - Service hours of operation, long waits for methadone scripts, short appointments, inflexible procedures, lack of childcare and geographical location of services
  - Difficulties with keyworkers, including lack of consistency which can affect rapport and trust, stigmatising staff attitudes and disparities in gender and age
  - Lack of wider support and aftercare/ongoing support

In the interviews, women were asked about their experience of services - both substance misuse services and services providing support to women involved in prostitution - and about issues that made it difficult for them to engage with services and make changes to their lives. The evidence review for this project suggested barriers could be divided into individual or personal barriers and service or organisational barriers, and both types were also highlighted in the interviews.

3.4.1 Individual barriers

As described above, the women interviewed had very low self-esteem and this had an impact on their 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. [Y-2]*

This may have an effect on women's motivation levels and, in addition, drugs are often the way they habitually cope with stress and 'black things out', so the tendency to relapse is strong. While getting treatment for drug use was often seen as the key to stopping

involvement in prostitution, women may continue to work to provide money for other things, and this:

> *… makes it harder - doing things with men that you wouldn't normally do means you need to do something to blot that out. [WM-7]*

The stigma surrounding involvement in prostitution may also provide a barrier to help-seeking, and some interviewees were reluctant to disclose their prostitution to keyworkers. The complexity and entrenched nature of their drug use and involvement in prostitution adds to this:

> *… it's down to the mental side of things that I've just got into that habit for so long, and it's not easy to step out of it once you've been doing it for 14, 15, 16 years. It's not easy to get out of that cycle, beat the habit, because it's like a comfort. [WM-7]*

Another issue is that the women are 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. Over half the women interviewed mentioned this sort of thing as a barrier to change, whether from dealers, partners, friends or acquaintances encouraging them to continue using drugs, or from clients or previous clients, or the need for cash encouraging them to continue working:

> *… punters who see you and pull up and ask if you're working makes things difficult [WM-4]*

> *… if you're still going around the same town and going to the same places to get your scripts and seeing the same faces then it's really hard to stop yourself going round in circles. [Y-3]*

> *There's always that thing where, if I need some cash, I can just go work at my local place. [Y-4]*

In the previous section, the role becoming pregnant or concern for children had in encouraging women to seek help was highlighted. However, in some cases they may prove a barrier to recovery. Two interviewees reported that they had lost access to their children despite complying with drug treatment, which then led to relapse. One interviewee who had sought help after her children were taken into care was told that if she stopped using heroin and came off methadone she would get her children back. She did this, but the children were still given for adoption, so she started using again. Three other women were avoiding accessing services or acknowledging relapses because they were afraid their children might be taken into care.

3.4.2 Organisational barriers

The interviewees highlighted a number of organisational issues that they felt posed barriers to service use or made it difficult for them to successfully change their lives. Two interviewees felt that the time taken to obtain a methadone prescription when they accessed drug treatment was too long, and that this encouraged drop out as motivation waned. Three people commented on the very short length of the appointments provided at a drug service, which in one area had reduced dramatically following a change in the organisation delivering the service. They felt these did not provide enough time for considering the issues they experience or the reasons underpinning their use of drugs and identifying support needs. For example:

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. [Y-3]

Another issue raised by several interviewees was service hours of opening. The need for 24-hour access to support when they were going through a bad patch and struggling not to return to their previous habits, and also to access clean needles were mentioned:

Drug taking doesn't stop at 6pm at night … if you're rattling you need one there and then.' [WM-8].

Several women also talked about the need for services to have some provision for childcare or to take account of the needs of those women with childcare responsibilities when making appointments.

I'm struggling at the minute to get childcare to go to a programme and work on myself and stuff – I think they could help a bit more with that. There isn't enough help for women, especially ones who are single parents with kids. [Y-9]

The location of the service was mentioned by a few women as being problematic. There is a trade-off between being accessible to the women by being located near where they work so they can access it 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.

I had a bit of a problem with the location – well, it wasn't really the location, more letting the people hover outside and it could be a bit intimidating especially if you wanted to get off the drugs or keeping to a script, and they're tapping you up or asking you to score. [Y-3]

Another issue raised by several women was the inflexibility of some services in respect of dealing with missed appointments, which posed problems for people living chaotic lives. One woman reported she had tried to access treatment but was thrown off her methadone script straight away 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' [WM-3]. Similarly:

I think they were a bit hard … if you didn't keep to appointments which, you know, I was really unmanageable, and it's hard to keep to appointments, it's all about your drug use and getting it and if you're rattling you can't make it anywhere or if I reacted after missing my prescription and trying to pick it up and the chemist said I was being aggressive – I'd react to that because maybe it wasn't true and then they'd ban me from getting a script. [Y-3]

I don't know about anyone else but I'm mightily confused when I've got 101 appointments to be here, there and everywhere, and I mix them up. [WM-8]

However, on the other hand one woman felt that services were far too lenient and should be tougher on people if they used drugs on top of their script. There was also recognition by many of the women that they could be difficult to help. This can make it even more important that time is taken to listen to them to identify their wide-ranging problems. As one woman who had serious mental health problems and a long history of serious abuse described:

Because I've got problems they say they can't get through to me but that's because (inaudible) … They don't spend enough time … they want to make decisions for you …

You aren't in the right frame of mind. I'm 32 … years old and I might be mental in the head but I still know what's what. [Y5]

The most commonly raised group of issues concerned keyworkers, particularly in drug services. Given the very negative self-perceptions highlighted above and the stigma around drug use and, in particular, prostitution, it is not surprising that many of the women interviewed found it difficult to establish a rapport with their keyworker. Many women chose not to disclose their involvement in prostitution to drug services and 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 the women have, it is nevertheless clearly damaging to the therapeutic relationship. It is also the case that some of the women had had quite negative experiences of care. For example:

With this pregnancy, the keyworker I had through that was crap. He didn't turn up to any of the called group meetings at all, even though he was working on the days they were going on. He sent a piece of paper through to the meeting with a list of 20 missed appointments, right. None of them had been sent out to me or given to me, so I hadn't missed them, they just hadn't been given out to me. I collared him about it and he said, oh no, that's just the automated system – so I asked him what did you submit them for ... He said they were asked for and they weren't even asked for … he's just not helping, he's a derogatory factor, and it could be because of him that I lose contact with my son. [WM-7]

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 keyworker much younger than themselves:

… especially now that I've got a bit older and I'm sitting with someone who might be 10 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. [Y-4]

It is important to note that some women had had excellent support from keyworkers, which will be considered in more detail in the next section. However, issues such as disparity in gender and age are likely to make it more difficult for any keyworker to establish a good therapeutic relationship with women like those interviewed who have complex and entrenched problems requiring a high level of ongoing support.

Another concern mentioned by several participants was that of having frequent changes in keyworker. For this group of women, who have very negative self-perceptions, it is particularly difficult to open up and discuss issues about which they are deeply ashamed, so it takes time for them to develop the trust necessary to do so. Having to frequently repeat the process can impede progress.

In the interviews, women were asked about the services they received and also services or support they felt were needed. An issue that was raised time and time again was a perceived absence of any support beyond a script (although initially a script was often the main thing they were seeking):

… helpful at giving me a script but nothing else, no other support. [Y-10]

I expected support – but I didn't get what I expected really. I got medication to substitute my using, but I didn't get any support for my lifestyle and my little girl … They didn't really ask me about the prostitution. [Y-2]

…it's really hard to stop yourself from going around in circles, with no moving on help available when you have stopped the drugs to get involved with voluntary work, to get into college – there's no moving on support if you did get clean. [Y-3]

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. [Y-4]

In addition to the lack of support to address their lifestyle and help to move on, several women highlighted the gap in ongoing support and aftercare to help them maintain a substance-free lifestyle and stay off the streets, which given the longstanding and entrenched nature of most of the women's problems is a significant issue:

I've noticed with [service] that once you're off the drugs they take you off the books and if you're feeling at a low point again you can't access as easily as you can when you have a keyworker … sometimes you do get those days where, you know … if you've got somebody to talk to, you can say today I feel like doing this and then you can discuss why that might be so and what you can do about it. [WM-8]

3.5 Positive experiences and effective interventions

Key findings:

- Positive aspects of services include:
  - Measures that increase accessibility e.g. outreach services, a flexible approach, drop-in access and telephone support
  - Involvement of peers e.g. as keyworkers, mentors, etc.
  - Staff understanding of the specific needs of these women
  - A non-judgmental and empathetic approach from staff
  - Integrated provision or strong case management to cater for all needs

Within the interviews many women highlighted positive experiences within support and treatment services. These provide an insight into the factors that may be necessary for interventions to be effective at helping women involved in prostitution recover and change their lives. Many of these are the flipside of the barriers and problems highlighted in the previous section.

Some women commented positively on the speed with which they were given a script:

I got a script from [service] – I got it in two days instead of a week. Normally sometimes you have to wait up to two weeks. It's important that they do both because it reduces the stress. [Y-5]

Others pointed to their flexibility:

… if I want an appointment, they do it around me, if you know what I mean. They'll ask me if this time's alright because of contact with my kids and stuff. [WM-2]

Quite a lot of the women interviewed found outreach and the one-to-one support available from staff around the clock by telephone, mainly in services supporting women involved in prostitution, extremely valuable. For example:

… When you're sitting at home going through a bad patch and twiddling your thumbs, and you don't know what to do with yourself it's nice to be able to pick up the phone

and speak to someone just to take your mind off things at that time … Because with crack it's all in the mind, it doesn't physically affect you as such, it's more mentally addictive, if you're putting your mind onto something else and focusing on something else, it takes your mind off the initial thought about wanting the drugs that you need. [WM-9]

The very wide range of support that they received was also important:

It's because they deal with a wide range of things – [sex work service] is for working girls, it's for a wide range of stuff, and they also help with drug problems. They can get you to relevant places and sort out relevant things for you … when you're working obviously you need to be checked and stuff, so you go see the nurse for regular checks and plus if I had anything with drugs or anything like that, [name] would sort it out … [service] dealt with a rape case, and also my housing – when I moved to [town] I had housing problems and I had to stay in a hostel… [WM-9]

Several of the women commented positively on particular keyworkers or staff in services who they had found particularly supportive:

The keyworker I've got is brilliant – they make a big difference. [Y-8]

… the people working for them are very down to earth and they're on a level so it feels like you forget that you're out with a keyworker, it's like you are out with a mate and they just listen and they've got access to all the right people and all the right places that needs accessing. [WM-7]

The women were also asked directly if they considered it important that the staff in the services 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 people said that they thought that it was because '… how can people give you advice if they haven't lived that life?' [WM-4]. The role peer support can play in addressing the double stigma felt by some women as a result of using drugs and being involved in prostitution was also highlighted. 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. [Y-10]

However, others suggested that it wasn't that important as long as the staff member had the right attitude:

That's never really bothered me, if I'm honest. When I was at the hostel my support worker was younger than me – somebody like 10 years younger than me at the time but it didn't bother me. The lady at [drug service] was a lot younger than me, but it really it doesn't matter because obviously they're trained to do that. At the end of the day, they're here to help. [WM-9]

… 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. [Y-3]

Another aspect of peer support that participants mentioned was as positive examples to provide motivation and encouragement that lasting change is possible:

You can talk to people or mix with other people who are trying to exit as well, so it gives you motivation. [WM-9]

Another aspect of services investigated during the interviews was whether women felt it was better to have a single integrated service dealing with both 'sex work' and drug use issues or whether they should remain separate. The majority favoured some integration, for a variety of reasons. Some felt it would be easier and more efficient and would save having to go over the same ground with people in the different 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.

Most girls out on the streets now are also using drugs. It would be a lot easier if people could talk openly and honestly about both in one session rather than talking to one person about their drug taking and then another person about working on the streets. It would be better to talk about both of them in one go rather than going through the same things twice to two different organisations who have to come together to discuss it anyway. Why not just have one group of people you can talk to? It saves time ... It would be so much easier as you wouldn't have to get used to one set of people in one place, and one set of people in the other. [WM-8]

I think it's helpful, yeah. You get used to the one person or the few people, you build a better relationship with them and therefore you listen more to what they say. When they say they care you can believe it. [WM-7]

Some other women felt that the services should be kept separate. However, this does not preclude close working to facilitate access to treatment. A couple of interviewees commented positively on a previous arrangement, now stopped, in which a worker from the drug treatment service attended the sex work service drop-in so that women who might want to access drug treatment were able to do so. They liked the fact that the keyworker was at drop-in – they didn't get pressured to access treatment, but chose to.

3.6 The role of family members

Key findings:

- Children were central to interviewees' aspirations for a better life; they were often a key driver for help-seeking.
- On the other hand, fear of having children removed from their care sometimes acted as a barrier to help-seeking, and losing their children could cement negative self perceptions and make efforts to change seem pointless.
- Partners and wider families are an important influence, which may be either positive or negative.
- The support of partners and other family members to their efforts to change was often highly valued by the women interviewed.
- However, very little support was reported for these family members despite the impact the women's lifestyle had on them.
- The double stigma of involvement in prostitution and drug use can make it particularly difficult for them to seek help. Although some women reported concealing their prostitution from their families, several indicated that they thought they knew really.

In the interviews, women were asked specific questions about their partners and other family members, including whether they knew about the women's drug use and involvement in prostitution and how they felt about it. In addition, they were sometimes mentioned spontaneously in answer to other questions, particularly children and partners. As would be

expected, the relationships varied enormously and could have both positive and negative effects.

3.6.1 Children

The central role that children play both as a motivation to tackle their problems and as a source of guilt when they do not has been highlighted above. Having a nice home and being a good parent was also central to the aspirations for the future of over half the women interviewed.

The negative impact on progress when they lose their children was also made very clear. There are difficult safeguarding issues to be considered but the way these are handled is important as well. The sense of hopelessness that is engendered when women work hard to comply with requirements only to have their children removed anyway reinforces all their negative self-perceptions and may put recovery beyond reach.

3.6.2 Partners

Most of the women who took part in the study were living with partners and their influence could be both positive and negative. Most, but not all, were also drug users themselves. Although some of the relationships were clearly abusive and contributed to the women's on-going drug use and involvement in prostitution, this was less than half of the cases, although some other women reported negative experiences with former partners. Examples of these negative experiences include:

> *When I first started at the age of 15 – it was actually a guy who got me into it and got me into the working, got me into the drugs. Once I got away from him a year later I got a lot more independent. [WM-9]*

> *He's manipulated and scared me into going down and working the beat and using scare tactics to get the money off me when I'd got the money. [Y-3]*

> *He doesn't like me doing it, but he can't get hold of the drugs and the money quick enough so it's one of them, he's a hypocrite … [Y-5]*

However, more women described the positive support they had from partners, whether they were drug users themselves or not. Where the partner was a drug user also, several women indicated that they gave up drug use together or their partner tried not to influence them to use when they did. For example:

> *He has his habit back - but he is on it. He won't use in the same room as me so there is no pressure to use from him. [WM-1]*

> *I went to the services with my ex-husband, he used to come with me. [Y-9]*

> *He was happy, he stopped himself, because you know, if he was doing it, I would want to but yeah, he stopped. [WM-2]*

Another woman reported how her partner, a former user, was very supportive of her drug service meetings and makes sure she attends them at times when she is feeling low and wavering about going. For another woman, developing a relationship with a non-using partner helped maintain her recovery:

> *I did it [gave up drugs] before I met him. I was still in the process of coming completely out of it. I wasn't dabbling anymore – I hadn't dabbled for eight months when I met him but I was still going through the procedure where you're going*

through the rough patch and you're not sure where you're going to dabble or not. But I didn't and I've never done it since. [WM-9]

3.6.3 Wider family

The interview included questions on the impact of the women's lifestyle on their families and whether the family members had received any help or support themselves. In discussing their wider families, the women interviewed mainly talked about parents and brothers and sisters. Most of the women reported that they were still in touch with their families and that they knew about their problems, at least about their drug problems. However, the shame that they feltl meant that they would sometimes conceal it or not talk about it. This was particularly the case around involvement in prostitution, with several women reporting that their families did not know about their sex work:

My mother will never know what I do. [WM-3]

My family has always known that I've been involved in prostitution, and I feel very ashamed because of my mum and family. I tell them that I'm no longer involved in prostitution. I only do it once a week, I don't go looking for it … they find me. [Y-1]

This concealment may cut them off from a valuable source of support:

I wouldn't want to go to my family because they don't know anything about it … well, they might have an idea that I use, but I certainly haven't admitted it to them, but I wouldn't go and ask anything from them. [Y-4]

Many of the women reported that their family members were supportive of them - '… they just want the best for me' [WM-2]; 'My family are standing by me' [Y-6] – and encouraged them to tackle their drug problems. Two of the interviewees said that their mothers sometimes came to services with them. The positive feedback they received when they sought help was clearly valued: 'Mum and Dad were made up' [WM-5]; 'They were over the moon. They're loving it' [WM-9]. For some women the support of their family was seen as essential to their recovery:

[The support needed is] my family, and they're there so I'll get there. [Y-6]

However, the flipside of this is that the women may be ashamed to own up to their families if they relapse because of the disappointment this would cause, which may cut them off from support at that vital time. This was the case for two of the women interviewed.
While most of the women interviewed suggested that their families were supportive of them, there were three cases where the families appeared to play a negative role. In one case a substance-using brother was sometimes violent and came round trying to get money out of her for his drinking. In two others, the family was seen as a negative influence and not providing help. In one of these the woman had herself been taken into care as a young child and said she had no feelings for her family. In only four cases did the woman report having other family members with substance use problems.

The impact on their families was recognised by the women: 'I've put my mum through a lot.' [Y-3]. One woman said her parents were devastated when she relapsed but her father had told her he was so pleased I'd made it to 31 because he thought I'd be dead by 25' [WM-7], giving an indication of the distress experienced by families. However, most women, when asked, said that their families had not been offered any support. Only three women said their families had been offered support.

3.7 Aspirations and hopes for the future

At the end of the interview, participants were asked how they would like their lives to be in the future. The word 'normal' was often used in this section, and here and throughout the interviews, the idea of moving and a fresh start was also often raised. However, the most common hopes mentioned involved children, as mentioned above, and to be substance-free, which were each mentioned by over half the women interviewed. Many also mentioned wanting a job and a nice house or home. A typical response was:

> *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. [Y-4]*

4 Service provider survey and site visits

Overview
Most of the services that responded to our online survey reported proactively seeking to engage with women who are involved in substance misuse and prostitution. However, when asked about specific 'good practice' measures, the picture became less positive.

Half of services or less indicated that they used approaches such as evening opening, outreach and special sessions. Only about a quarter said they had special sessions for this group of women or provided support around children and pregnancy.

A key issue for women involved in prostitution and substance use is social support from people who understand their issues. However, the provision of women-only spaces is limited and although peer support is quite widely available, women-only peer support cannot always be accessed, which can be problematic for this group of women. It also means this is not, strictly speaking, peer support.

Many of the services surveyed drew links between women's involvement in prostitution and substance use and experiences of violence. However, provision to deal with domestic and sexual violence was mostly by referral. Provision of wider support, including support with housing and education and employment support, was also generally provided through referrals and signposting to other services rather than being available in-house.

Through an online survey , follow-up telephone interviews and observational site visits – which included interviews with staff and service users – this study sought to determine what services are currently available that are designed to meet the needs of women involved in prostitution and substance use.

An online questionnaire was distributed to support services nationally, with a focus on ensuring high response rates in the two National Treatment Agency (NTA) regions in which the peer researchers conducted qualitative interviews: the West Midlands and Yorkshire and the Humber. A total of 64 valid[2] responses were received, including 17 responses from service providers in the West Midlands and 10 responses from providers in Yorkshire. The questionnaire was most frequently completed by service managers (n=29), with responses next most commonly received from keyworkers (n=12) and team leaders (n=9). The majority of respondents were based in substance misuse services (n=46), with responses also received from sex work or exiting prostitution projects (n=12), women's community projects (n=2) and four other related services.

Telephone interviews were then conducted with four survey respondents who agreed to participate in a follow-up interview, including two in the cities where peer interviews were conducted and two in other cities. Finally, we conducted observational site visits to six providers in the two areas where the peer interviews were conducted. These were identified through the online survey and the peer interviews. Services that agreed to a follow-up telephone interview or to a site visit were provided with information sheets about the research project, and were asked to sign consent forms (see Appendices).

4.1 Accessibility and appropriateness of services

Questionnaire respondents were asked what proportion of their clients in the past year were women who exchange sex for something they want or need and who use substances

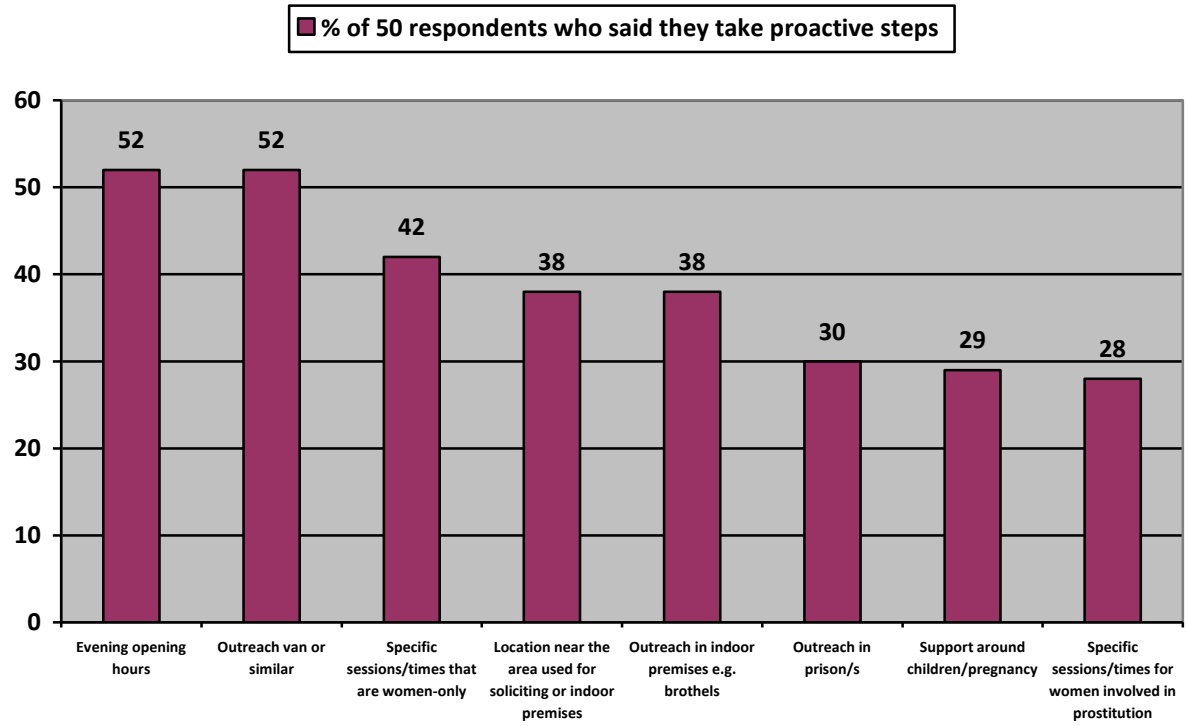
[2] A further 28 respondents agreed to participate in the questionnaire but did not answer any further questions and so were excluded from the analysis.

problematically. The responses to this question ranged from 0 to 100%. While the average proportion of service users represented by this client group was a quarter (25%), the median response was 5%, indicating that most of the services responding to the survey were not services with a special focus on this group. When substance misuse services only are considered, and on the basis of self-reported information from services, this client group represented 11% of their service users on average, with a median response of 3%. Respondents based in these services were more likely to report that they felt that this client group was under-represented in their service (n=26, 58% of 45[3] substance misuse service respondents did so), compared with 46% of respondents overall. Ten respondents reported that they didn't know whether these clients were properly represented in their services, with eight of these respondents being substance misuse services.

The vast majority of respondents (50 of 63 who answered the question; 79%) believed that they take proactive steps to ensure that their service is accessible to women involved in prostitution who use substances. There was no significant difference between substance misuse and other types of services in response to this question. However, when those services that said they take proactive steps were asked about specific steps (steps identified as good practice in the evidence review – see Figure 1, below), positive responses were low:

- only half of respondents provided evening open hours and/or outreach services;
- less than half of respondents provided women-only spaces; and
- less than a third provided sessions that are specific for this client group.

Figure 1: Proactive steps taken by those services who report specific attempts to engage this group.



Some respondents gave further details of the steps they take in an effort to be inclusive of this client group:

[3] 1 respondent did not answer this question.

We have a female sex working women's only GUM/Family Planning Clinic and substitute prescribing clinic – Service manager, sex work project, West Midlands

Evening outreach weekdays, currently expanding to cover early morning and weekends – Service manager, sex work project, West Midlands

Drop-in provision at a different venue to main services – Service manager, drug and alcohol service, South West England

We are just starting to do evening outreach in the red light district – Keyworker, drug service, South West England

We provide a Needle Exchange Bus which is currently doing targeted pieces of work to engage more women caught up in prostitution – Service manager, drug service, London

However, for several of these responses it was unclear how the support provided was specific to this client group and differed from the treatment that all service users would receive:

24/7 helpline admissions team experienced in working with vulnerable women so can ask questions tactfully and sensitively – Service manager, drug service, London

Not open regularly in evenings, however evening appointments are available and are offered if a woman is unable to/struggling to access the service during opening hours – Service manager, sex work project, South East England

In site visits, specialist sex work and women's community projects were particularly likely to raise the importance of women-only spaces. However, there may be benefits to including some mixed gender provision:

We are a very female-orientated project, but there are a couple of men that we have that are positive role models basically. And we try and encourage that. Actually, all men aren't bastards – Sex work and substance misuse project, West Midlands.

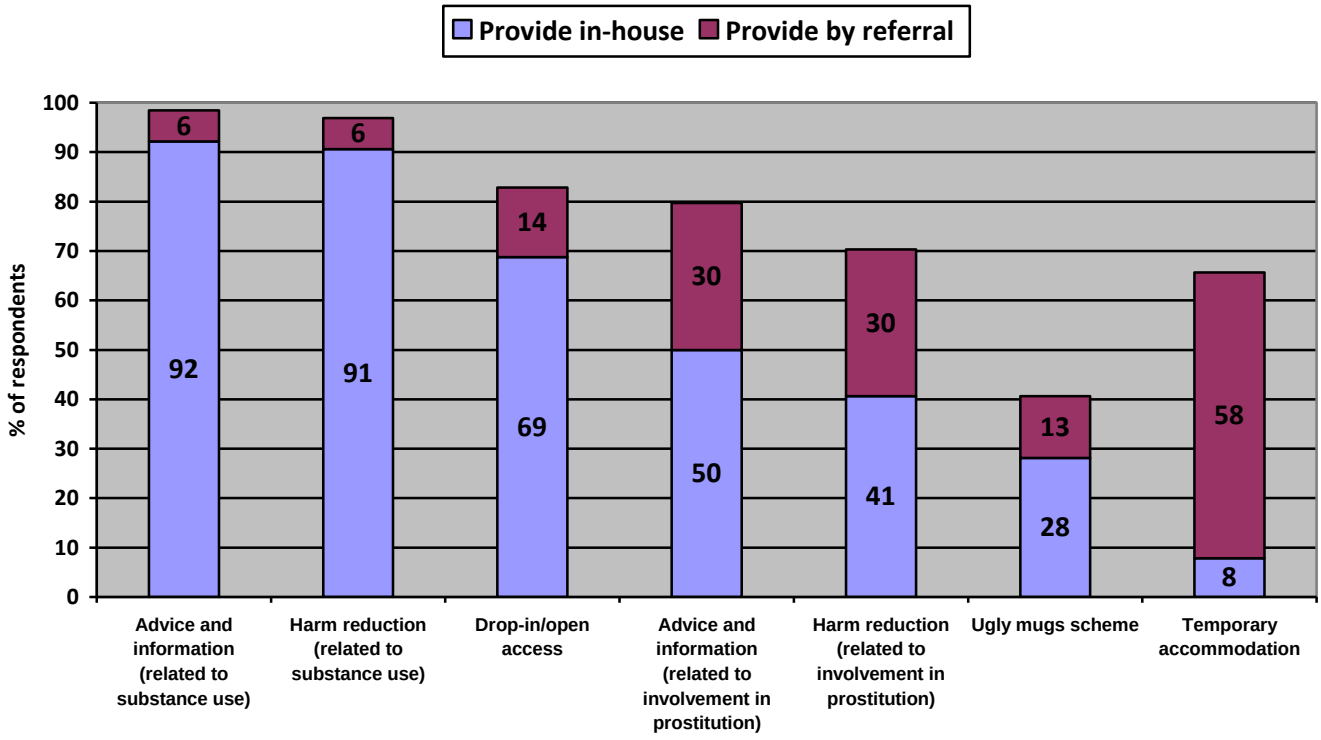
4.2 Nature of the support provided

Service providers were asked about the interventions they provide for this client group, discussed below with reference to the four broad types of support identified by Kurtz et al (2005).

4.2.1 Basic physical needs

Questionnaire respondents were overwhelmingly positive about the need to provide support related to involvement in prostitution within substance misuse services, with 41 (79%) agreeing or strongly agreeing with this. Substance misuse services appeared particularly supportive, with 47% (17 of 36) strongly agreeing with this statement, compared to just 25% of other providers who strongly agreed with this. However, this in-principle support contrasted sharply with current provision within services as shown in Figure 2.

Figure 2: Proportion of services providing different types of help to address basic needs



Only half of respondents reported that they currently provided advice and information around prostitution within their services, including just 13 of 46 (28%) substance misuse services. Even fewer respondents reported providing harm reduction related to prostitution (41% overall, 30% of substance misuse services).These low levels of support around basic needs relevant to prostitution within drug services contrasted with relatively high levels of support around substance misuse available within sex work, exiting and women's community projects. 13 out of 14 sex work, exiting and women's community projects reported providing advice and information around substance use in-house, as well as harm reduction advice related to substance use.

The evidence review indicated the importance of low-threshold services for this group of women, and encouragingly drop-in or open access support was widely available across the whole sample (n=44, 69%). Again, though, it was more prevalent in sex work, exiting and women's community projects (12 of 14 providers).

In one of the site visit interviews, a Team Leader in a drug service in the West Midlands expanded on this issue:

> *There may not be as much of a proactive approach [from services generally] with these women insofar as going out and engaging with these women – too much of an expectation that they will willingly come to you … with women in the sex industry it's more about engaging with them rather than expecting them to come to us.*

This view was supported by an NHS-funded sex work and substance misuse service in the West Midlands. A worker there described her experiences previously of working with a community drug team and attempting to engage women involved in street-based prostitution, and the contrast to the service she provides now:

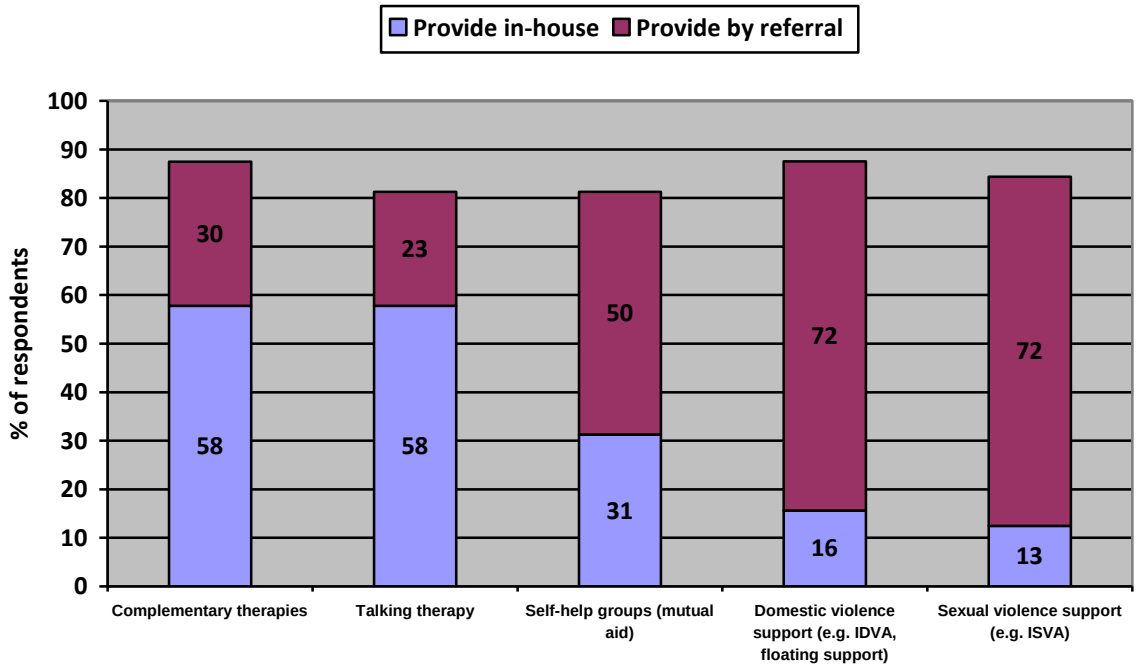
There were a lot of girls around there that we tried to work with, but they just could not grasp the structure of a community drug team. Because it worked for a lot of clients … but not for the girls. One of them used to turn up at five to six every day. I mean, we're locking the door. She couldn't grasp the structure of 'you can only have one appointment every two or three weeks.' Whereas the girls who come in here chaotically, you know, they come in and they can come in three days a week. One, it develops structure into their lives. Two, it gives them a couple of hours out where they're not out there being abused or attacked or using or all of the stuff that goes on in their lives – NHS sex work and substance misuse service

4.2.2 Mental/emotional needs

In the interviews with women with substance use problems involved in prostitution undertaken as part of this project, the need for ongoing counselling and support, for companionship and support to replace their old social networks, as well as support with specific mental health issues, were all identified. The online survey for services asked about these different types of provision.

Talking and complementary therapies were said to be fairly widely available amongst providers who responded to the survey. Over half of services (58%) said they provided these services in-house and about a quarter said they were available on referral.

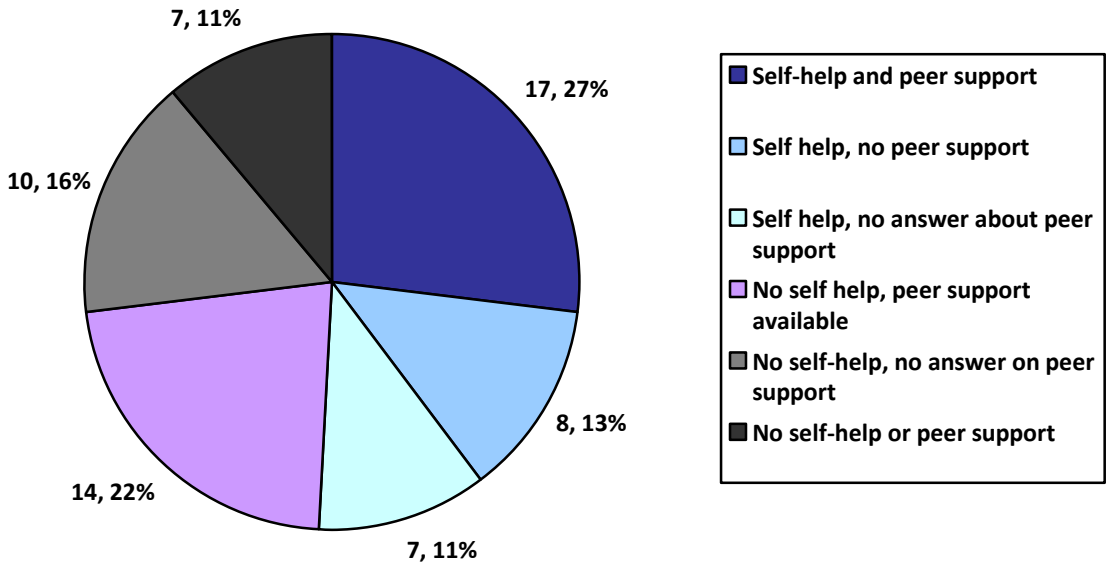
Figure 3: Proportion of services providing different types of help to address mental and emotional needs



Self-help and peer support

A third of respondents stated that they provide self-help groups (mutual aid) in-house, but respondents were also asked later in the questionnaire about the specific forms of peer support available. This revealed some potential variability in the interpretation of the term 'self-help groups (mutual aid)', since eight (13%) respondents indicated that they provide mutual aid but not peer support. In total, 73% of respondents (46 out of 63 providers who responded to this question) reported that they either provide self-help (mutual aid) and/or other forms of peer support.

Figure 4: Availability of self-help and peer support



The majority of providers were generally positive about peer support for this client group, with 36 of 49 (74%) stating that peer support was always or mostly positive:

> *Peer support for any type of recovery I feel is a really positive step. It is often a much more cathartic experience to talk problems over with someone who has direct experience – Substance misuse lead in community safety team, Yorkshire*

> *We are looking to expand this area currently with mentors. Women doing well often impact on those who are still chaotic, i.e., 'it is possible for me to do that' – Service manager, sex work project, West Midlands*

> *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 – Service manager, drug service, London*

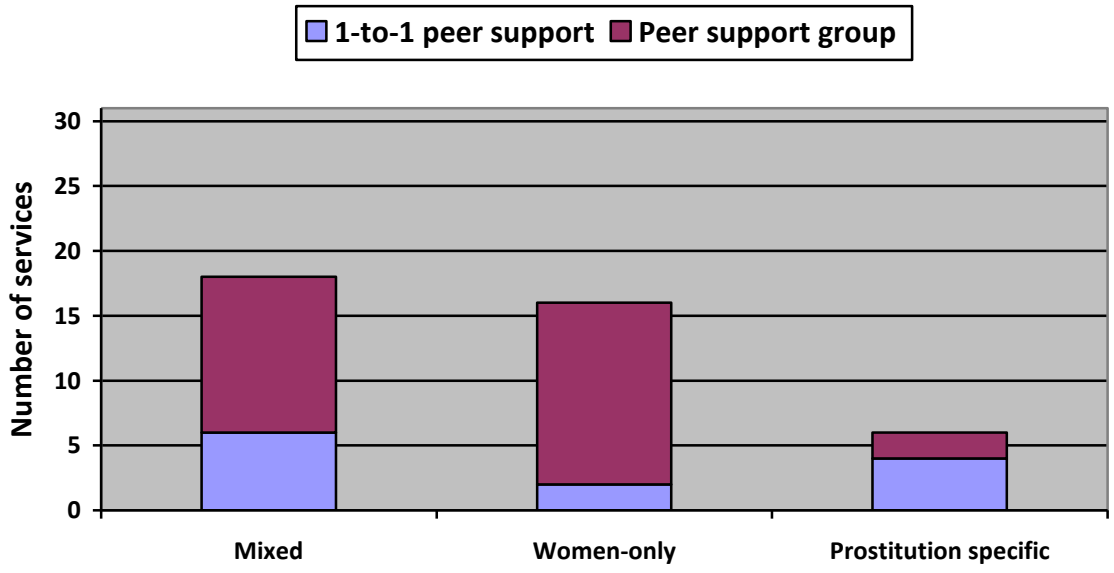
However, a significant minority stated a 'neutral' position on whether peer support was positive or not, or declined to answer the question and provided alternative answers:

> *The peer support model (in terms of recovery/abstinence/exiting) sets someone up as 'the success', the woman that everyone else has to look up to … The person who is 'the success' can never fail … What if they relapse, back into drug use, back into sex work? Who do they go to for support? – Service manager, sex work project, London*

> *I have seen it as a positive and negative. I have had concerns sometimes about the lack of training and supervision of peers and a lack of stability and distance from the peers' own issues. It can be detrimental to both parties – Service manager, drug service, East Midlands*

Peer support was widely available (n=31, 67%) amongst the providers surveyed and 19 of 46 (41%) providers reporting women-only peer support available, including six who provided this in groups or one-to-one that was specific to women involved in prostitution. However, substance misuse services were less likely than other services to have women-only peer support available, with 10 of 32 services (31%) providing this.

Figure 5: Availability of different types of peer support



During a site visit to a peer recovery project in Yorkshire, the coordinator of the women's group discussed 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.*

Another woman who was attending the women's group shared similar thoughts:

> *Even though I feel nice in mixed groups, with a women's group there is stuff I can talk about which I normally couldn't.*

These women's experiences of being less able to talk openly in mixed groups were in contrast to how men accessing the same service spoke:

> *I feel that because you are with people who are in the same circumstances, it makes it more relaxed, you can talk about your problem to someone that's going through it too. You can be very, very open and ask them anything.*

Further, a male group leader dismissed the idea of women needing a specific space to talk about relationship issues and abuse:

> *We wouldn't tackle gender-related abuse, but again it's not something – because the end result that we all want is a healthy lifestyle and that includes all issues. Past baggage, trauma, and there are specialists to deal with those particular issues.*

However, women-only peer support was not only valued by women for allowing them to talk openly, but also had a role in promoting women's safety in treatment. The women's group coordinator in this project also 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.*

Domestic and sexual violence support

While a high proportion of women interviewed by peer researchers identified experiences of violence and abuse, very few service providers surveyed indicated that support around these issues is provided in-house. Just 16% of providers had domestic violence services available, and only 13% had sexual violence services available in-house – and these were almost all sex work, exiting or women's community projects. In fact, only one substance misuse service – an NHS-based drug and alcohol service in Yorkshire – provided domestic and sexual violence services in-house.

A voluntary sector drug service we visited in the West Midlands suggested that it was more appropriate to address substance use first, and then provide support around domestic and sexual violence. However, this understanding of domestic and sexual violence support focused primarily on the psychological impacts of historical abuse, rather than an assessment of the health and safety risks posed by recent or ongoing abuse:

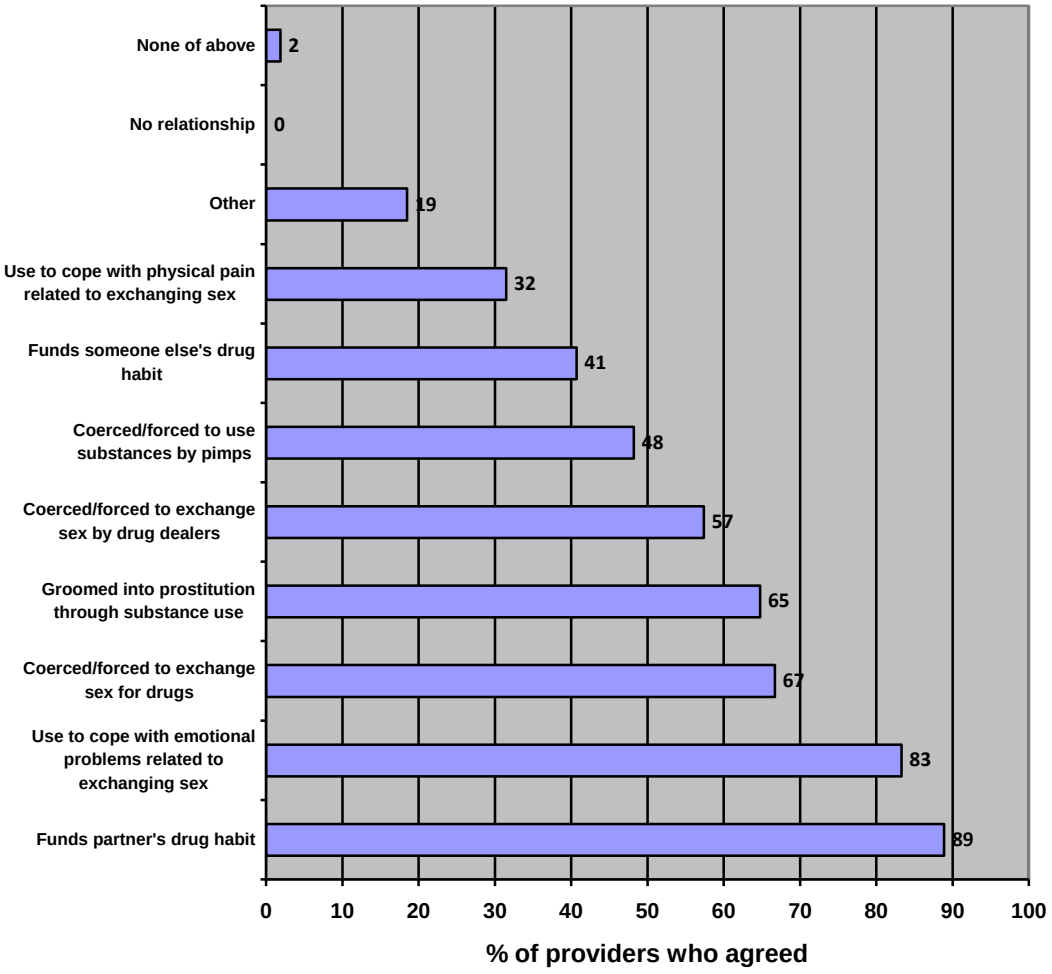
When we deal with those sort of issues, it can open up a can of worms … the way it works successfully is to say, do the full time programme and then part of aftercare, we will look into counselling. So you've actually dealt with and stabilised on your drug use … so you're feeling a bit confident and then when you're ready we can refer to counselling services. When you do it at the start, it sometimes doesn't work because your can of worms has just spilt out, you don't know how to deal with those feelings – voluntary sector drug service, West Midlands

A voluntary sector drug and alcohol service in Yorkshire reported high levels of experiences of abuse amongst their female clients who were involved in prostitution. In contrast to the approach of the West Midlands service, they highlighted the need to address the dynamics of domestic violence within treatment, as well as understanding drug and alcohol use as a coping mechanism:

There was a person who had a partner who was funding their drug use for both of them. There was the coercion element possibly, but also the safety. It's just so complex really … and you have to work with taking away something that's a benefit … I think we see the full scale, including some people who've been subject to really serious violence, right to the other end of the scale to where they might not have had any. Quite often, even if they're not experiencing it in their adult life, there's been something in their childhood.

Overall, many respondents drew links between women's experiences of violence and their involvement in prostitution and substance use, despite not providing domestic and sexual violence services in-house, as shown in Figure 6.

Figure 6: Providers' perceptions of the link between substance use and street-based prostitution



Nearly 90% of providers believe that their clients who sell sex are often doing so to fund a partner's drug habit and two thirds (67%) believed that women are coerced or forced to sell sex for drugs. An NHS-funded sex work and substance misuse service in the West Midlands highlighted the relationship between domestic violence and substance misuse amongst their clients, and how that impacts on treatment:

Worker #1: So if their partner brings them, or their punter or whatever, they cannot pass that door.

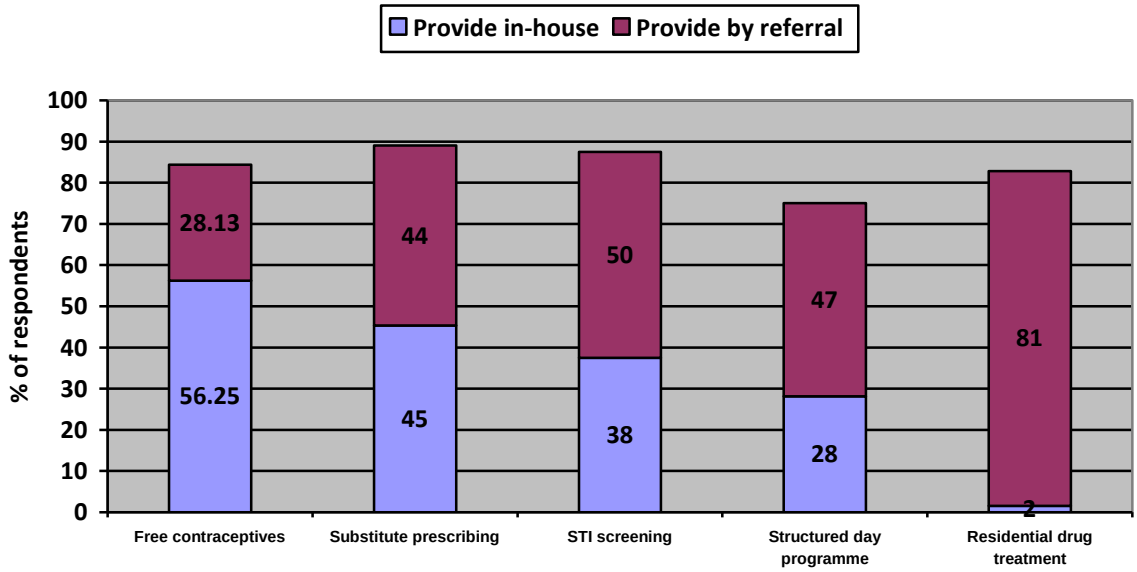
Worker #2: We have loads of guys trying to get in this door. And the reason that there's posters on the glass bits is because they pull up the chair and they will try and look through, they will and see everything that's going on and control it. And they all, there's a lot of men that can't stand the 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 #1: 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.

4.2.3 Healthcare needs

The particular types of healthcare needs that are important to women involved in substance use and prostitution and hence were included in the online survey relate to different types of drug treatment and sexual health services. The proportions of services providing different types of interventions are shown in Figure 7.

Figure 7: Provision for health care needs



Substitute prescribing

The need for flexibility and quick access to drug treatment was raised in the qualitative interviews with women involved in substance misuse and prostitution. In Yorkshire, a voluntary sector drug and alcohol service explained the lack of access in their local area to low-threshold prescribing, and their belief that this creates particular barriers for women involved in street-based prostitution in accessing treatment:

> *So a service that is very flexible for them to come in on a low dose, miss a few days, and then be able to come back and get the low dose without having to start the whole process again … In our service at the moment, if somebody misses a few doses they would have to be reassessed and booked in to see the doctor … There's certain groups of people, and it's not just sex workers, who would benefit from that. They're people that things happen that stop them getting to appointments, or they're not staying in the place they had the appointment letter sent to … they're possibly a bit more transient – Service manager*

This view was support by an NHS-funded sex work and substance misuse service in the West Midlands that offers low threshold prescribing:

> *A lot of the women have absolutely no one ... If we're not monitoring them, no one's monitoring them. If they drop out of treatment, they're way more likely to be the victim of some massive criminal hideousness. There's nobody watching out for that. Nobody knows if they're alive or not, or if they're missing or not, generally. They're so chaotic at the beginning, that if you put up huge barriers they're just not going to access any treatment. So actually, that knowledge that they can come in or out keeps some of the more desperate women alive.*

However, the same service also described how they set limits even around low-threshold prescribing, supporting women to take some responsibility for their own treatment.

> *[The methadone is] here between 11 and 2 [three days a week] they're told – it's actually 11 and half-two, because people always come five minutes before the end. So they come between 11 and 2, and the days it's not on site, I mean two of those days there's a doctor so in actual fact we'll generally do them a prescription. But if they don't, they can't have their meth.*

Some providers noted, however, that not all women they supported were heroin users and that drug treatment needed to have a wider focus than Class A drugs.

> *Much more cannabis use and alcohol, but Class As really do seem to have reduced … We've got a lot less really chaotic crack and heroin users. I mean it's partly I suppose because we haven't got the methadone programme here, but we're not seeing them the same in prison and on the streets … when you're thinking about women and you're thinking about rehabilitation, you've got to think about it holistically – Women's community project, West Midlands*

4.2.4 Longer term needs

The importance of addressing wider issues, such as employment and housing, to support the longer term change in lifestyle that women involved in substance misuse and prostitution need to achieve was clear from both the research review and the qualitative interviews with women themselves.

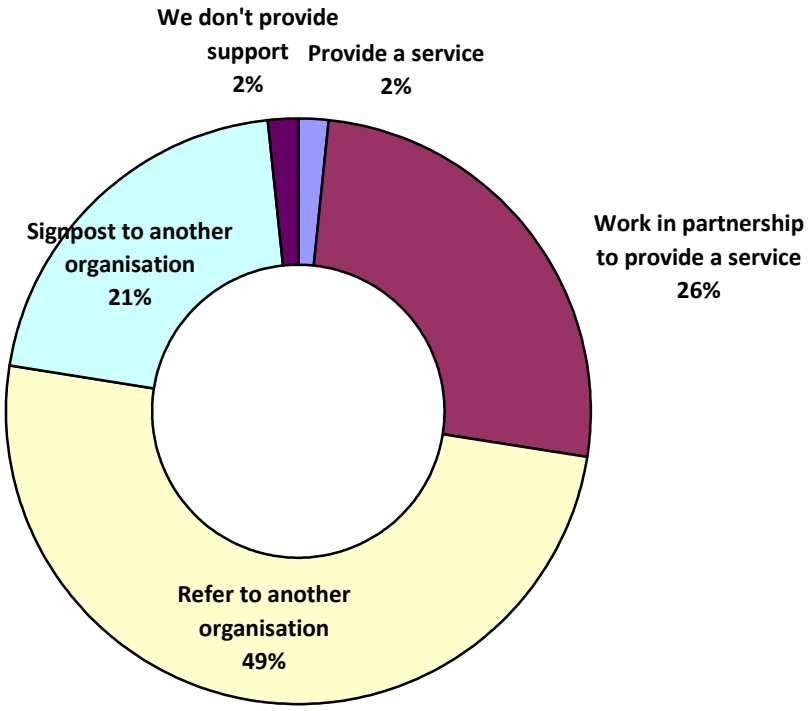
In the West Midlands, workers at the sex work and substance misuse project explained the benefits in their service of a 'one-stop-shop' approach and the link between access to healthcare and longer term needs such as access to housing and employment.

> *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've got a dentist. So the dentist will come in here and do a bit and then we've got our own drop-in over at the outreach project.*
>
> *Worker #1: Their dental hygiene is horrendous. So the fact that they've got a dentist that will complete all of their treatment and then forward them on to a dentist in their area works fantastically. Because a lot of the girls, in order to move them on, if they want to go to college or get a job – if they've got no teeth, they're not gonna go …*
>
> *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.*

Housing support

Most services (98%) reported providing some assistance with housing although in most cases this was not in-house. Only 2% of respondents said they provided the service in house, while 26% provided housing support in partnership with another organisation. The most common arrangement was to provide a referral to another organisation, which was how most services dealt with housing issues. A fifth provided signposting to other organisations.

Figure 8: Provision of housing support

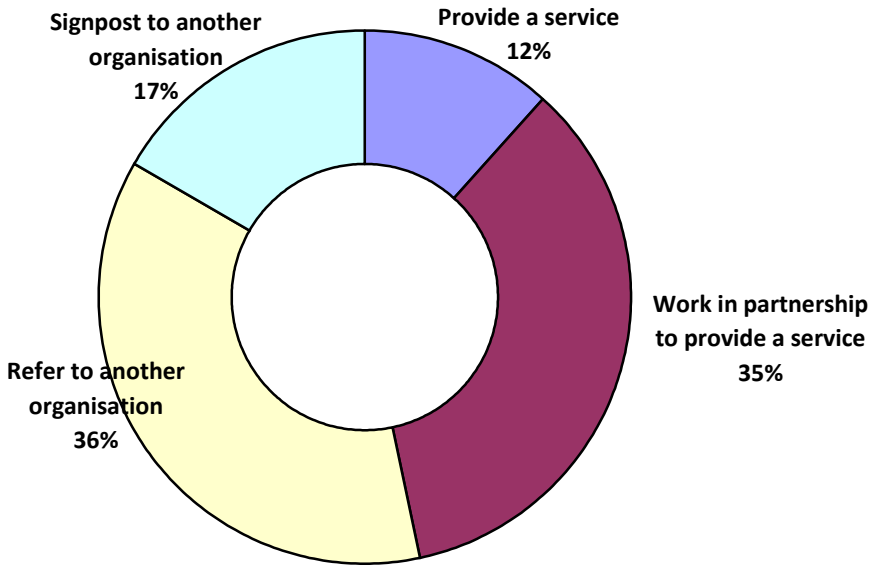


Education and employment

The importance for women involved in prostitution and substance misuse to have the opportunity to earn money in other ways also stood out in the other components of the project.

As can be seen from Figure 9, almost half of the services who responded to the online survey reported providing some education and employment support, 12% providing the service themselves and 35% providing the service in partnership with another organisation. About a third provided referrals to other organisations and 17% said they signposted people to another organisation.

Figure 9: Provision of Education and Employment Support



Alongside drug treatment or services for women involved in prostitution; Jobcentre Plus and Work Programme providers are also likely to be involved in this sort of provision. During a site visit to a women's community project in the West Midlands, a service user we spoke to had just had her pre-school age son returned to her custody after being cared for by his grandmother for most of his life. She spoke with us about her frustrations around accessing benefits and employment, and how this was linked to her caring responsibilities:

> *I went to the Jobcentre … and he said to me, well what have you been doing to look for work in the last two weeks and I said, it's been Christmas, there's no jobs. He said to me, well if you don't bring in your form the next time you sign, we could stop your benefits. Give me a break for heaven's sakes. And Mum said … just slow down and get into a routine with your child first, but it's easier said than done with the Jobcentre on your back.*

At a site visit with a drug service in the West Midlands, a female service user explained the need for sustained support:

> *It takes some time to get where you want to go. I couldn't believe [the groups] had finished, because they've been a tremendous help. It's like you're lost and confused. I am alone. I have one daughter, and it's a very lonely world. And I think they know when you're vulnerable. It's like a jungle of people, you know?.*

The same service user also spoke about her long-term views of the future around education and employment as a motivator to enter treatment in the first place:

> *What made me come [to the assessment]? Um, jobseekers! 'Cause I thought if I don't come, they won't give me a job! I wanted a job really, I wanted to improve my life, I wanted to get out and I wanted a day with structure. I always wanted a job but I didn't have any qualifications. And I thought to myself, I'm gonna get the opportunity in order to go to college and I'm gonna get help and some sort of support towards college.*

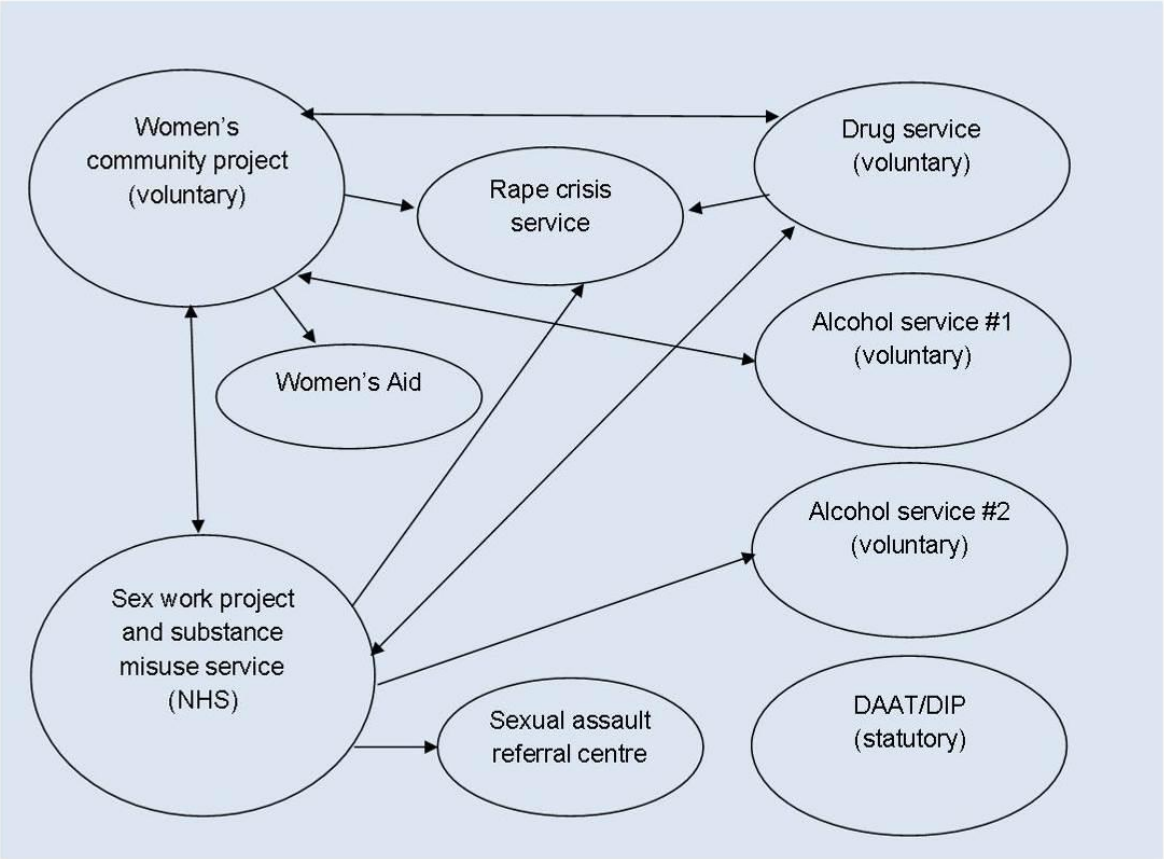
4.3 Providing services in partnership

The evidence review and peer interviews highlighted the value and importance of integrated provision when working with women with such complex needs and entrenched problems. Partnership working is therefore very important, and this was explored in some depth in two case study areas, West Midlands and Yorkshire and the Humber, where peer interviews were conducted and sites visits were conducted. Through this, an attempt was made to map the services and how they worked together in each area, and to identify how they met the different needs highlighted above.

4.3.1 West Midlands case study area

Figure 10 shows the main services of relevance to women involved in substance use and prostitution in the West Midlands case study area.

Figure 10: Map of the interrelationship of services in the West Midlands case study area



The services most directly involved are the three drug and alcohol treatment services, the sex work project and substance misuse service, and the women's community project. The other services are referred to as necessary. The Drug Intervention Programme (DIP) is largely separate.

Service provision and strength of partnerships in the West Midlands case study area[4]

In terms of the previously identified category of 'basic needs', there appeared to be good coverage of substance use advice and harm reduction services in the key services in this

[4] Service provision here looks at the previously identified categories of basic needs, mental and emotional needs, healthcare needs, and longer term needs. No information was available from the second alcohol service for any of these categories. For longer term needs, no information was available for either of the alcohol services.

area, as well as drop-in provision. However, there appeared to be very little provision for women in need of temporary accommodation (see Table 1, Appendices).

In relation to mental and emotional needs, sexual violence support was covered by the sex work and substance misuse service and by the women's community project through referral, presumably to the sexual assault referral centre and the rape crisis service. Domestic violence support was provided in-house in these services; they also provided talking therapies. The drug service apparently did not provide talking therapies, or access to domestic or sexual violence support, including through referral (see Table 2, Appendices).

Healthcare needs were covered well by some services, but in some instances, access to substitute prescribing, free contraceptives or STI screening was not available either in-house or by referral (see Table 3, Appendices). The women's community project reported that they used to have the NHS-funded sex work and substance misuse project provide methadone prescribing from their centre, but that that stopped about two years ago.

> *We don't have [methadone prescribing] now, but we have [Alcohol service #1] come in each week … so they come and do a session once a week. And then we've just started today actually, [the voluntary sector drug service] are doing some courses … Generally we just feed the clients through to the drug teams or whatever they need.*

The service manager noted that this is the one aspect of the service that women need but can't get in-house:

> *If they're under DIP, they've got to go to them. DIP will not come here. So it does defeat the object a little bit of, you know, a one stop shop – Service manager, women's community project.*

All of the services that provided information in relation to longer term needs indicated that access to housing or education and employment support was available in-house or by referral. In line with the findings of the online survey, access was more often by referral than available through in-house provision (see Table 4, Appendices).

In this area, then, women should be able to access support to address most of their needs from one or other of the service providers. However, this can be a barrier for women with multiple needs who are leading chaotic lives, and has been shown to be a barrier to recovery unless there are strong links and strong partnership working. The women's community project service manager highlighted difficulties they faced as a voluntary sector service in working effectively with NHS and other statutory agencies:

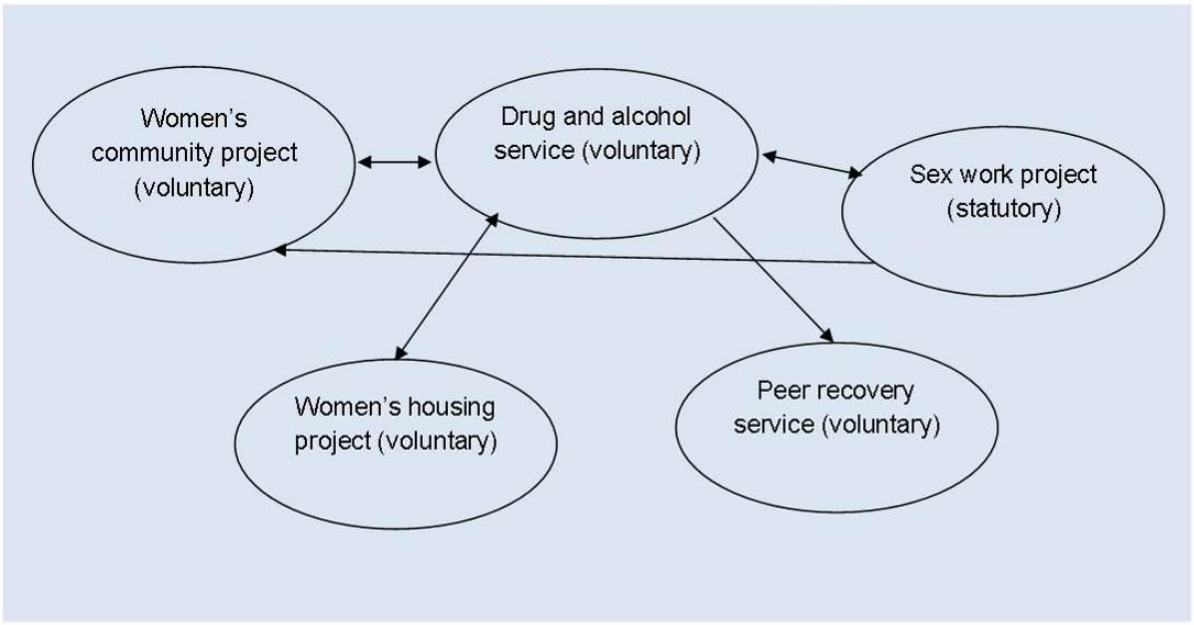
> *It's always been a little bit weak I think, with drug services … I just haven't found them that forward, that keen to really join … And I think it's a little bit because they generally come under health. Somebody like [the voluntary drug and alcohol services], because they were independent, then there tends to be a way, whereas your DIP teams and your community drug treatment just seem to be a little bit more stand-offish … They just don't seem that open to working together.*
>
> *We have worked with [the women's community project]. We had someone yesterday from [the NHS sex work and substance misuse service]. I think with drug services at the moment there's been a lot of changes, we're going out there again and promoting … [The NHS sex work and substance misuse service] prescribes medication, we don't prescribe medication, so we will work with [that service] while the service user is on the programme, so they'll be invited to a six-week review and they'll be invited to the*

12-week review … we'll be in constant communication with them – Voluntary sector drug service

4.3.2 Yorkshire case study area

Figure 11 shows the main services of relevance to women involved in substance use and prostitution in the Yorkshire case study area.

Figure 11: Map of the interrelationship of services in the Yorkshire case study area



Slightly fewer services were identified in the Yorkshire case study area than in the West Midlands one. There is a combined drug and alcohol treatment service in place of the separate drug and alcohol services in the West Midlands, but both areas have a sex work project and a women's community project. In this Yorkshire case study area there is also a women's housing project and a peer recovery service.

Service provision and strength of partnerships in the Yorkshire case study area[5]

In terms of basic needs, there was reasonable coverage of substance use advice and harm reduction services, and of drop-in support. However, as in the West Midlands case study area, there appeared to be gap in the provision of temporary accommodation – although it is possible that the women's housing project (from which we were unable to obtain any information) contributed here (see Table 5, Appendices).

In relation to mental and emotional needs, sexual violence and domestic violence support were provided in-house by the sex work project, and by the drug and alcohol service by referral. Access to complementary and talking therapies was also available across the services we obtained information from (see Table 6, Appendices).

With healthcare needs, access to free contraceptives and substitute prescribing was available in-house and by referral, respectively, in the sex work project, and the alcohol and drug service had substitute prescribing in-house. However, neither provided access to STI screening. Access to community-based structured treatment or residential drug treatment

[5] No information was available from the women's community project or the women's housing project for any of the categories.

was available from the drug and alcohol service, and the sex work project referred to residential treatment (see Table 7, Appendices).

In terms of longer term needs, access to housing and education and employment support was provided by the drug and alcohol service and the sex work project; the peer recovery service provided access to education and employment support. Again, this access was more often by referral than through in-house provision (see Table 8, Appendices).

Both the drug and alcohol service and the specialist sex work project described having a productive relationship with each other. Both the service manager and keyworkers in the substance misuse service highlighted that women don't always feel comfortable coming into their building because of people they may run into, so they collaborate with other services to offer safer spaces for women to meet them:

> *I've noticed that the workers, our workers and the [sex work project] workers, do work really closely together when they're working on a case. And that they're very flexible about where is the best place to see that person … it could be here, but if it's better to be at the [women's housing project] or the [sex work project] or elsewhere, then it'll be there – Service manager*

> *It's not just about place, it's about time too. For us, we kind of struggle because obviously they'd prefer afternoons if they're out working, but then the level of intoxication is kind of too high by the afternoon for our workers to be able to do psycho-social work with them. So it's about finding somewhere in the middle I guess - Keyworker*

However, the sex work project explained how the physical space of their service had changed over the past decade and described the impact they felt this had on the efficacy of their service provision:

> *[Ten years ago] we had a lovely big office with showers, big kitchen, settees – I didn't work there then, but I did a bit of volunteering. I think the women could come in and have a cup of tea, a shower, we could nurture them then. After that we moved to a place which had a kitchen but no shower, but you could make girls a cup of tea, some of them would come and have a little nap on the settee, their cheese toastie, a cup of tea, something like that. When I started we had that. And then obviously then with funding they moved us to an office where we'd have to see clients anywhere we could. That was about three years ago … and it was out of town as well. So we didn't get any girls dropping in, nothing like that. It were really hard for us working with the clients, 'cause obviously we're told 'funding's cut, you've got no funding' and the clients are going mad with us then because we couldn't see 'em… and then after that they moved us over to [the council offices], which was same again. Office like this. Little booths with a plastic sheet in the middle to see the clients. And it's so inappropriate for our clients*.

5 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.

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Appendices

1. Peer interviewee information sheet
2. Peer interviewee consent form
3. Information sheet for service providers
4. Service provider telephone interviewee consent form
5. Service provider case study consent form
6. Service provision and partnership working in case study areas: Tables 1-8

Peer Interviewee Information Sheet

Why do you want to interview me?
DrugScope and AVA (Against Violence & Abuse) have asked [name of interviewer] to conduct an interview with you. This is part of their research on what support women who exchange sex for something they want or need, might want to help to think about their drug or alcohol use.

DrugScope is a charity and is the UK's leading independent centre of expertise on drugs and the national membership organisation for the drug field. AVA is also a charity and its Stella Project provides training and advice for workers who support people affected by drug and alcohol use, domestic violence and sexual violence and mental health issues.
Peer researchers are members of the research target group (in this case women with histories of being involved in prostitution and of drug or alcohol dependency) adopt the role of active researchers, interviewing their peer group about their experiences.
As well as the peer interviews is conducting for us, we will:

- Gather information from other research that has already been done (a literature review)
- Conduct online surveys and telephone interviews with professionals who provide drug and alcohol services
- Visit five drug and alcohol services and write a report on how they work to support women
- Hold focus groups with service users, practitioners and policy-makers to receive feedback on what we find out.

We will publish a report which presents the findings from all these different sources. We will use the report to encourage professionals to improve the ways that they support women to reduce or stop using drugs or alcohol, based on what you and other people have told us.

What will happen if I agree to take part?
The peer researcher will interview you, using questions that have been given to them by DrugScope and AVA. The interview will last approximately an hour, depending on how much you'd like to tell them. The interview will be audio recorded (with your permission), and the researcher will give that recording to DrugScope and AVA. You will receive a £20 shopping voucher in return for taking part in the interview.

DrugScope and AVA will use what you tell the peer researcher to write a report about what women who exchange sex need in order to be able to recover from drug or alcohol use. We will collect some basic monitoring information from you (your age, ethnicity, sex, sexual orientation and disability status), but your contribution will be anonymous. We may use quotes from you in the report, but we won't give you name or any information that can identify you.

What will I be asked about?
The peer researcher will ask you questions about your experiences thinking about and seeking help to reduce or stop using drugs or alcohol.

You don't have to answer any questions you don't want to, and you can stop taking part in the interview at any time without giving a reason.

Some people can find it upsetting to talk about some of these things, especially if it's the first time they've ever spoken to anyone about it. If you feel upset you can stop the interview or take a break. Your interviewer can also tell you about places you can go to get support

I took part, but now I don't want my information to be used
You can choose not to be part of the research at any time before the report is published, even after you've already done an interview. You can call or email Shannon Harvey at AVA (Tel: 020 7549 0276, shannon.harvey@avaproject.org.uk) and tell her that you don't want to be involved anymore. She will delete the audio recording and destroy all other information they have about you.

Peer Interviewee Consent Form

Before taking part in this interview, please can you to read the statements below very carefully and tick next to each statement, then sign and date at the bottom of the page, to show us you agree to take part.

I have read and understand the information sheet I have been given and agree to take part in the interview conducted for DrugScope and AVA.	☐ Yes ☐ No
The peer researcher has explained to me why they are doing the interview and I have had a chance to ask any questions I want to ask.	☐ Yes ☐ No
I understand that the interview will be audio recorded and that the audio recording will be given to DrugScope and AVA.	☐ Yes ☐ No
If I choose not to have my interview recorded, I agree that the interviewer can take notes about what I say in the interview.	☐ Yes ☐ No
I agree that DrugScope and AVA can use the information in the audio recording to write a report and produce conference presentations about the needs of women involved in prostitution who want help to reduce or stop using drugs or alcohol.	☐ Yes ☐ No
I understand that all information about me will be kept confidential, and that DrugScope and AVA will not tell anyone that I have participated in this research, unless I say something that makes them think that I or someone else is in immediate danger.	☐ Yes ☐ No
I understand that I can stop being involved in the research at any time, without needing to tell anyone why.	☐ Yes ☐ No
I confirm that I have read and understood the information given to me and freely agree to take part.	☐ Yes ☐ No

Name: _____

Signature: _____

Date: _____ / _____ / 2012

PSUWIP Research Project
Information sheet for service providers

National charities DrugScope and AVA (Against Violence & Abuse) have received funding from the Pilgrim Trust to undertake a small piece of research on the experiences of women involved in prostitution seeking treatment for problematic substance use. DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for the drug field. Its aim is to inform policy development, reduce drug-related harms to individuals, families and communities - and promote health, well-being, recovery, inclusion and integration. AVA's Stella Project is the leading UK agency addressing addressing the intersecting issues of domestic and sexual violence, drug and alcohol use and mental health. It works for positive, sustained improvement in the way services are delivered to survivors, their children and perpetrators.

Rationale and research questions

Through this project, DrugScope and AVA seek to improve understandings of the experiences of women involved in prostitution seeking help for substance use problems, focusing on the challenges of meeting the needs of this highly marginalised group. Within this, we seek to explore themes such as whether perceived differences between harm reduction or exiting approaches are significant in supporting women's recovery, the impact of approaches that explore women's experiences of violence and abuse, and the relationship between treatment offered through drug and alcohol services and support offered through specialist projects for women involved in prostitution.

Our key research questions are:

- Do the drug and/or alcohol support needs of women involved in prostitution differ from those of women in recovery from drug and/alcohol dependency who are not involved in prostitution? If so, in what way do they differ?
- What services are currently available that are designed to meet the drug and/or alcohol support needs of women involved in prostitution?
- Do women involved in prostitution feel these available services meet their drug and/or alcohol support needs?

Aims

1. To identify the needs of women involved in prostitution who use substances problematically
2. To map and explore the diversity of drug and alcohol support services available to address these needs in the West Midlands and Yorkshire and Humber.
3. Develop good practice guidelines for both drug and alcohol services and specialist services for women involved in prostitution
4. Identify strategic and policy recommendations that could improve interventions and outcomes for women involved in prostitution who have drug and alcohol issues.

Methodology

The research design takes a triangulated, mixed methods approach, including the following components:

- Literature review, using a Rapid Evidence Assessment approach
- Semi-structured interviews with 20 service users in the West Midlands and Yorkshire and Humber, conducted by peer researchers (facilitated by Baseline)
- Online questionnaire targeted at drug and alcohol services and specialist services for women involved in prostitution in the West Midlands and Yorkshire and Humber
- Telephone interviews with selected respondents from the online questionnaire
- Case studies in five selected services, including participant and direct observation and unstructured interviewing
- Three focus groups with policy makers, practitioners and service users respectively.

Dissemination of findings
DrugScope and AVA will publish the research findings in a report. The report will include recommendations for policy makers, commissioners and service providers and will be launched at an event to which all research participants and other key stakeholders will be invited. Both DrugScope and AVA will use the research findings in their policy work on this issue throughout 2013 and beyond.

Information for participants
To meaningfully achieve our aim of mapping service provision that aim to address women's identified needs, we require close to full participation in the online questionnaire from service providers in the West Midlands and Yorkshire and Humber. The questionnaire will take around 15 minutes to complete and only needs to be completed by one staff member in the service (preferably the service manager).

Participants for follow-up telephone interviews and case studies will be selected on the basis of responses from the online questionnaire and the peer researchers' interviews with service users. Criteria for selection for this stage of the research will be focused on highlighting examples of promising practice in relation to support women's identified needs. You will be given an opportunity at the end of the questionnaire to indicate whether you would be willing to participate in this aspect of the study.

Service providers who participate in the questionnaire will usually not be identified in the final report, although when identifying cases of good practice, it may be appropriate to name some services. We will contact you for your consent before naming your service in the report.

Contact us
If you would like more information about this project, either before completing the questionnaire or at a later date, please contact Marcus Roberts at DrugScope (Tel: 020 7520 7550, marcusr@drugscope.org.uk) or Shannon Harvey at AVA (Tel: 020 7549 0276, shannon.harvey@avaproject.org.uk).

PSUWIP Research Project

Service Provider Telephone Interviewee Consent Form

Before taking part in the telephone interview, you need to read the statements below very carefully and tick next to each statement, then sign and date at the bottom of the page, to show us you agree to take part.

I have read the information sheet and understand why I am being asked to participate in the telephone interview and I have had a chance to ask any questions I want to ask.	☐ Yes ☐ No
I understand that the interview will be audio recorded and that the audio recording will be transcribed.	☐ Yes ☐ No
I agree that DrugScope and AVA can analyse my responses to produce a report about the needs of women involved in prostitution who use substances problematically, and services currently available to meet these needs.	☐ Yes ☐ No
I understand that all information about me will be stored confidentially, in accordance with the Data Protection Act, and that DrugScope and AVA will only name my service as an example of good practice if I explicitly agree.	☐ Yes ☐ No
I understand that I can stop being involved in the research at any time, without needing to tell anyone why.	☐ Yes ☐ No
I confirm that I have read and understood the information given to me and freely agree to take part.	☐ Yes ☐ No

Name: _____

Signature: _____

Date: _____ / _____ / 2012

PSUWIP Research Project

Service Provider Case Study Consent Form

Before taking part in the case study visit to your agency, you need to read the statements below very carefully and tick next to each statement, then sign and date at the bottom of the page, to show us you agree to take part.

I have read the information sheet and understand why DrugScope and AVA have asked me to participate in the case study visit. I have had a chance to ask any questions I want to ask.	☐ Yes ☐ No
I have read the case study guidance and understand that the researcher will be taking notes throughout the day and may audio record some of my interactions with them. I understand that I can verbally request that the audio recorder is not used at any time.	☐ Yes ☐ No
I agree that DrugScope and AVA can analyse information gathered during the case study visit to produce a report about the needs of women involved in prostitution who use substances problematically, and services currently available to meet these needs.	☐ Yes ☐ No
I understand that all information about me and my agency will be stored confidentially, in accordance with the Data Protection Act, and that DrugScope and AVA will only name my service as an example of good practice if the Service Manager explicitly agrees.	☐ Yes ☐ No
I understand that I can stop being involved in the research at any time, without needing to tell anyone why.	☐ Yes ☐ No
I confirm that I have read and understood the information given to me and freely agree to take part.	☐ Yes ☐ No

Name: _____

Signature: _____

Date: _____ / _____ / 2012

Service provision and partnership working in case study areas: Tables 1-8

Table 1: Coverage of basic needs by services in the West Midlands case study area

BASIC NEEDS							
		Provide in-house			Provide by referral		
	Sub use advice	**Prost. Advice**	**Drop-in**	**Harm reduction (sub use)**	**Harm reduction (prost.)**	**Ugly mugs**	**Temp accom**
Drug service (voluntary)		No			No	No	No
Sex work project & sub misuse service (NHS)							
Women's community project							No
Alcohol service #1 (voluntary)						No	No
Alcohol service #2 (voluntary)	No information	No information	No information	No information	No information	No information	No information

Table 2: Coverage of mental and emotional needs by services in the West Midlands case study area

MENTAL & EMOTIONAL NEEDS					
		Provide in-house		Provide by referral	
	Complementary therapies	**Talking therapies**	**Self-help groups**	**DV support**	**SV support**
Drug service (voluntary)		No		No	No
Sex work project & sub misuse service (NHS)					
Women's community project					
Alcohol service #1 (voluntary)		No		No	No
Alcohol service #2 (voluntary)	No information	No information	No information	No information	No information

Table 3: Coverage of healthcare needs by services in the West Midlands case study area

HEALTHCARE NEEDS					
		Provide in-house		Provide by referral	
	Free contraceptives	**Substitute prescribing**	**STI screening**	**Structured day prog.**	**Residential drug treat.**
Drug service (voluntary)	No		No		No
Sex work project & sub misuse service (NHS)					
Women's community project	No	No			
Alcohol service #1 (voluntary)		No	No	No	
Alcohol service #2 (voluntary)	No information	No information	No information	No information	No information

Table 4: Coverage of longer term needs by services in the West Midlands case study area

LONGER TERM NEEDS		
	Provide in-house	Provide by referral
	Housing	**Education and employment**
Drug service (voluntary)		
Sex work project & sub misuse service (NHS)		
Women's community project		
Alcohol service #1 (voluntary)	No information	No information
Alcohol service #2 (voluntary)	No information	No information

Table 5: Coverage of basic needs by services in the Yorkshire case study area

BASIC NEEDS							
		Provide in-house		Provide by referral			
	Sub use advice	**Prost. advice**	**Drop-in**	**Harm reduction (sub use)**	**Harm reduction (prost.)**	**Ugly mugs**	**Temp accom**
Drug and alcohol service (voluntary)		No			No	No	
Sex work project (voluntary)			No				
Women's community project (voluntary)	No information	No information	No information	No information	No information	No information	No information
Peer recovery service (voluntary)	No	No		No	No	No	No
Women's housing project (statutory)	No information	No information	No information	No information	No information	No information	No information

Table 6: Coverage of mental and emotional needs by services in the Yorkshire case study area

MENTAL & EMOTIONAL NEEDS					
		Provide in-house		Provide by referral	
	Complementary therapies	**Talking therapies**	**Self-help groups**	**DV support**	**SV support**
Drug and alcohol service (voluntary)					
Sex work project (voluntary)	No		No		
Women's community project (voluntary)	No information	No information	No information	No information	No information
Peer recovery service (voluntary)		No		No	No
Women's housing project (statutory)	No information	No information	No information	No information	No information

Table 7: Coverage of healthcare needs by services in the Yorkshire case study area

HEALTHCARE NEEDS					
		Provide in-house		Provide by referral	
	Free contraceptives	**Substitute prescribing**	**STI screening**	**Structured day prog.**	**Residential drug treat.**
Drug and alcohol service (voluntary)	No information		No information		
Sex work project (voluntary)			No	No	
Women's community project (voluntary)	No information	No information	No information	No information	No information
Peer recovery service (voluntary)	No	No	No	No	No
Women's housing project (statutory)	No information	No information	No information	No information	No information

Table 8: Coverage of longer term needs by services in the Yorkshire case study area

LONGER TERM NEEDS		
	Provide in-house	Provide by referral
	Housing	**Education and employment**
Drug and alcohol service (voluntary)		
Sex work project (voluntary)		
Women's community project (voluntary)	No information	No information
Peer recovery service (voluntary)	No	
Women's housing project (statutory)	No information	No information

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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