# Cycles of harm:

## Problematic alcohol use amongst women involved in prostitution

Laura Brown,
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## Contents

## Executive summary

### Background

Research by Eaves and London South Bank University, *Breaking down the barriers* (Bindel, Brown, Easton, Matthews and Reynolds, forthcoming[1]), identified problematic drug and/or alcohol use as the most common barrier (obstacle) faced by women exiting prostitution. Following the completion of this study, Eaves obtained funding from Alcohol Research UK to explore this barrier with greater depth, focusing specifically on problematic alcohol use.

This new research aimed to:

- Look at why and when women involved in prostitution use alcohol problematically
- Explore and compare the ways in which women involved in different aspects of the sex industry use alcohol
- Explore the different ways in which women use alcohol and how this relates to their involvement in prostitution and impacts on exiting
- Enable practitioners working with women involved in prostitution who have problematic alcohol use to gain a better understanding of the relationship between the two, thereby informing more effective interventions.

### Methods

The research took a mixed methodological approach, collecting both quantitative and qualitative data. The main focus of the study was follow up interviews with women who took part in the *Breaking down the barriers* study[2]. Interviews were also undertaken with practitioners working in the drugs and alcohol fields and in services supporting women involved in prostitution. Given the small scale and short time frame of the project, the majority of interviews with women and stakeholders were confined to London. An online survey was also distributed to a range of organisations and services that may come into contact with women involved in prostitution. The survey was distributed across England and Wales, extending the geographical scope of the study.

Data collection included the following:

- Nine interviews with women currently or formerly involved in prostitution who had past or current problematic alcohol use
- Seven interviews with eight stakeholders who worked in a range of services and organisations, both in frontline-based and policy/strategic positions
- An online questionnaire with fifty respondents[3].

### Key findings and conclusions

#### *Women involved in prostitution and problematic alcohol use*

- It is evident that alcohol is used problematically amongst women involved in prostitution. Furthermore, it appears that problematic alcohol use may be increasingly widespread amongst this particular group

[1] From here on referred to as *Breaking down the barriers*. During the course of the project the study was also referred to as the PE:ER Project.
[2] Due to difficulties re-contacting women who took part in the *Breaking down the barriers* study, five new participants were also recruited to this study via relevant support services.
[3] Some respondents to the (anonymous) online questionnaire may also have taken part in a stakeholder interview, meaning that there may be overlap within the sample.

- Alcohol was used by women in this sample in combination with other substances, particularly crack cocaine and cocaine
- *Breaking down the barriers* highlighted that 75% of women involved in off-street prostitution and 49% of those involved in on-street prostitution used alcohol during their involvement[4]. In this study, women in both the on and off-street aspects of the sex industry used alcohol problematically, although when and why women used alcohol sometimes differed by place of involvement. However, due to the increasingly transient nature of the sex industry[5] there was sometimes overlap and a blurring of the boundaries between on and off-street involvement in this sample. Therefore, the alcohol use and related needs and circumstances of women involved in different aspects of the sex industry may not be as dissimilar as previously thought
- Like other substances, there was a link between prostitution and problematic alcohol use, but this link could be complex and varying. It could also evolve and change during the time a woman was involved in prostitution
- Unlike other substances, alcohol appeared to be less of a driver for women's entry into prostitution
- Alcohol was predominantly used during involvement in prostitution in a self-medicating way, to mask feelings of distress, anxiety and experiences of selling sex. Some women continued to use alcohol after exiting from prostitution to cope with trauma, distress and mental health problems that were a legacy of their involvement in prostitution. Alcohol was also used as a coping mechanism by women before entry, for example to cope with loneliness and negative experiences during childhood and early adulthood
- Problematic alcohol use could be a barrier to exiting prostitution, but is perhaps less significant than other substances in this regard. Stakeholders were more likely than women interviewees to identify alcohol use as a barrier to exiting.
- Although most women did not view alcohol as one of the most significant barriers to exiting, alcohol use could be an obstacle in another sense. Since alcohol may be used as a coping mechanism, fear of losing this means of coping could make some women reluctant to access support and treatment for their alcohol use.

### *Services and support*

- For women seeking to exit, they require support for their alcohol use and involvement in prostitution. Support which was holistic and addressed all of women's needs was found to be the most beneficial to women in this study
- Specialist services[6] and exiting focused support were seen to be important for women involved in prostitution, although these provisions were reported to be limited in availability and inconsistent. Services need to ensure that they offer exiting support as part of a range of options, and build links with specialist services to ensure that women can access all of the support that they require
- Women also benefited from women-only services and female workers, although these provisions were also reported to be limited in their availability
- Drug and alcohol services need to understand the needs and circumstances of women involved in prostitution and recognise possible links between prostitution

[4] Percentages refer to the reported alcohol use of the 55 exited women in the sample. Alcohol use was not necessarily problematic.
[5] Bindel et al, 2013.
[6] A 'specialist service' is a service which provides targeted support and provision to women who are or have been involved in prostitution, addressing their specific needs in this regard.

and alcohol use. This includes awareness that alcohol can be used as a coping mechanism whilst in prostitution. Identifying and addressing the root cause of alcohol use is essential. All of this needs to be borne in mind when providing interventions

- Some drug and alcohol workers, as well as other service providers, lack knowledge and understanding of the needs and experiences of women involved in prostitution. This can pose a variety of challenges to women's successful engagement with service providers and the support they then receive. Many services are also failing to identify whether women are involved in prostitution in the first instance. Training for practitioners around identifying and supporting women involved in prostitution would lead to an improved understanding of women's needs and the intersecting issues, and a more consistent approach to service delivery
- Not all drug and alcohol services are inclusive of women involved in prostitution, and women in general. Drug and alcohol services need to ensure that they are accessible to women involved in prostitution, for example by providing women-only sessions and a women's worker.

***Policy and society***

- On a policy level, the Government's approach to alcohol use does not appear to be compatible with the needs and circumstances of women involved in prostitution. Women, and in fact all problematic users, need support and treatment which is individualised and provided at their own pace. There needs to be a change in emphasis, moving away from quick recovery interventions, to longer term, more sustainable recovery. This approach would recognise that recovery can be a lengthy process. It would also account for, and help to address, the trauma which can often result from involvement in prostitution
- The commonplace use of alcohol and its acceptability in our society appears to be a significant underlying challenge in addressing problematic alcohol use overall. Education and awareness raising around the harms of alcohol would be a starting point in addressing this broad-ranging challenge.

## Preface

*Breaking down the barriers* (Bindel, Brown, Easton, Matthews and Reynolds, forthcoming) was a three year study conducted by Eaves and London South Bank University, which assessed the effectiveness of different interventions that are designed to support women to exit from prostitution. The study included interviews with 114 women involved in both on and off-street prostitution, as well as women who had been trafficked into prostitution. It looked at the process that women go through when exiting, identifying a five staged model of exiting and the support and interventions that are beneficial at each stage. The study also explored the barriers (obstacles) that women face when exiting and identified nine common barriers. Problematic drug and/or alcohol use, physical and/or mental health problems and housing were the most frequent barriers faced. Women typically faced a number of these barriers which combined and interacted, creating complex obstacles to exiting. Whilst problematic drug and/or alcohol use was identified as the most common barrier, the study also highlighted the complex relationship between a woman's involvement in prostitution and her drug and/or alcohol use.

Following the study, Eaves were fortunate to obtain funding from Alcohol Research UK to undertake a small piece of research looking in greater depth at the problematic drug/alcohol use barrier. Due to the funder's area of work and expertise, as well as a lack of research looking specifically at alcohol use amongst this group, this study focuses primarily on alcohol. It does, however, incorporate findings that relate to women's use of other substances, where relevant. This study looks in greater detail at how women involved in prostitution use alcohol; differences in use depending on where women are involved in the sex industry; whether there is a causal link between prostitution and alcohol; and support and interventions which are beneficial to women with problematic alcohol use.

### Note on terminology

Eaves is a feminist organisation working with women who are vulnerable through experiences of violence. In line with the United Nations definition of violence against women and girls (VAWG), Eaves frames prostitution as a form of exploitation and VAWG. This is opposed to viewing prostitution as a career choice and legitimate form of work. The terminology used throughout this report reflects Eaves' position, for example use of the terms 'women involved in prostitution' and 'involvement' as opposed to 'sex worker' and 'work'.

The terms 'problematic substance use', 'problematic drug use' and 'problematic alcohol use' are used throughout this report. These terms have been employed because in both *Breaking down the barriers* and this study women self-reported, or were identified as having, problematic drug and/or alcohol use. Women's problematic alcohol use was identified by their key workers, or through descriptions of their behaviour that they provided in research interviews. A clinical definition of dependency or addiction was therefore not deemed to be necessary in this context. Instead, this research has drawn upon AVA's definition of problematic substance use:

> *"Problematic substance use is the use of substances (such as illegal drugs, prescription medicines or alcohol) in such a way that results in harm to the individual user or to the wider community. The range of harms includes problems for physical health, psychological health, violence, financial problems, family problems or social problems."* (AVA, 2013).

# 1. Background

## Involvement in prostitution and problematic substance use

### *Prevalence and trends*

Women's involvement in prostitution and problematic substance use has been extensively explored and documented in previous research. Yet to date, the majority of this work has focused on women's use of illegal drugs, primarily 'hard' drugs such as heroin and crack cocaine. Traditionally, these drugs have been the most commonly used amongst women involved in on-street prostitution, an aspect of the sex industry where women are believed to have the highest levels of substance use (Cusick et al, 2003; Dalla, 2002). Women involved in prostitution have been found to frequently use alcohol as well (Dalla, 2000; Benson and Matthews, 1995), although generally this has not been found to be their 'drug of choice' (Dalla, 2000).

Although there has been a greater focus on problematic drug use, with alcohol use being largely overlooked, the existing research nevertheless provides a useful basis for understanding problematic alcohol use amongst women involved in prostitution.

*Breaking down the barriers* (Bindel, Brown, Easton, Matthews and Reynolds, forthcoming[7]) highlighted high levels of problematic drug and/or alcohol use amongst women involved in prostitution (83% of women). Women were found to use a variety of substances, including alcohol, and many women reported poly-substance use, using illegal drugs in combination with alcohol. Of the women who had exited (55 women), the most frequent substance used when they were involved in prostitution was crack cocaine (76%), followed by alcohol (55%) and heroin (51%)[8].

Some studies (Dalla, 2000; Benson and Matthews, 1995) have highlighted frequent alcohol use amongst women involved in prostitution. Gossop et al (1995, 1994a) found concerning levels of alcohol use amongst women involved in on and off-street prostitution. Many women drank large amounts and around a quarter (22%) said they used alcohol everyday, with some drinking quantities which posed a danger to their health. Pearce et al (2002), who undertook case studies of 55 women aged 18 or under who were at risk of, or involved in, prostitution, found that every woman reported problems with alcohol. A number had also been hospitalised for injuries that were related to their alcohol use. More recently, the Home Office *Review of effective practice in responding to prostitution* (Home Office, 2011) indicated increasing levels of problematic alcohol use amongst those involved in prostitution. On the other hand, other research points to alcohol use amongst this group which is not that dissimilar to the rest of the population (Benoit and Millar, 2001). However, participants in the aforementioned study were asked about the frequency but not the amount of alcohol that they consumed. The authors acknowledge that they were therefore unable to determine if there was excessive alcohol use amongst those involved in prostitution.

### *Causality and relationship*

Whilst there is clear evidence for the use of both drugs and alcohol amongst women involved in prostitution, there is much debate about the relationship between drug use and prostitution: whether drug use precedes and 'causes' entry into prostitution or whether involvement in prostitution precedes and 'causes' drug use (Romero-Daza et al, 2003). A great deal of research has explored the link between drug use and

[7] From here on referred to as *Breaking down the barriers*. During the course of the study the project was also referred to as the PE:ER Project.
[8] These substances were not necessarily used problematically, for example some women reported using substances only once, recreationally or occasionally.

prostitution. Amongst on-street women there is argued to be a strong link, with the number of days per week that women sell sex being dictated by the extent of their opiate addiction (Smith and Marshall, 2007).

Much research has documented how drug use often comes before a woman's entry into prostitution. Bloor et al (2006) found that women, the majority of whom were involved in on-street prostitution, would use heroin for an average of three years before entering prostitution. Cusick et al (2003) report that the majority of women (56%) in their study started 'hard drug' use before they entered into prostitution, whilst other research shows that injecting drug use particularly precedes entry (Potterat et al, 1998). When problematic drug use comes before entry into prostitution, it is argued that women frequently enter prostitution in order to fund their existing drug use (Young et al, 2000). Church et al (2001) found that 63% of women involved in on-street prostitution entered to fund their drug use, whilst other studies estimate that around half of women enter into prostitution for this reason (Bloor et al, 2006; Gossop et al, 1994a). In Smith and Marshall's (2007) study, all women cited opiate addiction as their initial reason for entry into prostitution.

It should not be assumed though that drugs are the main motivating factor for women's entry into prostitution. Such an assumption is argued to be too simplistic and overlooks the complex links between drug use, women's histories and their involvement in prostitution (Matthews, 1998). Indeed, research findings are contradictory and some studies instead report that only a minority of women enter prostitution to fund their drug use (Benoit and Millar, 2001; Dalla, 2002, 2000). In Dalla's study (2002), the majority of women in on-street prostitution who reported drug dependency said they originally entered prostitution because of economic need; selling sex to pay for shelter, food or to support children.

The reality that some women's drug use only becomes problematic *after* their entry has been largely overlooked (Young et al, 2000). *Breaking down the barriers* found that over a third (36%) of women who had problematic drug and/or alcohol use whilst they were involved, entered prostitution before developing problematic drug and/or alcohol use. In Dalla's (2002, 2000) studies, many women reported drug use, (particularly drug addiction) after their entry into prostitution. Drug use was found to begin after prolonged involvement in prostitution, with substances being used as a coping mechanism or for escapism when women were selling sex (Dalla, 2002). The use of substances in this way has been explored, although other studies suggest that only a small number of women involved in prostitution use drugs to 'escape' or cope (Benoit and Millar, 2001).

It is apparent that problematic drug and/or alcohol use can come both before and after entry into prostitution. The relationship and causality is not always straightforward though, and any initial causal link can evolve and change. For example, a woman may not enter prostitution to fund her drug use but this may become the motivation for her continued involvement in prostitution (Sandwith, 2011). Alternatively, a woman may enter prostitution initially to fund her drug use but her drug use may then evolve to become a coping strategy for her continuing involvement in prostitution (Graham and Wish, 1994). Prostitution and drug use can also be a self-perpetuating cycle where the increase in one causes an increase in the other (Young et al, 2000). For example, if a woman's involvement in prostitution increases, drug/alcohol use may escalate and increase in order for her to cope with experiences when she is involved in prostitution (Bindel et al, forthcoming). For these reasons, it can be difficult to determine the actual causal links between drug/alcohol use and prostitution (Young et al, 2000).

### *Place of involvement*

The focus of research has predominantly been on drugs and not alcohol, but in terms of where women are involved in the sex industry, research has consistently found high levels of problematic substance use amongst women involved in on-street prostitution. The majority of on-street women are said to be problematic drug users (Hunter et al, 2004) and even when on-street women do not use drugs problematically, it is argued that nearly all begin to use drugs after their entry into prostitution (Dalla, 2002). Cusick et al (2003) found that 84% of women involved in on-street prostitution reported a current problem with 'hard drugs'. The link between drug use and on-street prostitution is argued to be so great that the on-street sex industry and drugs markets are said to be inextricably linked and integrated, with one playing a significant role in developing the other (May et al, 1999). Those selling sex have been found to make up a significant number of those buying drugs (primarily crack cocaine), whilst also being involved in distribution, and purchasing drugs for buyers of sex. As a result of these links (although to varying degrees depending on geographical location), a policy and service-based approach which addresses both the sex industry and drug markets together has been advocated (Hunter et al, 2004).

On the other hand, in comparison to women involved in on-street prostitution, women in off-street prostitution are reported to be less likely to enter prostitution because of their drug use, less likely to use drugs (heroin, crack cocaine, benzodiazepines and cannabis) whilst involved, and spend less money on drugs (Jeal and Salisbury, 2007). Focusing on 'hard' drugs, Cusick et al (2003) found that 13% of off-street or 'independent' women reported a current drug problem, significantly lower than the on-street group in their study. Other research has reinforced this finding, leading to the perception that only a small percentage of the off-street group use substances problematically (Benoit and Millar, 2001).

However, *Breaking down the barriers* suggested that levels of problematic drug and/or alcohol use between on and off-street women are not as dissimilar as previous studies have suggested. Ninety nine percent of the women involved in on-street prostitution and nearly two-thirds (61%) of women involved in off-street prostitution reported problematic drug and/or alcohol use whilst they were involved in prostitution. Of the women in the sample who had exited, the types of drugs used by women who were involved in different aspects of the sex industry was also explored. The substances most commonly used by women when they were involved in on-street prostitution were: crack (86%), heroin (56%) and alcohol (49%), whilst off-street women used alcohol (75%), cocaine (58%) and cannabis (50%) during their involvement[9] (Bindel et al, forthcoming).

### *Drug and alcohol use as a barrier to exiting*

In *Breaking down the barriers*, problematic drug and/or alcohol use was found to be the most common barrier that women faced when exiting prostitution (83% of women). Furthermore, there was found to be a complex relationship between drug/alcohol use and prostitution. This particular barrier was found to be linked with other obstacles women face when exiting, including health, housing and involvement with the criminal justice system. Cusick et al (2003) similarly found that prostitution and problematic drug use were mutually reinforcing, with drug use acting as a 'trapping' factor, creating difficulties for women wishing to exit from prostitution. In Cusick et al's (2003) study, all women involved in on-street prostitution were found to be 'trapped' in prostitution. Gossop et al (1994a) also found that women in their sample who problematically used heroin felt 'trapped' in prostitution because of the need to fund their drug use.

[9] These drugs were not necessarily used problematically, for example some women reported using substances only once, recreationally or occasionally.

## Exiting support and drug and alcohol services

Over recent years, there has been an increasing interest in exiting, both on a policy level and in practice, with some innovative projects providing practical and holistic exiting support. Addressing the drug use of women involved in prostitution has often been at the forefront of exiting support, an approach believed to be influenced by the high rates of drug use amongst women involved in on-street prostitution (Cusick et al, 2011). However, the consequence of this focus is that in an attempt to assist women to exit from prostitution, services may automatically shoehorn women into drug treatment. This is problematic as it means that women's drug/alcohol use is often treated in isolation from their other needs (Bindel et al, forthcoming).

Alcohol and drug treatment alone are unlikely to be successful in assisting women to exit from prostitution (Bindel et al, forthcoming; Hester and Westmarland, 2004). In *Breaking down the barriers*, few women felt that stabilising their drug and/or alcohol use was the primary reason for them exiting from prostitution. Ceasing or reducing heroin or crack use was seen as necessary, but not a sufficient condition for exiting. However, this is not to underplay the importance of drug and alcohol treatment and services for this group. Treatment can stabilise women and help them to take greater control of their lives (Bindel et al, forthcoming). For those who are involved in prostitution to fund their drug/alcohol use, treatment can also assist with exiting as they no longer have this main motivation to sell sex (Cusick et al, 2003).

Research has demonstrated that due to the multiple and complex problems women involved in prostitution often face, addressing problematic drug/alcohol use needs to be part of a holistic, tailored approach that addresses the other interlinked barriers and needs of women (Bindel et al, forthcoming). Also key to addressing women's drug/alcohol use and assisting them to exit, is an understanding of the complex interaction between prostitution and drug/alcohol use (Bindel et al, forthcoming; Cusick et al, 2003). Services also need to be available when women are ready and require them, particularly in the case of those seeking support during crisis. Thus, fast-tracking women into drug treatment can be useful as part of an approach which also addresses women's other, varied needs in a holistic way (Hester and Westmarland, 2004; Hunter et al, 2004).

There are barriers to women accessing and engaging with support though (National Treatment Agency (NTA[10]), 2002). It is thought that a large number of women accessing drug and alcohol services have been involved in prostitution (Drugscope and AVA, 2013), however, women in general are a hidden population of drug and alcohol users and are underrepresented in these services (NTA, 2010). Traditionally drug and alcohol services have been orientated towards the predominant group accessing them: male drug and alcohol users. This has meant that from the outset many drug and alcohol services are not inclusive of women and less tailored to identifying and addressing their specific needs (NTA, 2010, 2002; May et al, 1999). This can act as a barrier to women even accessing services (Smith and Marshall, 2007), as well as affecting the support that they receive. Women's needs, and particularly women involved in prostitution, can be multiple and more complex than men's (Simpson and McNulty, 2008). Women's needs can be directly related to their drug/alcohol use, such as physical and mental health problems, or be based on social factors such as having children and the stigma of being a female drug/alcohol user (NTA, 2010, 2002). Other barriers to accessing services faced by women involved in prostitution include services that are situated in 'red light' areas (Hester and Westmarland, 2004), opening hours of drug and alcohol services that are unsuitable/inaccessible for this group, and services that are mixed sex. The fear of

[10] The National Treatment Agency (NTA) is now part of Public Health England.

discrimination and judgement for their involvement in prostitution can also deter women from accessing services (Smith and Marshall, 2007; Bindel, 2006).

## The harms of alcohol

Alcohol use amongst the general population and its harms have been increasingly recognised and documented in recent years. This is useful for exploring some of the possible overarching impacts and harms that problematic alcohol use may have on women involved in prostitution. Globally, alcohol is listed as the third leading risk factor for premature deaths and disabilities (WHO, 2010) and is a causal factor in more than 60 different diseases and injuries (WHO, 2011). Over the last 50 years alcohol consumption in the UK has doubled. The harm caused by alcohol has increased many times more though due to the development of a heavy drinking culture, particularly binge drinking[11] (Nutt, 2010). Consequently, the UK is said to be facing a health crisis of huge proportions and the worst epidemic of harm from a legal substance since the 'gin craze' in the 1700s (Nutt, 2010). According to official statistics, 3.5 million adults in the UK are believed to be addicted to alcohol (House of Commons Health Committee, 2009, in Nutt, 2012).

In an attempt to address the harmful use of alcohol, the World Health Organization has produced a Global Strategy, focusing on ten areas for policy and interventions which can be implemented at a national level (WHO, 2010). The UK Coalition Government has implemented some of the points of the strategy[12] and recognised some of the alcohol-related harms in the UK, highlighting the resulting violent crime, costs to the NHS, and the impact of alcohol on health and mortality (HM Government, 2012). However, despite mounting evidence about the harms and the cost effectiveness of interventions to reduce alcohol-related harms (WHO, 2010), it is argued that these problems are not being taken seriously (Nutt, 2012). Addressing alcohol-related harms is said to be a low priority on the public health agenda (WHO, 2011) and policy responses that do exist are often fragmented (WHO, 2010).

## Policy perspectives: prostitution, alcohol and drugs

To date, the majority of Home Office publications have focused on on-street women's use of illegal drugs, warranted by evidence showing drug use to be more prevalent amongst this group (Home Office, 2004). *Paying the Price* (2004) was the first attempt to scope the issues connected to prostitution, with the aim of creating a coordinated Government strategy to address prostitution in England and Wales (Home Office, 2004). A subsequent publication by Hunter et al (2004) provided guidance for partnerships and service providers, advocating approaches which addressed drug markets and the on-street sex industry because of the links between the two. Holistic support to deal with the range of issues women face, and not just their drug use, was highlighted as important. The later *A Coordinated Prostitution Strategy* (2006) identified support for problematic drug use as a primary need of women involved in prostitution. It emphasised the need for women to be 'freed' from their drug use and for services to provide 'routes out' of prostitution. In more recent years, the current Coalition Government has not produced a prostitution strategy but did note in their *Review of effective practice in responding to prostitution* (Home Office, 2011) that alcohol use appears to be increasing amongst women involved in prostitution and that drug and alcohol use occurs in the off-street sex industry as well. It was noted that service providers need to understand the complex nature of drug/alcohol use amongst women involved in prostitution.

[11] The NHS defines binge drinking as drinking lots of alcohol in a short space of time or drinking to feel the effects of alcohol and to get drunk. Source: http://www.nhs.uk/Livewell/alcohol/Pages/Bingedrinking.aspx

[12] For example developing national strategies and action plans to reduce harmful alcohol use (Alcohol Strategy, HM Government, 2012). See WHO (2010) for a full outline of the Global Alcohol Strategy.

The Government's Drug Strategy (HM Government, 2010) sets out a locally-led, recovery-focused vision, with the aim of reducing drug use and dependency. Alcohol is also incorporated into this strategy, although a separate Alcohol Strategy was published in March 2012. The primary focus and priority of the Alcohol Strategy is binge-drinking and reducing overall alcohol consumption in the population. This has led to initiatives such as minimum pricing, prevention and education work, and encouraging responsibility amongst the drinks industry, including in relation to the marketing and advertising of alcohol. In reference to problematic users in general, emphasis is placed on individuals taking control of their use and changing their 'behaviour'. Both strategies stress the end goal of full recovery and abstinence. Preventing problematic alcohol use is also set as a priority; educating young people about the risks of alcohol and ensuring they can access advice and help. However, neither strategy focuses on the experiences of specific groups who are at risk of, or have, problematic alcohol use. No reference or application is made to women or those involved in prostitution. There is little mention of VAWG except for the assertion that alcohol can be a driver of domestic violence and the need to understand how alcohol can increase the severity of violence.

## Conclusion

To date, it is evident that research and policy has largely focused on the problematic use of illegal drugs amongst women involved in prostitution, primarily crack cocaine and heroin. Problematic alcohol use and its possible causal links with prostitution have received little attention. The Home Office (2011) review of prostitution does highlight though that alcohol is being increasingly used by women involved in prostitution. What research has been undertaken also indicates that alcohol is a substance used by this group. Based on previous work and what appears to be a trend of alcohol use amongst this particular group, further research is clearly needed to more fully explore the use of alcohol amongst women involved in prostitution.

## 2. Research aims

Drawing on the findings of *Breaking down the barriers*, this study aimed to explore with greater depth the relationship between women's involvement in prostitution and problematic alcohol use. Given the lack of research into this group's problematic alcohol use, this study focused primarily on alcohol. However, it did explore women's use of alcohol in combination with other substances (poly-substance use), where relevant.

The study had several aims and areas of focus which were derived from the findings of *Breaking down the barriers*, as well as gaps in previous research and evidence. The aims of the research were to:

- Look at why and when women involved in prostitution use alcohol problematically
- Explore and compare the ways in which women involved in different aspects of the sex industry use alcohol
- Explore the different ways in which women use alcohol and how this relates to their involvement in prostitution and impacts on exiting
- Enable practitioners working with women involved in prostitution who have problematic alcohol use to gain a better understanding of the relationship between the two, thereby informing more effective interventions.

These aims guided the focus of the research, as well as the content and structure of interviews, the focus of data analysis and the content of this final report.

## 3. Methodology

The research took a mixed methodological approach, involving the collection of both quantitative and qualitative data. The main body of the research involved follow up interviews with women who took part in *Breaking down the barriers*. Interviews were also undertaken with practitioners working in the drugs and alcohol fields and in services supporting women involved in prostitution. Due to the small scale and short time frame of the project, the majority of interviews with women and stakeholders were confined to London. Finally, an online survey was distributed to practitioners working in a range of fields and organisations across England and Wales.

Overall, approximately 67 individuals participated in this study. However, this number should be treated with some caution as some participants may be duplicated because they participated in an interview and subsequently completed the (anonymous) online survey. Nevertheless, it does provide an idea as to the approximate number of people that engaged with the research and the diverse experiences and views that the study has hopefully been able to capture, despite its small scale.

### Women involved in prostitution

Women were eligible to take part in this study if they were over the age of 18, were currently or formerly involved in prostitution and had previous or current problematic alcohol use. Problematic alcohol use was identified primarily through self-reporting. However, in *Breaking down the barriers* and this study, some women did not report their alcohol use as problematic during their initial assessment prior to interview, but subsequently disclosed alcohol use during their interview which was clearly problematic. These women reported alcohol impacting on their everyday lives or certain aspects of their lives[13]. In order to capture those who did not necessarily directly name or define their alcohol use as problematic, or minimised their use[14], this study relied on self-reporting[15] as well as drawing upon AVA's (2013) definition of problematic substance use[16]. Drawing upon this definition enabled women's problematic alcohol use to be identified through descriptions of their behaviour that they provided in research interviews.

As this study sought to build upon the findings of *Breaking down the barriers*, the aim was to re-interview women who took part in this earlier study. A purposive sampling strategy was used in order to select suitable women. This involved an initial re-analysis of statistical data and interview transcripts in order to identify women in the original sample who had reported, or had been identified as having, problematic alcohol use (36 women). Women who had given their permission to be re-contacted by the research team and who had frequently engaged with the *Breaking down the barriers* study were then re-contacted. Seventeen women were contacted either directly (in the cases of women who had provided their personal contact details) or via the support service through which they were initially accessed. Four women were successfully re-contacted and interviewed. The other women that the researcher attempted to re-contact had either changed their numbers, did not answer calls, or were no longer in contact with the support service listed. Sadly since the end of *Breaking down the barriers*, three women who fitted the criteria for this project had died in circumstances related to their involvement in prostitution[17].

[13] For example, one participant spoke about harming herself and others when she drank alcohol and her need to consume alcohol in order to cope with her involvement in prostitution. This woman's alcohol use and that of another interviewee would also escalate once they had one drink.
[14] See 'Limitations' on page 18 and '5. Findings' for a discussion of this.
[15] Women with problematic alcohol use were also identified by their key workers.
[16] See 'Note on terminology' on page seven for this definition.
[17] All three of these women had long term involvement in prostitution, were entrenched in the 'lifestyle' and had multiple physical and mental health problems relating to their involvement in prostitution.

Although the number of women the researcher was able to re-contact is low, this is not surprising given the often chaotic and transient lifestyles of women involved in prostitution. Consequently, additional interviewees were recruited via three support services for women involved in prostitution. Via this method, a further five interviews were conducted.

The interview process typically lasted between 45 minutes and one hour. Women were provided with a project brief by the researcher, followed by time for questions, and completion of the consent and personal details forms. The first part of the interview then consisted of a short needs assessment. This collected a range of quantitative data including demographic data, information on women's involvement in prostitution, their health, and drug and alcohol use. The needs assessment was then followed by a semi-structured interview. The interviews were loosely structured, with a topic guide containing questions that were framed around the aims of the research, but with flexibility to allow women the space to explore topics and areas that they felt were particularly relevant to their own circumstances. At the end of the interview women were invited to talk about anything else that they felt was relevant, before having a de-brief style conversation and being given the contact details of the researcher. Every woman was given a £10 retail voucher in thanks and recognition for their time and contribution to the research.

**Stakeholders**

Seven interviews were also undertaken with eight practitioners and professionals working in the drugs and/or alcohol fields or services supporting women involved in prostitution, including exiting services. These semi-structured interviews were conducted with the aim of providing an insight into professionals' knowledge and understandings of this client group and their alcohol use. Again, interview questions were based around the research aims and practitioners provided a range of information which enhanced the data gathered from the interviews with women.

Stakeholders interviewed were as follows:

- Commissioning Manager (substance misuse)
- Team Manager at a London-based substance misuse service
- Support Worker (exiting focused) at a prostitution specific support service
- Project Co-ordinator for a drugs and sexual violence project, part of a second tier women's organisation
- Team Leader and an Outreach Worker for a London-based outreach team
- Clinician at a London-based university hospital
- Exiting Worker at an exiting focused service.

**Other methods**

As well as semi-structured interviews, a short online survey was distributed via the online survey tool SurveyMonkey. This was sent to over 200 practitioners and professionals in England and Wales who work in a range of statutory and voluntary organisations including: drug and alcohol misuse; housing and homelessness services/organisations; women's services (including prostitution specific support services); criminal justice services; health services; and service commissioners. The survey aimed to collect both quantitative and qualitative data from a wider number of professionals than could take part in the semi-structured interviews, and expanded the geographical scope of the study beyond London. The survey questions included: the services that respondents and their organisations provide to women involved in

prostitution; respondents' understanding of the relationship (if any) between involvement in prostitution and problematic alcohol use; whether there exists any barriers, gaps and challenges to supporting women involved in prostitution; and recommendations for policy and practice. Fifty individuals responded to the online survey. Given that this was an unsolicited survey, and one focusing on a single, specific client group and topic, this is considered to be a relatively good response rate.

### Data analysis

All interviews were transcribed, with names, places and services anonymised. A thematic analysis of the interview transcripts was undertaken, identifying the key themes in relation to the research aims. These themes are presented in the findings section. The findings from the interviews undertaken with the women and stakeholders are discussed together under each theme. Some of the quantitative data gathered from the needs assessments are incorporated into the discussion for illustrative purposes and to complement the findings from the qualitative interviews[18]. Responses to the online survey were analysed using SurveyMonkey's analysis tool and these findings are also incorporated into the discussion.

### Ethics

Researching women involved in prostitution raises a number of ethical issues and considerations. Undertaking research into vulnerable and marginalised groups requires consideration of ethics not only during the conception of a project but throughout its course (Bindel et al*,* forthcoming), with ethics shaping the process and manner in which research is undertaken.

Given the small scale and short time frame of this project, specific ethical approval was not sought in the formal sense. However, this study was based on the findings of *Breaking down the barriers*, which achieved ethical approval from more than one source[19], and involved re-interviewing some of its participants. Additionally, the Project Researcher and Project Manager of this study were part of the *Breaking down the barriers* research team. They are therefore experienced in undertaking this type of research and knowledgeable of the ethical protocols and practices that were followed throughout the *Breaking down the barriers* study. To ensure additional ethical oversight and guidance, this study appointed an academic advisor to oversee the various stages of the project. The advisor chaired the advisory group for *Breaking down the barriers* and has years of academic experience of conducting ethical, robust social research focusing on vulnerable groups. The research team also worked in line with the British Sociological Association's and Social Research Association's codes of ethics, as well as Eaves' policies around data protection, confidentiality and working with vulnerable people.

Particularly pertinent to this study was the potential harm to research participants which could result from their participation in the research. From the outset it was recognised that women involved in prostitution are a vulnerable group to engage in research. Even for women who have exited for a substantial amount of time, re-living their involvement in prostitution via an interview can be distressing. With this in mind, the research team ensured that every woman was suitable to take part in an interview. This was decided with the assistance of women's key workers (where relevant), who, based on their knowledge of women's circumstances were able to assess their stability and the appropriateness of them taking part in the research. After interviews,

[18] Also see '4. Profile of women participants' for some of these data.
[19] *Breaking down the barriers* received ethical approval from London South Bank University Research Ethics Committee and Camden and Islington NHS Research Ethics Committee.

key workers were de-briefed (within confidentiality limits) and any concerns the researcher had regarding an interviewee's wellbeing were discussed with the interviewee and, if necessary, her key worker. In the case of participants from *Breaking down the barriers*, the researcher initially spoke to every woman to determine her current situation, briefed her about the project and then gave her a period of time to consider whether she wished to participate in the research. Women were also offered information and advice post-interview, given the contact details of the researcher and the women's drop-in centre at Eaves.

Given the focus of this study, obtaining informed consent was an important consideration. There was always the risk that women may have recently consumed alcohol or been intoxicated at the time of interview, which would affect their ability to provide informed consent to participate in the research. Every effort was taken to safeguard participants, and individuals' suitability to take part in the research was judged on a case-by-case basis. Where interviews were undertaken at support services, the researcher liaised with key workers before interviews began to ensure that women were fit to take part. In order to further ensure that women were able to give informed consent, every interview began with the researcher explaining the organisation of Eaves; the aims of the research; how their information and data would be anonymously and confidentially stored; their right to only answer questions that they wished to; and their right to confidentiality[20]. Women had the opportunity to ask any questions they had about the project and the interview process, and participants were informed that they could withdraw from the research process at any time. The researcher could also terminate the interview if they deemed that the participant was not in a suitable state to continue. Before the interview commenced women signed a consent form that reiterated this information.

### Limitations

As with all social research, this study has a number of limitations that need to be borne in mind when reading the findings and conclusions of this report. Firstly, the short time scale and limited funding for the project considerably restricted its scope and the size of the research sample. With greater resources the study could have involved a larger sample and expanded beyond London.

The specific focus of the study meant that a purposive sampling strategy was employed so that only women involved in prostitution who had current or former problematic alcohol use were selected for interview. This means that the sample is not representative of all women involved in on or off-street prostitution in the UK and the findings are not generalisable to the entire population. As with any research into the sex industry it is extremely difficult to achieve a representative sample because of the lack of definitive evidence about the size and characteristics of the industry (Shaver, 2005). Instead, this study and its findings are intended to provide a snapshot of problematic alcohol use amongst women involved in prostitution, alcohol use in different aspects of the sex industry, and an insight into service provision which is beneficial for this group.

Another limitation to consider is that the research largely relied on women self-reporting, or at least disclosing, their problematic alcohol use, either in the needs assessment or during the semi-structured interview. In general, research has shown that people under-report the amount of alcohol that they consume and/or give answers which they believe are favourable (Collis et al*,* 2010; Ely et al*,* 2001). This trend was apparent in this study and *Breaking down the barriers*, with women tending

[20] Women were informed of their right to confidentiality and the limitations of this in specific circumstances, such as safeguarding concerns.

to minimise their alcohol use, particularly during the needs assessment portion of the interview. As interviews progressed though, some women would discuss and reveal their problematic use of alcohol, although they still did not name it as such. This has two implications, firstly it means that when sampling for this project, some participants from *Breaking down the barriers* who did have problematic alcohol use may have been excluded from the sampling if they did not disclose their use at any point. Secondly, it may indicate that the findings in this report are actually an underestimation of women's alcohol use as they may not have reported the full extent of their use. This research limitation has important implications for services and practitioners in itself, and will be discussed in further detail in the findings section.

## 4. Profile of women participants

Nine women took part in semi-structured interviews. Their key characteristics were as follows:

- Interviewees were between the ages of 26 and 52
- At the time of interview, three women were currently involved and six had exited from prostitution
- Four women were predominantly involved in on-street prostitution and five were predominantly involved in off-street prostitution[21]. Several women had been involved in a variety of locations throughout their involvement though, and appeared to be part of a more transient group[22]. Three women had been involved on-street but also had 'regulars'[23], used their phones[24] and met buyers through friends. However, they still solicited on-street and were involved in the on-street 'lifestyle'. On the other hand, one woman who was currently involved in off-street prostitution had previously been involved in clipping[25] and had been entrenched in the on-street 'lifestyle' for many years before moving off-street.
- All women self-reported physical and/or mental health problems in response to questions in the needs assessment section of the interview. These included, but were not restricted, to: arthritis, liver cirrhosis, agoraphobia, stress, anxiety, depression, panic attacks and PTSD
- Eight women were currently unemployed and on benefits. Several of these women were undertaking voluntary work and/or studying for qualifications
- All except one woman used alcohol problematically when they were involved in prostitution[26]
- The duration of women's problematic alcohol use ranged from several years to the majority of their lives. For some, problematic alcohol use was not continuous, several women stopped for a period of time and then commenced again
- Five women reported histories of problematic alcohol use in their families; other research has highlighted this familial link (Dalla, 2003)
- Women reported using a range of other substances, sometimes in combination with alcohol. Other substances that women reported using problematically were: crack cocaine (6), cocaine (5), heroin (3), cannabis (2), amphetamines (2) and benzodiazepines (1)[27]
- All women had accessed support services at some point in their lives. These services included: generic health services; substance misuse services; specific alcohol services; residential treatment for substance misuse; accommodation services (both refuges and longer term housing); women-only services; and specific prostitution support services (including exiting focused services)
- Three women who had exited had not received support specifically for their involvement in prostitution. Two of these women said that such support would have been beneficial at the time they were exiting.

[21] This was determined by where women were predominantly involved at the time of interview. For those women who had exited this was where they were predominantly involved before exit.
[22] Bindel et al, 2013.
[23] 'Regulars' refers to buyers that women sold sex to on a regular basis.
[24] This refers to women being contacted by buyers via their mobile phones as opposed to soliciting on or off-street. Buyers may be regulars or have been passed on a woman's telephone number. Women may also use their phones to contact regular buyers or display their numbers in telephone boxes (referred to as carding).
[25] Clipping refers to the practice in which women solicit for sexual services in exchange for cash or goods and then take the payment but do not provide the 'service' promised.
[26] This woman fitted the criteria for the research but as the interview progressed it became apparent that she did not use alcohol problematically when she was involved in prostitution. She has been retained in the sample though because her alcohol use is relevant to this study; she used alcohol problematically after exiting prostitution, replacing other substances that she used whilst she was involved.
[27] Additional women did use these substances but not problematically. For example, they may have used a substance once, recreationally or occasionally.

## 5. Findings

### Problematic alcohol use and prostitution[28]

#### *Prevalence*

All women interviewees reported or were identified[29] as having past or current problematic alcohol use. Eight women used alcohol problematically whilst they were involved in prostitution. The remaining woman used other substances whilst she was involved but used alcohol problematically before and after her involvement. Several women reported using alcohol problematically on and off throughout their lives (including when they were involved in prostitution).

Gossop et al (1995, 1994a) found that over three quarters of women would use alcohol before and during selling sex. In this study, a few women reported using alcohol before selling sex to increase their confidence, but more so to make the experience of selling sex more bearable:

> *"If I knew that it was going to happen then I would kind of drink before it so that I didn't really know what was going on or I could forget about what was happening"* (I5, off-street).

Some women noted though that they would not use alcohol heavily before selling sex as it would affect their mental state and levels of awareness, putting them at increased risk:

> *"You can't do that drunk; you've got to have your wits about you"* (I6, off-street).

A few women reported using alcohol as part of their 'lifestyle' in prostitution, drinking with buyers and other women. Others reported drinking alcohol after selling sex to de-sensitise themselves, block out their experiences and reduce anxiety:

> *"Just to forget about what just happened for the last couple of hours, what I had to go through. Yeah and the dirty, cheesy old men that I've been around or… the place that I've been or what they've asked me to do"* (I1, on-street).

Although some degree of alcohol use amongst women involved in prostitution was recognised by all stakeholders, there were mixed views about the prevalence of *problematic* use. Some stakeholders said that problematic alcohol use was common amongst women involved in prostitution and is also becoming increasingly prevalent amongst this group. A few women thought that this was because alcohol is cheaper and more readily available compared to other substances. In this study, several women had switched to using alcohol because of this:

> *"I couldn't afford it [cocaine] and alcohol was cheaper… I can go down to the corner shop and I'm out of my face on £6...Whereas, to get half a gram is like £20/£25"* (I8, off-street).

The Commissioning Manager noted that in the general population there is an increasing shift away from other substances towards alcohol, with alcohol becoming the 'drug of choice'.

On the other hand, some participants did not believe that *problematic* alcohol use amongst women involved in prostitution was common or a concern. They reported

[28] Due to the small sample, where place of involvement is discussed in the findings of this report this is informed by the data collected from stakeholders as well as the interviews with women.
[29] Not all women reported their alcohol use as problematic, see '3. Methodology'.

that women involved in prostitution did use alcohol, but Class A drug use was more prevalent, more problematic and generally of greater concern.

### *Themes*

Four women who had current problematic alcohol use tended to minimise their alcohol consumption, with some not recognising that it was problematic. All but one of these women were still involved in prostitution. Several stakeholders said that this minimisation was quite common:

> *"Some of them think 'oh no it's fine, I can handle it' but they can't…until they come and see us or are referred to a drug agency, that's when they then realise how bad they have been drinking and how it has affected them"* (ST8, Exiting Worker, exiting service).

Participants noted that women also have a tendency to minimise their alcohol use if they are poly-substance users, tending not to see alcohol as the problematic substance. It was suggested that this minimisation of alcohol use might be influenced by service providers' own perceptions of alcohol:

> *"Women themselves tend not to focus on their alcohol use. And I don't know if that's because… there's other drugs that they know that professionals think are more important"* (ST2, Project Coordinator, second tier women's organisation).

All women reported using alcohol in combination with other substances, some on a frequent basis. Women most commonly reported using alcohol with crack cocaine. Two women noted an increasing trend of these two substances being used together amongst women involved in prostitution, particularly those on-street:

> *"…Everyone is doing it now [alcohol and crack cocaine], everyone. And it seems to be a big addiction … 'cos before it used to be crack and heroin…Now it's crack and alcohol and it's really bad"* (I3, on-street).

This trend was also recognised by stakeholders and seems to differ from previous studies (Cusick et al, 2003; Gossop et al, 1994a) which highlight high rates of combined heroin and crack cocaine use, particularly amongst on-street women.

Several stakeholders spoke about a pattern amongst on-street women who have problematic heroin use then developing problematic alcohol use once they are stable on methadone. The trend of replacing one substance with another was found amongst three women who took part in this study but extended to substances other than heroin, and affected off-street women as well. Some participants believed that this trend was because the root cause of substance use was not being addressed and women were replacing substances in order to cope:

> *"That's why we see women moving from heroin to get onto methadone to then go on drinking because they are not actually dealing with the actual problem, the actual trauma or whatever it is that they are trying to cope with"* (ST1, Support Worker, prostitution specific service).

### *Causality and relationship*

One woman interviewee did not think that there was a link between her involvement in prostitution and problematic alcohol use. The majority of participants, however, were adamant that there was some sort of link or relationship[30]:

[30] This included the woman who did not use alcohol problematically when she was involved in prostitution. She noted that she could see a link between other women's alcohol use and their involvement in prostitution.

*"They are interlinked, no doubt about it. Doesn't matter what anybody says, they are interlinked and if they say it is not they haven't really thought about what they are saying"* (I3, on-street).

Women and stakeholders noted that this link or relationship was not specific to alcohol, but applied to substances in general.

Six women reported problematic alcohol use commencing before they became involved in prostitution. Some of these women reported drinking alcohol quite heavily since their teenage years. Women who used alcohol problematically before entry used it as a form of escapism and as a coping mechanism, including to cope with feelings of loneliness, experiences of childhood violence[31] and abusive partners.

Previous research (Cusick et al, 2003; Potterat et al, 1998) has reported that when drug use precedes entry into prostitution, women commonly enter prostitution in order to fund their drug use. A few stakeholders thought that this causation applied to alcohol, but generally other substances were seen to be a greater influence on women's entry into prostitution. In this study, three women reported entering prostitution to fund their drug use and one woman entered to fund her combined drug and alcohol use. One woman gave her insight into prostitution and substance use being interlinked in this way:

*"When you become an addict it makes you more vulnerable to sexual exploitation, and to coming into prostitution because it's a way and a means of getting it*" (I9, off-street).

Only one woman in this sample started exchanging sex solely to fund her alcohol use. Substances were not the only cause of entry though, with women in the sample also citing financial need and coercion as reasons for entering prostitution.

Research has documented how involvement in prostitution can cause psychological distress and a range of mental health problems (Bindel et al, forthcoming; Tomura, 2009; Farley et al, 1998), as well as feelings of shame and guilt (Tomura, 2009; Young et al, 2000). Substances, particularly crack cocaine, can be used to cope with these feelings and distress (Young et al, 2000). In this study, women most commonly cited using alcohol as a way to cope with their involvement in prostitution and the impacts that it had on them. Stakeholders agreed, highlighting the importance of seeing alcohol use as a symptom for much deeper underlying problems, particularly trauma and distress:

*"Drug and alcohol use are generally a symptom – whether it is a coping strategy or a way of numbing things. It becomes a symptom of whatever else is going on – there are certain types of life events and traumatic events where you might see drug and alcohol use more often than not"* (ST6, Team Manager, substance misuse service).

Alcohol use and prostitution were also found to be part of the self-perpetuating cycle which Young et al (2000) identified in relation to other substances, where an increase in prostitution can lead to an increase in substance use, or vice versa. Women commonly reported increasing their use of alcohol as their involvement in prostitution progressed, in order for them to cope:

*"I think it just got worse and worse … my involvement became more frequent…I would start drinking most days…I would find that the more and more things*

[31] Research has shown high rates of childhood violence amongst women involved in prostitution (Bindel et al, forthcoming).

*happened, the more I needed to drink to be able to forget and block everything out*" (I5, off-street).

Stakeholders confirmed the existence of this cycle, with one noting that this was particularly applicable to alcohol over and above other substances that women use.

Whilst there appears to be a link between prostitution and alcohol use, stakeholders stated that this link or relationship is complex and not linear. This is apparent from the women in this research who reported using alcohol in a variety of ways before, during, and after their involvement in prostitution. Like Graham and Wish (1994), this study found that any link can also change and evolve. Some women in this study who entered prostitution to fund their drug and/or alcohol use continued to use alcohol, but as their involvement in prostitution progressed, their alcohol use evolved to be a coping mechanism. Another woman who initially used alcohol socially with buyers later began to use alcohol to cope with her involvement. Due to this complexity, one stakeholder was hesitant to describe a relationship in concrete terms, believing that the label of 'relationship' can divert attention away from women's actual experiences. Thus as Dalla (2002) highlights, whilst there are clearly some links between prostitution and alcohol/drug use, entry into prostitution and women's continued involvement is complex and the result of multiple personal and contextual factors.

### *Place of involvement*

There were some differences between on and off-street women's use of alcohol. However, because some women were more transient between places there was some blurring of these differences. The increasingly transient nature of prostitution and the overlap between being located on-street and off-street has been identified in recent research (Bindel et al, 2013). This is important to bear in mind as the alcohol and drug use, as well as the needs and circumstances, of on and off-street women may not be as dissimilar as previously thought (Bindel et al, forthcoming).

Problematic alcohol use was generally seen by stakeholders and survey respondents to be more prevalent amongst women involved in on-street prostitution. Women involved in on-street prostitution were reported to use alcohol extremely heavily, with stakeholders noting that this group are often physically dependent and defined as 'alcoholics'. This group's alcohol use, combined with their involvement in the on-street 'lifestyle', was seen to make women extremely chaotic.

Problematic alcohol use amongst off-street women was highlighted by two stakeholders, but one noted that very little is known about this group's use of substances. Off-street women were not necessarily viewed as 'alcoholics' and it was noted that their use tends to be lower than that of on-street women. However, stakeholders believed that off-street women do still use alcohol problematically, with alcohol being used as a coping mechanism, and women's alcohol use impacting on their physical and mental health.

The on-street women in this study reported a tendency not to drink large amounts of alcohol before selling sex because of the increased risk posed when they were soliciting on the street. Two on-street women reported using alcohol to cope with their involvement in prostitution, whilst one woman used it to cope with feelings of loneliness and boredom[32]. This woman also described specifically using alcohol to come down from crack cocaine. In the off-street group there was a tendency to drink before and/or whilst selling sex, primarily to increase confidence and cope with selling

[32]The remaining on-street woman did not use alcohol problematically when she was involved in prostitution.

sex. Off-street women also tended to drink alcohol socially, sometimes with other women and buyers. Like the on-street group though, they drank after selling sex to cope, relax and de-stress.

Although women were asked about the types of alcohol that they drank whilst they were involved in prostitution, because of the overlap between women's place of involvement there were not any notable trends in women's 'drinks of choice' and what aspect of the sex industry they were involved in.

Poly-substance use was reported to be common amongst both groups. Stakeholders noted that on-street women frequently use alcohol in combination with crack cocaine, also reflected by three on-street women in this study[33]. Off-street women were deemed to use other drugs problematically with alcohol, most notably cocaine, prescription drugs and amphetamines. Indeed, the three off-street women in this study who used cocaine problematically did so in combination with alcohol. Three off-street women also spoke about using alcohol in combination with prescription drugs, and how this combination caused them problems.

### *The harms of alcohol*

The harms of alcohol have become increasingly recognised (Nutt, 2012; WHO, 2011, 2010) and this was a theme that consistently emerged throughout this study. In comparison to other substances, several stakeholders and all of the women interviewed thought that the harm caused by alcohol was as serious, if not worse:

> *"It's the most harmful drug, you couldn't get more harmful and they [the Government] still aren't taking it seriously"* (ST7, Clinician at a London-based university hospital).

For many, the only differentiation between alcohol and other substances was its legality:

> *"It is a horrible pernicious drug and it is just as bad as any other drug, it's just made legal"* (I9, off-street).

Previous research supports these views (Nutt et al, 2010), listing alcohol as the most harmful substance overall out of twenty illegal and legal substances. This was accounting for sixteen measures of harm caused to both the individual consuming the substance and to wider society.

Women interviewees described the impact that alcohol had had on their physical and mental health. In particular, alcohol had affected their physical appearance, led to liver problems and made episodes of depression and anxiety increasingly worse. For several women, the physical and mental impact that alcohol use had had, or which they had observed in others, caused them to reduce or stop their alcohol use. Some stakeholders believed that the physical health problems that result from alcohol are actually more severe and longer lasting than other substances. One stakeholder also noted the health consequences of poly-substance use[34], a particular harm which may be important to consider given that poly-substance use appears to be common amongst women involved in prostitution.

Previous research (Cusick et al, 2003; Green *at al*, 2000) has noted how the use of substances may increase women's vulnerability to violence and other risks whilst they

[33] The other on-street woman used alcohol and crack cocaine but not whilst she was involved in prostitution.
[34] This stakeholder noted that alcohol potentiates the effects of any substance it is consumed with. A particular concern is the combination of alcohol and cocaine, which when consumed together form cocaethylene, a chemical which is more harmful than when alcohol or cocaine are consumed alone.

are selling sex. Stakeholders and women believed that women involved in prostitution also face similar, increased risks when under the influence of alcohol:

> *"It is a risk anyway when they are going out…but then with alcohol it just increases their risk ten-fold I think because they are not aware of what's going on"* (ST1, Support Worker, prostitution specific service).

A few stakeholders and women believed that alcohol is more 'risky' in this sense than other substances. As noted previously, some women said the increased risk that alcohol posed to their safety was the reason why they did not drink heavily before selling sex.

Women also spoke about the wider harm and impact that their alcohol use had caused in their lives. For some women, their alcohol use had been a contributing factor in their children being taken into care. Several also spoke about the impact it had had on their relationships with family and friends:

> *"Absolutely, completely cataclysmic…The worst thing that I have ever done… alcohol… it has just led me into shit on every level. It's cost me boyfriends, it's cost me girlfriends, it's nearly cost me my relationship with my family"* (I7, off-street).

It was suggested that education around the harms of alcohol would help to reduce some of these consequences. Early interventions via GPs and other health services, along with harm minimisation advice (including dispensing vitamins to prevent encephalitis[35]), were seen to be ways to minimise some of the alcohol-related health problems. One stakeholder stated that the UK Government also needs to acknowledge these harms and take extensive action, making alcohol-related harms a public health priority.

### *Exiting*

Alcohol use was seen by participants in this study as a barrier to exiting prostitution, but there were disparities between the views of women and stakeholders. A few women said that alcohol could act as a barrier because alcohol use was so intertwined with involvement in prostitution. Many stakeholders and the majority of survey respondents also believed that like other substances, alcohol use could be a barrier to exiting. For some, alcohol was seen to be such a large barrier that it had to be addressed in order for a woman to exit, otherwise:

> *"...they will definitely run back in it, they will jump back in it"* (ST8, Exiting Worker, exiting service).

However, some stakeholders and most women tended to see Class A drug use and other obstacles as more significant barriers to exiting[36]. Since some women used alcohol solely to cope with their involvement in prostitution, some said that having exited prostitution they then reduced their alcohol use because they no longer had to drink as heavily to cope. A few women continued to drink after exiting though, to cope with the trauma, distress and mental health problems that were a legacy of their involvement in prostitution.

Although most women did not view alcohol as one of the most significant barriers to exiting, alcohol use could be an obstacle in another sense. Since alcohol may be used

[35] One stakeholder noted that a particularly concerning alcohol-related health problem is encephalitis.
[36] For example, one woman who was currently involved and had problematic crack cocaine use sold sex to fund her drug use and noted that as long as she used drugs she would need to be involved in prostitution.

as a coping mechanism, fear of losing this means of coping could make some women reluctant to access support and treatment for their alcohol use. One woman with current problematic alcohol use said that this was the main reason why she was hesitant to seek support for her alcohol use:

> *"I know that I need some help with it 'cos I know that it's not a healthy way to kind of deal with stuff. But then at the same time…I still feel the benefits of it in terms of it helps me sleep and its helps calm me down and stuff"* (I5, off-street).

## Services and support

### *Service provision (including in drug and alcohol services)*

Reflecting recommendations from previous research (Bindel et al, forthcoming; Hester and Westmarland, 2004), holistic service provision which addresses all of women's needs was favoured by participants in this study. One-stop-shop type services were preferred as they enabled women to access a range of support in one place, as opposed to attending multiple services and having several key workers. Some women stated that they preferred this type of service, which provides drug and alcohol support in-house, as they found it too intense to attend a stand-alone drug or alcohol service where everyone else who attends are also problematic users.

Specialist services[37] for women involved in prostitution were deemed to be essential. These services were seen to have an in-depth knowledge and understanding of prostitution and women's needs, and able to provide exiting focused support. These types of services were described as being in short supply though. The provision of exiting support in all services was also noted to be inconsistent and not standard practice across services, seldom being proactively offered. Stakeholders believed that services need to be more aware of exiting and proactively offer this, as also recommended in *Breaking down the barriers*. Increased and sustainable investment in specialist provision was called for, along with the need for local authorities to collect data on women who are involved in prostitution in order to demonstrate a need for such services.

Access to appropriate housing was also seen as essential. Stable and secure housing is a crucial element in treatment for alcohol/drug use (Hunter et al, 2004), whilst a lack of safe housing can be a barrier to exiting (Bindel et al, forthcoming). However, several stakeholders stated that housing is a major problem in supporting women involved in prostitution. It was reported that there is a lack of housing provision specifically for women involved in prostitution, whilst the limited accommodation on offer is often inappropriate, particularly if it is mixed sex or located near a 'red light' area. Refuges also tend not to accept women involved in prostitution and/or women who use substances because they are deemed to be too 'high risk'. The need for specialist accommodation schemes (both refuges and longer-term housing) that are specifically for women involved in prostitution was highlighted. Such accommodation assists women with making changes at their own pace, helps stabilise them, and enables women to address their multiple needs (Matthews and Easton, 2012).

All women said that the atmosphere and ethos of a service was really important in encouraging them to attend. Women wanted a service which was relaxed, non-judgemental, welcoming and friendly:

[37] A 'specialist service' in this context is a service which provides targeted support and provision to women who are or have been involved in prostitution, addressing their specific needs in this regard.

> *"They were…it felt accessible, I can't explain it… the building, the people there, the woman who answered the door, the women who were there. They made a point of not being 'us' and 'them'"* (I9, off-street).

This type of environment was particularly important to several women because of the shame they felt about their involvement in prostitution, and their fears of being negatively judged; concerns which often act as barriers to accessing services (Smith and Marshall, 2007).

Women also valued a women-only space and female workers, including at drug and alcohol services. Due to negative experiences, including male violence, women-only spaces were seen as a safe environment, and a female key worker someone that women were more likely to feel comfortable discussing their circumstances with. However, stakeholders highlighted problems accessing women-only services or spaces and obtaining a female worker, including in drug and alcohol services.

Empowerment and work around self-esteem and self-worth were mentioned by participants as important areas of focus for services. Diminished sense of self-worth and self-esteem resulting from involvement in prostitution, as well as the stigma of being a female drug/alcohol user, were noted by participants in this study and have been documented in previous research (Drugscope and AVA, 2013; Tomura, 2009; Smith and Marshall, 2007). Addressing these issues is a significant part of women's recovery (Bindel et al, forthcoming), and women in this study recognised this:

> *"It's about building your own thingy [value] up… and people saying 'you are alright, it don't matter what you did: yeah you did this, but there is life after it'"* (I9, off-street).

For some women, volunteering and access to education assisted with increasing their self-esteem, whilst also providing them with diversionary activities which kept them busy. Several women said that feeling valued and cared about by key workers and other people in their lives also played a large role in increasing their self-worth:

> *"So they must see something good in me...because I could feel love from these people…yeah! I am someone! I have got some kind of value"* (I3, on-street).

### *Support and key working*

Women preferred support from services, including drug and alcohol services, that was provided on a one-to-one basis. The value and importance of services, including drug and alcohol treatment, taking a relationship-based approach[38] has previously been emphasised (Bindel et al, forthcoming; Smith and Marshall, 2007). One-to-one support with a case management approach was seen to provide women with a central person who can support them on an on-going, consistent basis, whilst also linking women into other services. This approach was also seen to provide women with support which is flexible and delivered at their own pace, including tailored exiting support. One-to-one support is also important if lapse or relapse occurs (both in terms of alcohol/drug use and involvement in prostitution), which several women in this study experienced. When this occurs it is important that women receive one-to-one support to see the lapse/relapse as a learning opportunity rather than a failure (Bindel et al, forthcoming).

Some women also said that they preferred support from a worker who had previously been a problematic substance user, feeling that they could relate better to peers who have a 'lived' understanding of alcohol and drug use. One woman spoke about her

[38] A 'relationship-based approach' involves women receiving support from a dedicated key worker.

negative experiences of accessing drug services where workers did not have such experience:

> *"And lots of people I saw…didn't have a clue what they were doing...they'd just learnt the job and they didn't have no life experience, and I couldn't relate to them. I felt like I knew more than them"* (I9, off-street).

The relationship that women had with their key worker was one of the most valued aspects of support. Consistency in key workers and a positive relationship impacted on the progress that women made in addressing their alcohol/drug use, and if relevant, in exiting prostitution. Several women in this study had changes in key workers which had affected their ability to trust their key worker and their motivation to engage with a service. Qualities which women saw as particularly important in key workers were trust and respect, as well as being caring, honest, open, non-judgemental, personable and 'down-to-earth'; qualities also advocated amongst key workers in National Institute for Health and Care Excellence[39] (NICE) guidelines (NICE, 2011). Women valued having a key worker who was also able to advocate on their behalf. Several stakeholders who worked with women involved in prostitution recognised this supportive element to be an important part of their work:

> *"If she wants to exit it will be a tough journey…but we have to be supportive... And yes she might fall along the way, but, you know, it's for us to like pull her back up and get her back on there… they are going to need that support from us... we have to be there for them"* (ST8, Exiting Worker, exiting service).

Whilst one woman benefited from group work in a drug and alcohol service, several said that they did not like this form of support in any services, mainly because groups tended to be mixed sex and attendees often came from different backgrounds. Women felt uncomfortable talking about their involvement in prostitution in mixed groups and feared judgement. Differing levels of drug/alcohol use within groups was also a concern. Other women said that they preferred groups which were specifically for women involved in prostitution or were women-only, a form of support recognised and recommended by the NTA (2002).

### Drug and alcohol services and treatment

Due to the increasing use of alcohol amongst women involved in prostitution, suitable treatment for alcohol use is seen to be an important part of a strategic response to prostitution (Home Office, 2011). As well as the elements of service provision outlined above, women and stakeholders in this study also spoke about aspects of service provision specific to drug and alcohol services.

Women in this study reported accessing community-based drug services as well as stand-alone alcohol services. Some had accessed harm minimisation focused advice and support, including via outreach services. Women also reported accessing more structured and focused interventions, including informal and structured psychosocial interventions[40], self-help groups and Twelve Step recovery programmes. They tended to access this support once they had hit 'rock bottom' in terms of their alcohol/drug use and/or involvement in prostitution[41]. The usefulness of different interventions

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[39] Formerly The National Institute for Clinical Excellence.

[40] These are evidence based interventions designed to assist clients in making changes to their substance using behaviour. They focus on the individual and internal changes as well as wider, social and contextual changes. Interventions can be on an individual basis or within a group, and include cognitive behavioural therapy, relapse prevention therapy and motivational techniques (http://www.dldocs.stir.ac.uk/documents/mocdmupdate2006.pdf; http://www.nice.org.uk/nicemedia/live/11812/35973/35973.pdf)

[41] For example, alcohol-related health problems, violent experiences when selling sex or reaching their limit and feeling like they could not continue selling sex.

varied for each woman in this study; what worked for one woman was not necessarily beneficial for another. Women progressed through alcohol/ drug treatment and support at different paces and some lapsed or relapsed at various points.

Several women had accessed residential treatment and/or detox for their alcohol use and use of other substances. Previous policies have advocated the benefits of this treatment for women involved in prostitution (Home Office, 2006, 2004) and stakeholders agreed on this point. Living in the same area whilst trying to address substance use and other problems can be a barrier to change as women remain in the same environment where they are involved in prostitution and are surrounded by the same social groups (Bindel et al, forthcoming; Drugscope and AVA, 2013). For some women, residential treatment was thus seen to be preferential to community-based services:

> *"She's done it [treatment in the community] several times and it just doesn't work…because she is back in the community and she is amongst those same peers, the same friends who are doing it. 'Cos she is surrounded by it"* (ST8, Exiting Worker, exiting service).

Residential treatment provided some women with a break from their involvement and a safe, supportive environment in which they could address their multiple needs. For other women in this study, this form of treatment was not beneficial because they found it too rigid or they were not ready to address their use in such an intense way.

A few women reported cutting down their alcohol use by themselves, being prompted to do so by the impact that their use was having on their health and life in general. Some of these women did access support from other services and/or their GP in the process of cutting back on their use.

### *Knowledge and skills of drug and alcohol workers*

Participants believed that drug and alcohol workers require knowledge and understanding of the needs and circumstances of women involved in prostitution. This includes around the harms of involvement in prostitution, the multiple needs of women, and the exiting process, including the stages of recovery and support that are required.

It was also seen to be vital for drug and alcohol workers to understand any possible links between prostitution and alcohol use. This includes when women are using alcohol as a coping mechanism:

> *"There is a reason why people use… and until you get the crux of that, I don't think anyone can really ever get over it and move on"* (ST1, Support Worker, prostitution specific service).

It was noted by participants that such a depth of knowledge and understanding provides an insight into the triggers for alcohol use, the associations that may have developed between alcohol and prostitution, and importantly, the root cause of women's alcohol use. Any link then needs to be borne in mind when providing interventions, and it was believed that this would lead to greater success in treatment. Indeed, it has been shown that there are improved outcomes for women when treatment is gender responsive and trauma informed (Messina et al, 2010).

Participants noted that women's multiple needs have to be addressed by drug and alcohol services, as opposed to addressing women's alcohol and/or drug use in isolation. For some women in this study, receiving treatment and support solely for

their drug use was sufficient and had led to their exit because they no longer had to fund their drug use. However, most women needed holistic support which addressed all of their needs including their alcohol/drug use, as one stakeholder explained:

> *"You know everything links together so they need to address one to get out of the other because it's like they need the drink, 'I've got to fund it by working on the street'…so it is the drink, the prostitution, you know, goes hand in hand"* (ST8, Exiting Worker, exiting service).

Holistic work which addressed all of women's needs, and not just their alcohol use, was not seen to be standard practice amongst drug and alcohol services though. One stakeholder described service provision in this respect as a 'postcode lottery', with the quality and type of service provision varying from place to place. Indeed, a recent study found low provision in drug services for supporting women with their involvement in prostitution (Drugscope and AVA, 2013).

Inconsistencies were also noted in drug and alcohol workers' knowledge and understanding of the multiple needs of women involved in prostitution and the interlinking issues that they may face:

> *"I think they are not understanding how involved the women are in prostitution and how it affects them"* (ST8, Exiting Worker, exiting service).

Participants thought that many drug and alcohol workers also lack an understanding of how prostitution and alcohol/drug use can be linked, including how alcohol can be used as a coping mechanism. This is a gap which has been previously highlighted (Young et al, 2000) and which stakeholders in this study thought could be particularly problematic:

> *"If you are just trying to get someone to reduce their substance use...if that's their coping strategy for their experiences of trauma...then actually the substance use is probably the one thing that's keeping them alive"* (ST2, Project Coordinator, second tier women's organisation).

In line with recommendations from previous research (Bindel et al, forthcoming), several stakeholders advocated dedicated training for drug and alcohol workers, and other practitioners, around identifying and supporting women involved in prostitution. It was hoped that this would lead to an improved understanding of women's needs and the intersecting issues, and a more consistent approach. Stakeholders also highlighted partnership working as a way of ensuring women's interlinking needs are met, enabling more effective links and referral pathways to be established. It is an approach which is argued to be the most effective response for women involved in prostitution (Bindel, 2006) and is advocated by the NTA (2002) and the Home Office (2006, 2004). In two stakeholders' boroughs, professional forums were beneficial in encouraging such joint working.

On a more strategic level, it was suggested that violence against women and girls (including prostitution), and problematic alcohol and drug use should be more effectively linked within strategies and policies to reflect the intersection of these issues and advocate a more joined up approach. This was a recommendation also made in recent research which looked at services for women involved in prostitution with problematic substance use (Drugscope and AVA, 2013).

### *Availability of drug and alcohol services*

Several stakeholders raised concerns that the availability of alcohol-specific support services is decreasing, and so accessing them can be difficult. Drug services, which cover a range of substances including alcohol, were also seen to be lacking in availability:

> *"We are trying to get rid of all addiction services. I mean this Government doesn't believe in addiction, it thinks it's a lifestyle choice...we are fighting a battle to make sure there are any services left"* (ST7, Clinician at a London-based university hospital).

Stand-alone alcohol services were viewed as important because of the differing treatment required for problematic alcohol users compared to other substance users. The lack of drug and alcohol support service provision was seen to restrict the ability of services to respond when women are seeking support, thus impeding women's motivation to seek help. This barrier has been previously highlighted (Smith and Marshall, 2007) and some women interviewees had experienced this:

> *"To access services in the past it were a six week wait… And I think what you tend to find is when somebody goes to get clean...we've decided now…it's when you are ready. Six weeks down the line, you don't know where you're going to be at"* (I9, off-street).

As others have suggested (University of Stirling et al, 2013), stakeholders advocated more funding for services, particularly for alcohol-specific support services.

Despite the benefits of residential treatment for some women, stakeholders were concerned that this provision is also limited in availability due to funding cuts and current Government policy. Places for residential treatment were reported to be limited, with a greater focus on treatment within the community. Some women reported having to wait for a long time to access residential treatment, whilst several other barriers were noted. Primarily these revolved around this form of treatment being mixed sex and not catering for women's needs and circumstances, for example if women had children. These barriers can affect the number of women accessing this type of treatment, as well completing it (Romero-Daza et al, 2003), and indeed one woman in this study left residential treatment because she didn't want to be separated from her son.

## Challenges

### *Male orientation of drug and alcohol services*

It has been acknowledged that drug and alcohol services are designed for the majority of people who access them: males under the age of 35 (NTA, 2002). The NTA claims though that these services are now more inclusive of women (NTA, 2010). However, participants in this study still saw a large gap in this respect. The male orientation of drug and alcohol services and lack of provision for women involved in prostitution, and women in general, was seen to be a significant barrier to women accessing drug and alcohol services, as well as receiving holistic support. This was seen to be the case for both community-based services, as well as residential treatment.

It was noted that drug and alcohol services need to be more creative about how they encourage women to access their provision. The Team Manager at the London-based substance misuse service described how the service she worked at had become more inclusive of women; appointing a dedicated women's worker, providing

a women-only space, peer support and women-only groups focusing on relevant topics (such as relationships, domestic violence and sexual health). Another way to ensure that drug/ alcohol services are more inclusive of women is by commissioning services that are tailored to their needs (Simpson and McNulty, 2008). In a similar vein, stakeholders suggested stipulations in funding contracts that ask how drug and alcohol services will provide for women (including women involved in prostitution), and for services to be audited on their provision in this regard.

### *Identification*

Identification, or lack of, was another significant barrier and challenge in supporting women involved in prostitution with problematic alcohol use. Stakeholders reported that drug services (which cover a spectrum of substances) may fail to identify women's alcohol use, or minimise it and focus on Class A drug use instead. A few women interviewees reported experiencing this. Stakeholders also raised concerns that if alcohol use commenced or increased during treatment for other substances, this tended not to be identified. The generic focus of drug workers on all substances was seen to be one cause of this gap:

> *"The alcohol service has sort of become a kind of pale model of the drugs service…drug workers have much less understanding of alcohol...The alcohol workers…their skills were different"* (ST7, Clinician at a London-based university hospital).

Two stakeholders thought this focus was also due to the perception that Class A drug use is more prevalent amongst women involved in prostitution, and therefore a main presenting need. It was suggested that drug workers need to widen their skill base and continually assess for alcohol use, so use can be monitored and brief interventions can be offered. Improved identification of problematic alcohol use within all services was also advocated, especially health services.

Participants also highlighted inconsistencies in regards to drug and alcohol services identifying women's involvement in prostitution. This lack of identification was not seen to be specific to drug and alcohol services though, and has been found to be common across services (Bindel et al, forthcoming). Stakeholders noted that even if identification questions are included in assessments, workers are often not confident in asking them. This is problematic given that women can be reluctant to voluntarily disclose their involvement in prostitution (May et al, 1999). It means all of women's needs may not be identified and addressed, and the negative consequences of this were noted:

> *"If there isn't enough information you could be setting up that client to fail, if they don't know the real reason behind her using"* (ST8, Exiting Worker, exiting service).

Training was seen to be the main way to improve workers' abilities and confidence around identifying and responding more effectively to women involved in prostitution.

### *Challenges of working with women*

Several stakeholders in frontline roles and almost half of survey respondents said problematic alcohol use itself was a significant challenge when working with women. Engaging with women was reported to be difficult because they were frequently intoxicated and forgot appointments or were not in a suitable state to work effectively with. A few stakeholders based in coordinating services also noted that these challenges affect their ability to engage women with other services they may need.

As previously discussed, women may minimise or not report their alcohol use and can fail to recognise the problematic nature of it. Some stakeholders noted that this also poses a challenge when working with women. One stakeholder and some women thought that this minimisation and denial of problematic use is the reason why some women repeatedly go through treatment and don't complete it. Stakeholders said that overcoming this barrier involves working with women to build insight, helping them to understand their alcohol use and its impacts, and how it might relate to their involvement in prostitution:

> *"We just kind of look at the reasons for the drinking, how often they are drinking. Then maybe sort of challenge them: what would it be like for them to be not drinking and could they do a period of time not drinking…And sort of discuss where alcohol fits in their life and how it is impacting them"* (ST1, Support Worker, prostitution specific service).

Working with women who have problematic alcohol and/or drug use and mental health problems (dual diagnosis) was seen to be a particular challenge. This is a significant challenge given that there are high rates of mental health problems amongst women involved in prostitution who have problematic substance use (Drugscope and AVA, 2013). When women access treatment it can be difficult to determine the relationship between alcohol/drug use and women's mental health problems (Bindel et al, forthcoming). It can also be difficult for women to access mental health services due to the requirement that clients be substance-free (Shelter, 2007). Stakeholders thought that part of this problem is that mental health and drug/alcohol services typically work in isolation, despite the issues they address clearly being connected. It has been recommended that these services work more together, developing a shared understanding of the issues in question (Hovarth et al, 2012). One stakeholder reported this to be beneficial in the service where she worked.

### *Policy challenges*

Stakeholders were doubtful about the impact that the Alcohol Strategy's actions could have on women involved in prostitution who have problematic alcohol use. One stakeholder and a few women believed that minimum pricing and regulating the advertising and marketing of alcohol were good approaches to reducing alcohol-related harms overall in the population. Such population approaches have been advocated (NICE, 2010; WHO, 2010) and participants in this research thought that this could eventually impact in some way on problematic alcohol use in the general population. However, several stakeholders and women said that the minimum pricing policy could actually be damaging for women involved in prostitution with problematic alcohol use, resulting in women having to sell sex more frequently or commit crimes to continue to fund their alcohol use:

> *"If you are dependent on alcohol, you find a way to find the alcohol you need. Especially for women involved in prostitution, if you need a bit more money, you go out and stand on the street"* (ST2, Project Coordinator, second tier women's organisation).

Stakeholders were also sceptical about the policy emphasis on abstinence. It was argued that this focus de-emphasises individualised support which is problematic because treatment needs to be individualised, it is not a 'one size fits all' approach and the goals of treatment vary (Adamson et al, 2010). Indeed, whilst abstinence suited one woman in this research, the benefits and successes of different interventions varied for women in this study. Imposing a particular treatment goal on someone is more likely to lead to an unsuccessful outcome (Adamson et al, 2010).

Instead, there are benefits to just reducing alcohol use (Gastfriend et al, 2007), and stakeholders in this study noted that for some women involved in prostitution this approach is more appropriate:

> *"For some clients some harm reduction advice is actually where they are at…I'd rather we communicated some harm reduction messages, that would be much more realistic than talking about becoming drug-free"* (ST6, Team Manager, substance misuse service).

When abstinence is promoted as the end goal, stakeholders also thought that other successes and achievements are not recognised and appreciated, also highlighted by Adamson et al (2010). As part of an individualised approach, it was believed that success should be measured in relation to each individual person:

> *"Sometimes drug services, because they are now particularly focused on abstinence because of the new drugs policy… the drugs worker will turn around and say: 'well you are still using, that's not good enough'… you've got to look at where they are coming from and what their aim is…That is a success and let's celebrate that"* (ST1, Support Worker, prostitution specific service).

The drug and alcohol policies' emphasis on quick recovery and completion of treatment was not seen to be realistic or appropriate for women involved in prostitution. Stakeholders thought that it was incompatible with the time that it takes to recover from the trauma and distress that is commonly experienced by women involved in prostitution. The NTA (2002) has also highlighted that women in general benefit more from extended treatment programmes.

A few stakeholders noted that despite the current national drug and alcohol strategies, their services had maintained an individual focus. In terms of more appropriate policy, several participants advocated an approach that frames alcohol and drug use as a health issue, rather than the current drug and alcohol strategies which refer to problematic substance use as 'behaviour':

> *"It [the Government] needs to realise that it's an illness and it's not a criminal thing. It's an addiction…people have got issues and need help"* (I9, off-street).

Participants said that policy needs to advocate service responses which are individualised, more holistic and have a longer term focus in their approach, rather than only concentrating on the number of people entering and completing treatment. Women and stakeholders also advocated a preventative approach; identifying and targeting those who may be at risk of developing problematic alcohol use. Education and awareness raising, particularly in schools, was also seen to be an important part of preventative work. Participants noted that education should also go beyond alcohol, focusing on prostitution, the sex industry, relationships and abuse. It was thought that this would help to reduce the stigma surrounding prostitution, prevent exploitation and encourage women and girls to seek support.

### *Society and alcohol*

A major and overarching challenge to addressing problematic alcohol use that stakeholders and women highlighted was the acceptability and legality of alcohol in society. This was seen to be the underlying cause of many of the barriers, gaps and challenges that have been explored throughout these findings.

It is argued that the acceptability of alcohol in society increases the likelihood of addiction (Nutt, 2012) and some stakeholders and women agreed with this. It was

noted that alcohol has become even more available, appealing and acceptable because of pricing and advertising. A few women thought that this level of acceptance is the reason why an increasing number of women involved in prostitution are problematically using alcohol:

> *"And you find a lot of people who was on the hard drugs go to the drink as a different thing... Because ...it's more acceptable to be able to have a drink because it's legal"* (I8, off-street).

Akin to previous research (Nutt, 2012), participants also thought that the legality of alcohol creates a false distinction and hierarchy between other substances and alcohol, leading to the perception that alcohol use is less harmful and problematic:

> *"And I think people take the moral high ground with drink…There's like a snobbery: 'it's alright to drink, you know, I'm not a bag head, I'm not a smack head'"* (I9, off-street).

The social acceptability of alcohol was also seen to affect problematic users and services' ability to recognise alcohol use as problematic:

> "*I don't think people have as much self-awareness of drinking ...it took a long, long time for me to kind of realise and admit that it was a problem for me… I think it's just so normal in our society that people don't have the kind of awareness...that it might start to become problematic*" (I5, off-street).

Several stakeholders and women said that the social use of alcohol posed a challenge to successfully addressing problematic alcohol use. One stakeholder noted this to be a particular difficulty compared to other substances:

> *"If you are a heroin or crack user part of your recovery will be cutting off those relationships with people who are also using, there's no escaping peer groups who use alcohol*" (ST2, Project Coordinator, second tier women's organisation).

The social use of alcohol can increase the likelihood of lapse and relapse (Nutt, 2012), and some women in this study said that they found it hard to stay abstinent because alcohol consumption is so common and widely accepted. Because of this, some had decided to decrease their use to recreational levels rather than trying to attain abstinence.

The widespread use of alcohol and its acceptability was seen to be a significant challenge and it was noted by many participants that there was no simple way to address this. Education and awareness raising around the harms of alcohol, as well as regulating alcohol, were seen to be starting points in addressing this overarching challenge.

## 6. Conclusion

It is evident that alcohol is a substance used problematically amongst women involved in prostitution. Furthermore, it appears that the prevalence of problematic alcohol use may be increasing amongst this particular group. Alcohol is also commonly used in combination with other substances. Women may minimise and under-report their alcohol use for a variety of reasons though, a tendency which practitioners need to be aware of.

It is apparent that there is a link between prostitution and problematic alcohol use but this link is complex and can also evolve as a woman's involvement in prostitution progresses. Whilst alcohol is not necessarily a major driver of women's involvement in prostitution, it is used in a self-medicating way; to mask feelings of distress, anxiety and the experiences of selling sex, as well as to cope with previous traumatic experiences.

Women involved in both on and off-street prostitution use alcohol problematically, although when and why women use alcohol can differ by place of involvement. However, because of the increasingly transient nature of prostitution, these differences can be blurred. Women and their circumstances therefore need to be considered and responded to individually, rather than simplistic assumptions about their experiences and needs being made on the basis of where they are involved in the sex industry.

Problematic alcohol use can be a barrier to exiting prostitution, but is perhaps less significant than other substances. Nevertheless, because alcohol use and prostitution can be linked, women require holistic support which addresses all of their needs, not just their alcohol use. For many women, this holistic approach is essential in order for them to exit from prostitution. It is crucial for drug and alcohol services to recognise any link between prostitution and alcohol use, and bear this in mind when providing interventions. This includes awareness that alcohol is often used as a coping mechanism for deeper, underlying problems. Identifying and addressing the root cause of alcohol use is important if women are to successfully address their use and related problems.

It is clear that there are a range of gaps, barriers and challenges to supporting women involved in prostitution who have problematic alcohol use. Increased and sustainable funding for services for women involved in prostitution is required in order to address some of these gaps. Training for practitioners who support women involved in prostitution (including drug and alcohol workers) is also essential in order to ensure an understanding and approach that addresses all of women's needs and the interlinking issues that they face. On a policy level, the approach to alcohol and drug treatment in the national alcohol and drug strategies does not appear to be compatible with the circumstances and needs of women involved in prostitution. Women, and in fact all problematic users, need support and treatment which is individualised and provided at their own pace. On a wider scale, the social acceptability of alcohol in our society appears to be a significant, underlying problem and challenge in addressing problematic alcohol use overall. Education and awareness raising around the harms of alcohol would be a starting point in addressing this overarching challenge.

## 7. Recommendations

### *General service provision*

- Increased and sustainable funding for specialist services to support women involved in prostitution
- The provision of one-to-one support with a case management approach needs to be standard provision for women involved in prostitution
- Exiting support needs to be provided as part of a range of options within all services. Alternatively, services need to be able to refer women to services which do have this provision
- There needs to be an increased provision of one-stop-shop services and women-only services. At the very least, services need to provide women-only spaces and sessions provided by female workers
- Staged accommodation (both short term and longer term) which is specifically tailored for women involved in prostitution needs to be made more widely available, and such schemes need to be sustainably funded
- Links and referral pathways need to be built between services to ensure that service provision is holistic and integrated, and women can be easily referred to specific services. Links particularly need to be built between drug services, mental health services and exiting support
- Services (including drug and alcohol services) need to be actively identifying women involved in prostitution, although this needs to be undertaken in a sensitive way
- Training should be provided for a range of professionals, including drug and alcohol workers, around identifying and supporting women involved in prostitution. Training needs to be focused on the circumstances and experiences of women involved in prostitution and how to effectively support them. This should include training on the harms of involvement in prostitution, the multiple needs of women whilst they are involved, and the exiting process, including the stages of recovery and support that are required. Training should also highlight the differences in needs and circumstances of on and off-street women, but also stress that there can be similarities and overlaps between these two groups.

### *Alcohol and drug services and support*

- Drug and alcohol workers need training to facilitate an understanding of women's involvement in prostitution and their needs, and the possible links between prostitution and alcohol use. This understanding needs to include the ways in which women use alcohol as a coping mechanism for their involvement in prostitution
- Alcohol and drug service provision needs to be holistic in order to account for women's multiple, complex and interlinking needs. Women involved in prostitution should not be shoehorned into drug/alcohol treatment. Instead, an approach is required which addresses all of women's needs relating to their involvement in prostitution, as well as their alcohol and/or drug use
- It essential that the root cause of women's alcohol use is identified and addressed. Drug and alcohol services need to understand and account for women's experiences of trauma and violence which can result from their involvement in

prostitution. With this in mind, treatment should take an individual approach and if necessary, be more longer term in its focus

- Drug and alcohol services need to ensure they are inclusive of women, for example by providing women-only spaces, groups and female workers
- Drug and alcohol services should be widely available and flexible so that women are able to access support when they are ready and need it. Services should consider their location and other factors, such as childcare, to ensure optimum accessibility for women involved in prostitution
- There needs to be active identification of problematic alcohol use within drug services. Drug services need to be aware that women may minimise or not report their alcohol use, and that alcohol use may commence or increase through the course of treatment for other substances. Alcohol use needs to be assessed on an on-going basis
- Harm minimisation support and advice around alcohol needs to be available to reduce alcohol-related harms, including the harms of combining alcohol with other substances. Such provision would also provide a link into more structured treatment when women are ready to access this.

***Policy***

- Prostitution should be framed in a policy context as a form of violence against women and girls (VAWG) in order to recognise the particular experiences of this group and the risks and harms that women face
- The national alcohol and drug strategies should frame substance use as a health problem rather than the current focus which emphasises the individual and their behaviour. This would recognise the social and external factors at play in alcohol and drug use instead of placing sole responsibility on individuals
- Both the alcohol and drug strategies need to directly acknowledge the problematic use of specific groups, including women involved in prostitution, and incorporate actions that address specific sub-groups of problematic users, alongside the population-wide focus on binge drinking and the UK's heavy drinking culture
- The strategies need to take a wider focus in terms of treatment and recovery. Goals need to go beyond that of abstinence, recognising that this is not the appropriate end goal for every problematic user
- There needs to be a change in emphasis, moving away from quick recovery, to longer term, sustained recovery. This would recognise that recovery can be a lengthy process, particularly for those who have experienced trauma such as women involved in prostitution
- Education and awareness raising should be provided around the harms and effects of alcohol, including in schools. This should take place alongside drugs education in order to highlight the parallel harms.

***Local authorities and commissioners***

- Every local authority needs to have a VAWG strategy which makes the links between having problematic drug/alcohol use and experiencing violence, including being exploited in prostitution
- Local authorities should ensure the provision of training around identifying and supporting women involved in prostitution. This should be a requirement for all

service providers who may have women involved in prostitution accessing their services

- The extent of prostitution in communities and the needs of women involved should be identified and mapped within each local authority. This would enable authorities to demonstrate a need and make a clear case for service provision for this group
- Specialist services need to be commissioned that are specifically for women involved in prostitution
- Commissioners need to stipulate requirements that commissioned services (particularly drug and alcohol services) provide for women involved in prostitution. Services should then be audited with regard to this provision
- There should be increased funding of residential treatment for those with problematic alcohol and drug use who require this type of intensive intervention, including women-only residential treatment.

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