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**Sex Work, Drug and Alcohol Use: Bringing the Voices of
Sex Workers into the Policy and Service Development
Framework in Wales**

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**Dr Tracey Sagar, Debbie Jones and Dr Katrien Symons
College of Law and Criminology, Swansea University**

Authors

Dr Tracey Sagar is an Associate Professor in Criminology, College of Law and Criminology, Swansea University. **Debbie Jones** is a Lecturer in Criminology, College of Law and Criminology, Swansea University. Both are founder members of the *All Wales Sex Work Safety Group*, academic advisors to the *Cardiff Sex Work Forum*, and Co-Directors of the *Consortium for Sexuality Studies: Research, Innovation and Practice* at Swansea University.

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Acknowledgements

This document reports on the second stage of a research project that has been carried out to provide a better understanding of the connections between sex work and drug and alcohol misuse in Wales. It details and discusses the results of a questionnaire carried out with 40 sex workers in South Wales, and in doing so enhances an understanding of problematic drug and alcohol use amongst sex workers. Recommendations are also made with the aim of improving service provision for sex workers in Wales.

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Terminology

Sex Work

The term 'sex work' has been increasingly used to describe a range of activities associated with the sex industry. For example, sex work has been divided into two 'types' of 'sex work'- direct and indirect sex work. Direct sex work has been defined by the directness and explicitness of the sexual service itself and has been used to demarcate activities commonly thought of as prostitution, escorting and perhaps lap dancing from other activities such as phone chat sex, pornography, glamour modelling and webcam sex which have been classified by some as indirect sex work. In addition, many academics (including the authors of this report) believe that the term 'prostitution' is an historic stigmatising label which defines people by the act of selling sex and denies individuals agency to make the decision to sell sex, although it is recognised that this decision is often made in very difficult circumstances. This report uses the terms 'sex work' and 'sex worker' with regard to adults who provide direct commercial sexual services.

Importantly however, this report distinguishes between adult 'sex workers' and children under the age of eighteen years who engage in commercial sex. All of the participants in this research project were over the age of 18 years, however for those participants who were engaged in commercial sex under the age of 18 years, it is acknowledged that their experiences fall within what is referred to as 'sexual exploitation' in recognition of the abusive relationship between children / young people and adult exploiters / perpetrators.

Drug Using Sex Workers / Sex Workers who Use Drugs

According to Melrose (2009: 84) an important distinction has to be made between sex working drug users and drug using sex workers:

“sex-working drug users’ may be, for instance, sex workers who are also recreational drug users, ‘drug-using sex workers’ may be those individuals for whom drug usage has become problematic and/or those who engage in sex work specifically to fund their drug use.”

This report acknowledges this distinction and differentiates between those individuals who are involved in sex work and who use drugs and those for whom drug use is problematic and who sell sex specifically to fund their drug use.

Executive Summary

Summary of phase one of the project

Phase one of the project consisted of a comprehensive literature review that connected sex work to problematic drug and alcohol use in the United Kingdom (UK). Within this context the review also conducted an analysis of the legal and policy framework in England and Wales and made the following key observations:

- There are clear links between sex work and problematic drug and alcohol use
- Sex work is very complex; tackling problematic drug and alcohol use is likely to be one of many issues for sex workers that need to be addressed simultaneously
- A harm reduction approach (as opposed to a full recovery approach) has the potential to support sex workers
- Evidence on what treatment works, for whom and in what circumstances is lacking, as is comprehensive guidance for service providers

Towards the development of effective national guidance for service providers, the review recommended in-depth empirical research in Wales to better understand:

- Trajectories into sex work
- Drug and/or alcohol use amongst sex workers
- The needs of drug and/or alcohol using sex workers and harms experienced
- The barriers individuals may face in accessing support
- The views and opinions of sex workers on support services
- How service provision can better meet the needs of drug and/or alcohol using sex workers

Summary of phase two of the project

The findings documented in this report are derived from interviews carried out with 40 sex workers in the South Wales area. In accordance with the recommendations of phase one of this project the interviews focused on:

- Pathways into sex work
- Health and safety
- The needs of drug and/or alcohol using sex workers and harms experienced
- The barriers individuals may face in accessing support
- Sex worker perceptions on service provision

The objective was to collate information:

- To assist service providers to be able to better identify and meet the needs of drug and/or alcohol using sex workers
- To assist service providers to be able to better support drug and/or alcohol using sex workers and to reduce short term and long term harms
- To inform the development of a national policy for Wales

Key findings include:

Socio-demographic characteristics

- The overwhelming majority of respondents self identified as White British ($n = 38$), female ($n = 37$ with one transgender male to female) and heterosexual ($n = 28$)
- Ages of the respondents ranged from 18 – 50 years with just under 50% ($n = 19$) being over thirty years
- Eight reported having a disability with six respondents referring to mental health problems

- Eighteen held educational qualifications ranging from GCSE to College Diploma level. Sixteen held no qualifications
- Twenty-two respondents had experience of previous employment with most occupations being in relatively low paid work (bar work for e.g.)

The sex workers who took part in the research can thus be categorised as predominantly White British. However, they were from different age groups with different qualifications and had different experiences of employment. It is also noteworthy that sixteen respondents held no qualifications and thus it is important that service provision is geared towards providing educational assistance for those who wish to step out of sex work.

Organisation of the work

- There was mobility between off and on street sex working
- At the time of interview the majority were working on the street ($n = 22$) but the respondents also worked in off street locations, from their own homes ($n = 12$) and did outcalls ($n = 19$)
- The working days and hours for sex workers were varied with the majority working 'most days' and over thirty hours per week ($n = 19$)

The findings suggest that there is a need for investment in Outreach provision to ensure that they are able to provide a flexible service provision as well as being able to expand that provision to reach those workers who are less visible and who work from their own homes.

Pathways into sex work

- Twenty-three respondents were under the age of 18 years when they first started sex work with fifteen of these being under the age of 15 years when they first started
- Ten respondents however were over the age of 29 when they first started sex work

- The majority of respondents had entered into sex work to support their drug use ($n = 25$)
- Respondents also spoke of:
 - Experiences of abuse
 - Parental neglect
 - Domestic violence
 - Family breakdown
 - Bereavement
 - Peers who took drugs

The research substantiated what is already known about sex work, namely that there are key vulnerabilities and risks associated with a person's entry into sex work – these vulnerabilities and risks have been consistently identified in sex work research for several decades.

Partners, family and friends

- Sixteen respondents had partners
- Approximately one third of the respondents who had a partner had suffered violence from their partner ($n = 5$)
- Just under half of the respondents kept sex work a secret from family and friends
- Twenty-four respondents had children but twenty-one of the twenty-four had children who did not live with them
- Nine respondents had children who were adopted or who were in care or living in a foster home and had no contact with their children

Feelings of social isolation associated with sex work and the lack of supportive social networks are important issues to consider when providing any assistance to sex workers but in particular in the context of drug treatment and experiences of family breakdown this may necessitate more intensive support from service providers.

Experiences with the care system

- Just under half of the respondents ($n = 19$) had experienced local authority care

- Reasons for entering care were related to:
 - Parental drug use
 - Family breakdown
 - Domestic violence
 - Parental neglect
 - Parental physical abuse
 - Parent's poor mental health/inability to cope
 - Sexual abuse by parent/family member
- Most of the respondents who had been in care were under the age of 9 when they were placed in care
- Four respondents had been subjected to sexual exploitation while in care
- The majority of the nineteen respondents who had experienced care left between the ages of 14 and 18
- Thirteen respondents said that they had not received any support when leaving care
- Thirteen respondents said that they had needed help with accommodation when leaving care (other support required included, counselling, help to rebuild family relations, help with schooling, financial and budgeting assistance, befriending, support for drug use and information on sexual exploitation)

The research also indicated a cycle of parent/child breakdown. It was also evident that not being able to see their own children had a devastating impact on their lives. The cycle of parent/child breakdown is an issue of concern and it suggests the need for social services to become more involved with multi-agency approaches to sex work – particularly so given that children who are looked after in the care system may be vulnerable and exposed to risks of sexual exploitation. The research also indicated a continuing gap in the provision of support for young people leaving care – and specifically the need for housing assistance.

Accommodation and homelessness

- Approximately half of the respondents did not have secure accommodation with five being homeless at the time of interview
- Fifteen of those who had secure housing were in rent arrears
- Fifteen respondents reported having had to leave a property due to rent arrears (eight due to domestic violence and six due to drug use)

- The majority of respondents ($n = 28$) indicated that they had experienced multiple periods of homelessness
- Twenty-five respondents indicated that they had slept rough at some time

All of which emphasises the importance of prioritising the housing needs of sex workers within multi-agency work.

Safety

- Over 50% ($n = 21$) had experienced violence from clients. In most cases the violence was extreme
- Seven respondents had experienced violence from other sex workers
- Twenty-two respondents indicated that they felt able to report violence to the police
- Sixteen respondents indicated that they *did not* feel able to report violence to the police. Reasons included:
 - feeling judged
 - not feeling comfortable talking to the police
 - not trusting the police
 - feeling embarrassed
 - fearing that they would be charged with prostitution related offences
- Respondents wanted self defence training, drug awareness and peer support to help to keep them safe

While it is pleasing to see that the majority of respondents felt able to report violence to the police there is still a significant number (approximately 40%) of respondents who did not feel able to. Thus the findings indicate that there is still a need for proactive work in this area to encourage sex workers to report violence.

Mental and physical health

- Thirty-five out of the forty respondents suffered from depression and anxiety

- Twenty-three respondents suffered panic attacks and paranoia
- Mental health issues also included irritability, agitation, aggression, insomnia and confusion
- Fifteen respondents indicated that they had dental health problems
- Respondents also indicated suffering from hepatitis C ($n = 11$), liver damage ($n = 5$) and high blood pressure ($n = 4$)
- Other physical health problems reported included:
 - kidney damage
 - bronchitis
 - blood clots
 - heart problems
 - low blood pressure

The mental and physical health problems experienced by the respondents had a devastating impact on their lives. Mental health problems prevented them from doing basic tasks in their daily lives such as going to the shops, looking after children, being able to cope. While physical health problems led them to reporting that they were in pain, upset and tired. The findings indicate that the respondents needed a variety of health interventions which should be delivered as part of a wider harm reduction strategy for sex workers.

Prison and probation

- Eighteen of the respondents (45%) had been in prison
- Twenty-four respondents (60%) had received a probation order
- Offences predominantly related to theft
- Ten respondents had been in prison over 5 times with four respondents having been in prison more than 10 times
- Only eight respondents reported having received help with accommodation; only seven had received help with benefits and four mentoring support
- Respondents said they had needed assistance from prison and probation services with housing and support to stay off drugs ($n = 13$)

The respondents appeared to have received support when in prison more than at any other point in their lives – they spoke of receiving assistance with drugs and alcohol

problems, literacy and numeracy, education and training. However, as already noted they did feel unsupported when leaving prison – particularly the need for assistance to find and secure housing.

Alcohol and drug use

- Over half of the respondents drank alcohol but alcohol use was only problematic for six respondents
- However, nine respondents reported that they drank alcohol to sell sex
- Fifteen respondents indicated that they mixed alcohol and drug use frequently
- The vast majority of respondents ($n = 37$) had used drugs
- 70% of those respondents who has used drugs took heroin almost every day
- 70% of those respondents who used drugs also indicated that they used cannabis and 63.3% crack cocaine but this was not daily
- Injecting and smoking were the preferred methods of taking class A drugs with nineteen respondents stating that they had shared needles, syringes, spoons and filters
- Nine respondents indicated that they had started taking drugs due to physical and sexual abuse in childhood
- Five respondents indicated that they had started taking drugs to cope with losing their children
- Respondents also told us that they continued to take drugs to cope, relax, escape, forget problems, cope with depression and to sell sex
- Sixteen respondents reported taking drugs to sell sex
- Increased drug use was due to a variety of reasons but predominantly drug use increased when respondents had more money
- Only three respondents indicated that their drug use had increased due to sex working but twenty-nine respondents indicated that their drug use had increased *since starting* sex work

- Of the sixteen respondents with partners twelve said that their partners also took drugs. However, eleven respondents indicated that sex working paid for their personal drug use *and not* the drug use of a partner
- Eighteen respondents indicated they used drugs with family members, thirty used with friends and twenty-six with other sex workers
- Respondents also reported exchanging sex for drugs, with twenty-one respondents stating they took drugs with clients and that clients provided them with drugs
- The majority of respondents who took drugs ($n = 28$) reported that withdrawal had a negative impact on their sex work with seventeen respondents indicating that withdrawal led to them having sex when working without a condom
- The vast majority of respondents who used drugs ($n = 29$) purchased drugs from a dealer; the majority spent under £30 per day on drugs and the majority funded their drug use through sex work as well as offending with shop lifting being the most common offence ($n = 25$)
- The majority had bought and/or purchased prescription opiate drugs

Sex work and problematic substance misuse is complex and often mutually reinforcing. Drug use was found to be problematic for the majority of the respondents – whether or not sex work was carried out specifically to fund drug use. The connections between sex work and problematic drug/alcohol use as well as associated risks which can impact on mental, physical and sexual health brings to the surface once again the need to develop a more coherent harm reduction approach to ensure that the multiple risks sex workers face are managed effectively and that sex workers receive wrap around support.

Stopping taking drugs

- Twenty-eight out of the thirty respondents who were taking drugs wanted to stop
- The respondents highlighted issues with drug treatment service provision which they saw as obstacles to them stopping taking drugs including:
 - long waiting lists
 - the length of time it took to get a prescription
 - a lack of relapse prevention

- service inflexibility
 - a lack of professional support workers
 - the need to have one consistent support worker
 - having to mix with other drug users while accessing treatment
 - service providers not understanding ‘the reality’ of their situations
 - being approached by dealers when accessing drug treatment centres
- Out of the thirty respondents who were drug users, only sixteen (43.2%) had received counselling to help them stop taking drugs
 - The respondents indicated that they needed the following to stop drug use:
 - more counselling
 - more one to one support
 - more professionals
 - a friendly and empathetic service provider
 - staff who did not judge or stigmatise them

The findings emphasise that from the perspectives of the respondents there is room for improvement in drug treatment service provision, also very importantly the need to prioritise counselling and one to one support to assist sex workers to stop taking drugs.

Services

- The respondents wanted services to assist them with homelessness, obtaining food, debt management, sexual health and violence
- Cyrenians Cymru and Safer Wales StreetLife were held up as being the most helpful services
- The police, educational institutions, housing and probation were considered to be the least helpful services – particularly respondents indicated that they felt they had not been treated well by these services
- Housing and counselling were highlighted as the services that were most needed followed by drug treatment and help with benefits
- Respondents reported trying to access but failing to access counselling, benefit advice, emergency food and accommodation
- Getting access to services was important to the respondents but services being friendly, accessible with experienced staff was equally important

- Respondents told us they wanted:
 - better housing assistance
 - fast track long term prescribing
 - shorter waiting lists for drug treatment and quicker prescriptions
 - more services
 - more motivational support
 - easier access to counselling
 - the police to be more approachable

- Housing and getting on a prescription were *most needed* at the time of the interviews

Key conclusions include:

- ❖ The majority of the sex workers who took part in this research could be said to have experienced a wide range of physical, social, emotional, situational and economic circumstances which singularly or in combination increased their vulnerability and exposure to risk and harm.
- ❖ The findings demonstrate links between direct sex work and problematic drug use. The research found that the majority of sex workers were drug using sex workers – that is sex workers who took up sex work in order to fund drug use.
- ❖ For the majority of sex workers who took part in the research problematic drug use and sex work were re-enforcing and this impacted extremely negatively on their lives in a wide variety of ways – bringing sex workers into the criminal justice system, causing poor physical and mental health, leading to heightened risk taking whilst sex working.
- ❖ Problematic substance use is one issue (although an extremely important issue) that needs addressing alongside several others such as homelessness and rent arrears which can significantly increase the risk of a person becoming ‘trapped’ in sex work and continuous drug and/or alcohol misuse.
- ❖ The respondents who wanted to stop taking drugs also wanted to attain the basics in life, including the chance to feel safe and secure in their own home. They also wanted debt advice and counselling in particular to help them move

on to attain some stability in their lives. The respondents' desire for life skills assistance – up-skilling, training and education was also evident.

- ❖ The respondents wanted to take control of their physical, social, situational and economic environments. However, none of the respondents indicated a belief that they were in a position to stop taking drugs or make positive changes to their lives without substantial and wide ranging support.
- ❖ Respondents identified several obstacles to them accessing the support that *they feel* they need. They want to see reduced waiting times for methadone prescriptions, more flexibility in service provision and particularly drug treatment services, more professional staff, the opportunity to receive treatment away from other substance users, staff not to judge and stigmatise them, and perhaps most importantly multiple issues to be addressed simultaneously.
- ❖ Respondents valued friendly services that had professional staff who were experts and who had empathy and understanding for their situations and needs (especially Cyrenians and StreetLife).
- ❖ The findings emphasise that equal attention needs to be paid to sex workers' physical, social, situational and economic needs in the context of reducing drug and/or alcohol use.

Key recommendations include:

- Fast tracking to reduce the waiting times for drug treatment and the length of time it takes sex workers to get a methadone prescriptions and more flexibility in drug treatment service provision (for example, extended opening hours).
- Consistent support workers and ongoing one to one support (before/during/after drug treatment).

- Problematic drug using sex workers being treated away from other problematic drug users.
- The development of holistic approaches that offer treatment to partners/family members of drug using sex workers.
- The expansion of Outreach services to enable them to identify, locate and reach out to sex workers who are less visible and who work off street from their own homes / participate in outcall work.
- More accessible solution focused therapy and counselling.
- The provision of transitional housing, emergency accommodation and permanent accommodation which must be prioritised for:
 - sex workers who are problematic substance users
 - sex workers who wish to step out of sex work
 - sex workers who experience domestic violence

This accommodation should be situated outside of working/drug taking/violent environments.
- Continued liaison between the police and other service providers (especially Outreach) to develop trustful relationships with sex workers to increase the reporting of violence and sexual assault.
- Ugly Mugs reporting and information on incidents of violence shared across regions.
- Crime prevention initiatives including self defence, peer support programmes, rape alarms, and mechanisms for reporting of concerns from sex workers.
- Education and training opportunities to assist those sex workers who wish to step away from sex work.
- Multi-agency partnership work should include representatives from housing, counselling, social services and education/training.

- Multi-agency strategy development to ensure that approaches are tailored to the individual – ensuring that all needs are addressed **simultaneously**.
- Proactive multi-agency work to develop and implement preventative strategies employed to protect children from sexual exploitation and grooming – with a particular focus on those who are in looked after care.
- All stakeholder service providers to receive comprehensive training on:
 - sex work issues
 - the risks associated with sex work (physical, social, situational and economic)
 - the interconnected needs of sex workers and those sex workers who are problematic drug and/or alcohol users
 - the impact of stigma and judgement on sex workers
 - the impact of problematic social networks and the need for positive influences/role models in their lives
 - the importance of ‘befriending’ and providing an empathetic and friendly service
 - the importance of preventative work to identify child sexual exploitation at an early stage
- The development of an *All Wales strategy* that adopts a comprehensive harm reduction approach which is geared to meet the needs of all sex workers (whether engaged in direct or indirect sex work) and which provides wrap around support for those who need it.

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PHASE TWO

1. Introduction

1.1 Background

In phase one of this project we reviewed literature pertaining to sex work and substance misuse in the United Kingdom and we also placed this within an analysis of the legal and policy framework of England and Wales. Key observations arising from the literature review included:

- ✚ It is widely acknowledged that street sex work makes up around 10% of the overall sex market; this is also thought to be the case in Wales (Sagar et al, 2011).
- ✚ Drug use has been found to be far less prevalent in off street sex work as opposed to street based sex work (May and Hunter, 2006).
- ✚ Sex markets are known to play a significant role in the development of drug markets and vice versa (May et al, 1999).
- ✚ Since the 1980s sex work and drug markets which form part of the informal illicit economy have flourished in the UK bringing increasing levels of poverty, social deprivation and social exclusion as well as the consequential entrenchment of welfare (Melrose, 2009).
- ✚ In recent decades the increasing propensity for drug use, particularly heroin and crack cocaine amongst those engaged in street based sex work has been reported (May et al, 1999).
- ✚ When drug misuse is combined with alcohol misuse this can have a devastating effect on the lives of sex workers (Plant, 1997).
- ✚ The causal relationship between drug use and sex work is very difficult to demonstrate in any precise way (May and Hunter, 2006). However it is known that drugs and alcohol can be used to cope with negative feelings about sex work.

- ✚ Drug use is not problematic for all sex workers, however for 'drug using sex workers' (sex workers who sell sex to fund their drug use) this can be very problematic (Melrose, 2009).

Key vulnerabilities are connected to sex work and problematic substance use:

- Poverty
- Age
- Sexual abuse in childhood
- Local Authority care
- Homelessness

Associated risks increasing the propensity of sex workers to participate in drug taking are also known to include:

- The control of a pimp
- The potential for and experience of physical and sexual violence (from pimps, clients and partners)

Drug taking whilst sex working is also known to increase a variety of sexual health risks including:

- Blood born viruses for sex workers who inject drugs
- Inconsistent condom use where drugs are exchanged for sex without a condom

There are also serious health implications associated with problematic drug use among sex workers, for example:

- Abscess
- Overdose
- Unwanted pregnancies
- Miscarriages
- Depression

- Anxiety
- Irregular periods
- Chest pain

The review concluded however that in addressing the issue of sex work and substance misuse it should be remembered that:

- + It is wrong to assume that all sex workers (particularly if they work on street) are drug using sex workers (selling sex for drugs)
- + Drug use may only be one part of a chaotic, desperate and problematic lifestyle
- + Situational vulnerabilities (such as homelessness) can significantly increase the risk of a person becoming 'trapped' in sex work and continuous substance misuse
- + The stigma surrounding sex work can prevent a sex worker disclosing her occupation to services due to fears of judgement
- + Drug using sex workers can face double discrimination leading to them feeling socially isolated
- + Violence against sex workers remains under reported

Phase 1 of the research also included a review of the literature on service provision which revealed the importance of Outreach work for sex workers as well as the need to adopt a holistic approach to sex work and drug/alcohol misuse. Key findings from the review included:

- + Where sex work and substance misuse are mutually reinforcing, 'exiting' sex work is extremely difficult
- + Support and particularly drug treatment has to be available as soon as it is needed
- + Addressing accommodation needs should be prioritised in the same way that drug misuse and health needs are prioritised
- + All needs should be met simultaneously to help sex workers achieve stability in their lives

- ✚ Sex workers need to be provided with information on violent offenders and emergency accommodation/re-housing options should be provided where sex workers are experiencing violence/abuse
- ✚ Sex workers can require support on a variety of issues – emotional (such as one to one counselling) and practical (accessing benefits for example)
- ✚ Training and education may be required but only once a sex worker has acquired stability in his or her life
- ✚ Drug treatment is important and it should be part of, but not necessarily at the forefront of any ‘exit’ plan
- ✚ A holistic approach which centres on harm reduction is essential
- ✚ A harm reduction approach is likely to offer greater support to a sex worker where it is tailored to individual need

The 2008-2018 ‘Substance Misuse Strategy for Wales’ is committed to harm reduction and it prioritises:

- Harm minimisation
- Treatment
- Aftercare
- Recovery

The Strategy’s Action Area 2 emphasises the need to enable, encourage and support those who misuse substances to reduce harm to themselves and their families and communities. The document commits to:

- Expanding harm reduction services
- Continuing to develop the capacity of substitute opiate prescribing across Wales
- Providing coherent care pathways
- Providing wrap around support and post treatment aftercare
- Identifying and minimising barriers to accessing treatment
- Work towards providing a full range of treatment options in all areas but prioritising deprived areas

In adopting a harm reduction approach to substance misuse, the Welsh Government has committed to developing a range of services in Wales. While sex workers are

not mentioned specifically, both the strategy and action plan are closely aligned with the recommendations of expert sex work researchers and academics. Thus, in summary, there is the potential to develop service provision and policy specifically targeted at providing support for sex workers in Wales.

However, to further the evidential framework in Wales and to ensure effective service development in this area, the inclusion of sex worker voices in policy development is vital. This is not only important in terms of ensuring that services actually meet the needs of their clients but also to fulfil the Welsh Assembly Government's 2004 commitment to client consultation/participation within the Substance Misuse Treatment Framework.

1.2 Focusing the Research in Swansea and Cardiff

This document reports on the findings from interviews carried out with 40 sex workers in the South Wales cities of Swansea and Cardiff.

Swansea and Cardiff were adopted as the geographically targeted research areas in recognition of the recently published Sex Work Research Wales: Summary of Findings (Sagar et al, 2014) which concluded that sex work (both on and off street) is most concentrated in the cities of Swansea, Cardiff and Newport – cities which are joined by the M4 corridor. However, in Newport the vast majority of sex work (at the time of the report in 2014) was found to take place 'off street'.

Given the wealth of literature suggesting that substance misuse is far less problematic in off street establishments, a decision was taken to focus the research in Swansea and Cardiff.

1.3 Aims and Objectives of Phase 2

- To understand *need* from the perspectives of sex workers themselves
- To bring sex worker voices firmly into the policy development framework

- To consider the potential for drug treatment as part of a harm reduction approach for sex workers
- To understand the role of alcohol in sex workers lives
- To make recommendations where appropriate for policy development

1.4 Structure of the Report

The report begins with an outline of the methods employed to carry out the research.

It goes on to detail and discuss the findings from interviews with 40 sex workers which are presented under the following key headings:

- Socio-demographic characteristics
- Organisation of the work
- Pathways into sex work
- Partners, family and friends
- Experiences with the care system
- Accommodation and homelessness
- Safety
- Mental and physical health
- Prison and probation
- Alcohol and drug use
- Stopping taking drugs
- Services

Finally, the report critically considers the need for the development of a more comprehensive harm reduction policy approach to sex work and substance misuse in Wales and makes recommendations to support the development of more effective policy and practice.

2. Methodology

2.1 Research Objectives

The overall objective was to provide an evidence base to inform policy development and service delivery in Wales and to consider the need for the development of a national Strategy for Wales in relation to sex work and drug and/or alcohol misuse. Working with local sex work projects in Swansea and Cardiff and with Welsh Government's Substance Misuse Policy Officer, the research aimed to:

- Understand the relationship between sex work, drug and/or alcohol use
- Identify *need* from the perspectives of sex workers
- Understand what works and what doesn't in relation to existing service provision from the perspectives of sex workers
- Identify gaps in service provision

2.2 Research Questions

Specifically, the research was guided by the following research questions:

1. What are the characteristics of the participants?
2. What are the routes into sex work?
3. What are the participant's perceptions of their safety?
4. What are the participant's levels of physical and mental health?
5. What are the participant's motivations for and levels of drug and/or alcohol use?
6. What are the participant's experiences of accessing services?
7. What gaps exist in service provision from the perspectives of sex workers?
8. What levels of support are needed?

2.3 Methodological Framework

The study comprised four stages:

2.3.1 Stage 1- Planning

This stage involved the development of the research instruments in collaboration with the following key stakeholders:

- Dr Rhian Hills, Senior Policy Manager, Welsh Government
- Carol Daly, Policy Lead Advisor on Sex Work, Deputy Regional Lead South Wales (IOIS and DIP), South Wales Policy and Crime Commissioner and Wales Probation Trust Partnership
- Nici Evans, Chair of the Cardiff Sex Work Forum, Partnership Development Manager, Cardiff Partnership Board
- Cyrenians Cymru, Swansea
- Safer Wales StreetLife, Cardiff

The research instrument used in this study took the form of a structured in-depth questionnaire which included dichotomous yes/no answers and open ended questions. The reason that this method of data collection was chosen was based on a number of considerations:

1. Based on previous research conducted by Sagar and Jones (2010), it was known that drug using sex workers are unlikely to participate in semi-structured interviews because of the length of time such methods take.
2. A short questionnaire was unlikely to allow the research team to explore the complexities of drug and/or alcohol misuse and sex work.

The research instrument was piloted with sex workers by staff at Cyrenians Cymru, Swansea. The purpose of the pilot was to assess the reliability of the research instrument and to facilitate the inclusion of sex worker voices – thereby enhancing the inclusiveness and validity of the research. Once this had been done amendments were made before implementation.

Data collection was assisted by a number of field workers (Criminology post graduate researchers at Swansea University) as well as service provider gatekeepers. Utilising a structured in-depth questionnaire ensured consistency in terms of the questions asked to participants and thus increased the validity of the data.

2.3.2 Stage 2 - Data Collection

Data collection took place between November and December 2014.

Sex workers were interviewed during a series of 'engagement events' in Cardiff and Swansea which were hosted by sex worker Outreach projects. Events like this had already been utilised by the research team with sex workers in previous research projects and evaluations suggested that sex workers not only enjoyed taking part in such events but that they could bring about a sense of wellbeing and self-worth (see, Sagar et al, 2014).

At the events, sex worker participants were offered refreshments, a 'pampering' service such as a manicure and an activity session such as cake decorating. Researchers from the University alongside staff from the sex worker Outreach projects administered the questionnaire with the participants at the events. Participants were also given £10 for taking part in the research, as well as having travel expenses covered where appropriate to do so.

2.3.3 Stage 3 - Data Analysis

Data from the questionnaires were analysed with the assistance of Excel to organise and sort the data. More complex qualitative data was analysed using a number of qualitative analytical methods (including coding and thematic analysis).

2.3.4 Stage 4 - Report Writing

The final element of the study involved the completion of a final report and dissemination of the findings where appropriate.

2.4 Ethical Considerations

This study was approved by the Ethical Standards Committee of the Centre for Criminal Justice and Criminology at Swansea University; all those involved in the data collection process abided by Swansea University's ethical practices and procedures set out by the British Society of Criminology.

However in relation to this study, the following issues specifically required careful ethical consideration:

- over-researching the sex worker population in Cardiff and Swansea
- informed consent and anonymity for those participating in the study
- payment for participation in the research

2.4.1 Over-researching Sex Worker Populations

The over-researching of visible sex worker populations (i.e. on street sex workers and those working in off street establishments such as saunas/massage parlours), has been identified as an issue which those carrying out research into sex work should be concerned with (Sanders et al, 2009). Indeed, in this study this ethical responsibility was considered at some length by the research team particularly given the recent drive for evidence based policy in Wales in relation to sex work which in turn has promoted a research agenda in Cardiff and Swansea. However, it was acknowledged that the implications of this research drive had been overwhelmingly positive, not only in terms of producing a sound knowledge base for policy and service development but more importantly perhaps for presenting the voices of sex workers.

Furthermore, through the adoption of creative research methods which combined research with a variety of activities we were able to overcome this to a significant extent. Instead of simply drawing on sex worker populations to collate data, we created meaningful social events which were primarily designed to ensure that sex workers felt socially included. In short, during the data collection the researchers strived to make the process enjoyable and empowering for the participants.

2.4.2 Informed Consent and Anonymity

A covering letter was supplied to all of the participants informing them of the aims of the research, the benefits of taking part in the study, their rights not to take part, their right to withdraw from the research at any time without penalty, and their right to anonymity. All participants were asked to sign an informed consent form and were

reminded throughout the interview of their rights to withdraw from the study at anytime or refuse to answer any questions.

In line with other research conducted elsewhere (Shaver, 2005; Sagar and Jones, 2010 and Sagar et al, 2011) ensuring that the participant's anonymity was an overriding consideration within the research. Equally importantly, the data was stored securely within the University and data protection legislation adhered to.

2.4.3 Paying for Participation

Arguments for and against paying sex workers for participation in research have traditionally focused on the unease regarding the notion that women who sell their bodies as a commodity are always vulnerable to exploitation and that paying women who sell sex to partake in research is also akin, in some circumstances, to exploitation (O'Neill, 1996; Jones, 2010). Further arguments put forward by those opposed to paying for participation, is that as there is a strong association with street sex work and addiction to drugs and or alcohol (Home Office, 2006), the money paid to the women would be used to 'feed' their 'habit' and this should not be condoned. However, the views of the researchers in this study were that payment has been shown to increase participation in research (Sagar et al, 2011) and importantly that it is not the role of researchers to make 'judgments' about how research participants spend the money offered in return for participation in research.

Moreover, in the research conducted previously by Sagar and Jones, (2010) and Sagar et al (2011) in relation to on and off street sex work in Cardiff, a small sum was offered to those who took part. Accordingly, it was agreed that £10 would be offered as recognition of the time taken to participate in the research. Participants signed a receipt once payment had been issued.

2.5 Target Population and Sampling

The locations of Swansea and Cardiff were identified as areas that had the largest numbers of drug using sex workers in Wales (Sagar et al, 2014). Participants were identified via targeted sampling.

In total 40 participants who fulfilled three qualifying criteria took part in this study:

- they were over the age of 18
- the participants were currently or had previously been involved in the sale of sex (direct and intimate sexual services with a client) for money or other material compensation
- they were currently using on or had previously used drugs and/or alcohol

Participants were either identified by service providers or were self selecting.

2.6 Gatekeepers

The value of utilising gatekeepers as custodians of access to knowledge has been well documented (Bryman, 2004). Such benefits include building up levels of trust between researchers and participants which in turn allows for an honest and truthful dialogue to take place (Bryman, 2004). In terms of sex work, traditionally gatekeepers are drawn from health agencies or Outreach services specifically targeted at sex work markets and sex worker service provision. This research would not have been possible without the help of Safer Wales StreetLife in Cardiff and Cyrenians in Swansea to facilitate and conduct the engagement events. Indeed, the seamless process of data gathering achieved in this research project stands as a testament to the successful and ongoing partnership work between academics at Swansea University and practitioners who are committed to improving services for sex workers in Wales.

3. Findings

In total 40 respondents were interviewed. This section discusses the results which are divided into the following key themed sections:

- Socio-demographic characteristics
- Organisation of the work
- Pathways into sex work
- Partners, family and friends
- Experiences with the care system
- Accommodation and homelessness
- Safety
- Mental and physical health
- Prison and probation
- Alcohol and substance use
- Stopping taking drugs
- Services

3.1 Socio-demographic Characteristics

3.1.1 Gender and Age

Most respondents were female ($n = 37$) with two male respondents and one male-to-female transgender respondent.

Table 1 gender of respondents

Gender	Frequency
Female	($n=37$)
Male	($n=2$)
Transgender male - female	($n=1$)
Total	100% ($n=40$)

The respondent ages ranged from 18 to 50 (mean age = 30.43). It is worth noting that despite common misconceptions that the majority of sex workers are young (see also Sagar et al, 2014), just under 50% of the respondents ($n = 19$) were 30 years and over.

3.1.2 Ethnic Background and Area of Residence

The majority of the respondents were White British ($n = 38$), again this finding is consistent with other sex work research that has been carried out in Wales (see, Sagar and Jones, 2010; 2011; Sagar et al, 2014). One respondent had a mixed Asian ethnic background and one respondent declined to say. All of the respondents lived in the South Wales area, in and around the suburbs of Cardiff and Swansea. However, at the time of interviewing five respondents told us that they did not have a fixed address.

Table 2 ethnicity of respondents

Ethnicity	Frequency
White British	($n=38$)
Mixed Asian	($n=1$)
Missing	($n=1$)
Total	100% ($n=40$)

3.1.3 Sexual Orientation

The majority of the respondents ($n = 28$) reported being heterosexual, one was lesbian, one was gay, nine identified as bisexual (including one male and one transgender respondent) and one respondent did not identify with any of these categories.

Table 3 sexual orientation of respondents

Sexual Orientation	Frequency
Heterosexual	($n=29$)
Bisexual	($n=9$)
Gay	($n=1$)
Lesbian	($n=1$)
Missing	($n=1$)
Total	100% ($n=40$)

3.1.4 Disability

Eight respondents reported having a disability which mostly referred to mental health problems ($n = 6$). However, one respondent reported spinal problems (physical and mental health is discussed more in detail in section 3.8 of this report).

3.1.5 Education

Six respondents had GCSE/O level/CSE awards, three respondents had a college diploma, five respondents had an NVQ/GNVQ level 3 award, two had A-levels, two had NVQ/GNVQ level 4 awards. Six respondents did not specify their education level or said they didn't know. Sixteen held no qualifications.

Table 4 educational achievement of respondents

Highest education level (Q13)	<i>n</i>	%
GCSEs, O levels, CSEs	6	15.0

College diploma	3	7.5
NVQ/GNVQ level 3	5	12.5
A levels	2	5.0
NVQ/GNVQ level 4	2	5.0
Other	6	15.0
No qualifications held	16	40.0
Total N	40	100%

3.1.6 Employment

The majority of the respondents ($n = 36$) did not have another type of employment and those who did referred to non-paid (voluntary) engagements. Around half of the respondents ($n = 22$) had experience with another type of employment before getting involved in sex work. Table 5 shows the types of employment the respondents had experienced, with some (but certainly not all) being relatively low paid.

Table 5 type of employment

Occupation	<i>n</i>
Accountancy	2
Bar work/work coffee shop work	5
Carer in nursing home	2
Coal miner/manufacturer/ building	1
Call centre	1
Customer Assistant	1
Factory work/kebab shop	1
Hairdresser	1
Kitchen work	2
Chef	1
Medical doctor	1
Milkman	1
Support worker at social housing	1
Supermarket work	1
Telesales/cleaner/sales	1
Total N	22

Some of the respondents who had held another type of employment before entering sex work had been forced to leave their job due to a variety of reasons:

- **six** respondents mentioned that leaving their job was related to their use of drugs
- **three** respondents had to leave because the place where they worked closed down
- **one** respondent was fired for not turning up at work and '*going out instead*'

Importantly therefore, while drug use appeared to be connected to loss of employment for some of the respondents, this cannot be said to be the only cause of job loss/becoming unemployed in the sample. As the findings make clear, for some of the respondents the reasons for leaving alternative paid work before entering sex work were extremely varied; some reasons were connected to the use of alcohol and illness, and others due to events in their lives. As some of our respondents explained:

"It was due to alcoholism, long term sickness and depression."

"I turned up to work drunk one day, my employer did not find out but I felt guilty and did not go back."

"I was on the sick for post-natal depression and the money is better in sex work. I looked through free ads and found an escort agency."

"I was a victim of bullying."

"I left when my boyfriend died due to depression."

"My father was ill and I needed to take care of him."

"I became pregnant."

"The nursing home closed down."

Importantly, as already noted, the demographic characteristics of the respondents being mostly female and White British corresponds to other sex work research carried out in Wales since 2010 (Sagar and Jones, 2010; Sagar et al, 2011; Sagar et al, 2014). Likewise, the respondents were mixed in ages with significant numbers

aged over thirty years which again correlates with other research in Wales (see for example, Sagar et al, 2011; 2014). The findings also re-affirm that some sex workers can hold a variety of educational qualifications as well as having had experienced of other types of employment (see Sagar et al, 2011). Thus, it would be wrong to stereotype sex workers in Wales as being young, of predominantly foreign origin, without qualifications or previous work experience. However, a lack of educational qualifications and previous work experience could be factors that need to be taken into account in any service that is geared towards assisting sex workers who wish to step out of sex work.

3.2 Organisation of the Work

We wanted to know how the respondents organised their work and so we asked them a variety of questions to build up a picture of where they worked, why they worked in the location/environment that they did, and how many days/hours per week they worked at what time of day.

3.2.1 Location/Environments

Respondents were asked about the locations where they sell sex:

- Over half of the respondents reported working on the street ($n = 23$)
- The second most popular location was doing outcalls ($n = 19$)
- The third most popular location was a massage parlour or brothel ($n = 15$)
- A significant number of respondents also worked from private houses ($n = 12$)
- Other locations included cars ($n = 2$) and saunas ($n = 1$)

We also asked the respondents where they worked from '*mostly*':

- Fourteen reported working 'off street'
- Thirteen reported working 'on street'
- Five indicated that they worked 'on and off street equally'
- Eight reported that they worked 'mostly from home'

3.2.2 Mobility Between On and Off Street

While some respondents did talk of moving between parlours there was also considerable movement between working the street and working off street. Many of the respondents ($n = 15$) had changed from working mainly on street to working off street or vice versa and this took place due to a variety of motivations.

Motivations for moving *from the street to off street locations* included:

- Wanting to avoid harassment experienced on the street
- A lack of safety on the street (risks of assault and violence)
- Less risk of being caught by the police on the street
- Less risk of being seen by the public
- Client requests
- Avoiding bad weather

Motivations moving *from off street locations to the street* included:

- A lack of customers off street
- A change in appearance making it more difficult to attract clients off street
- More money to be made on street
- Drug use not being allowed in parlours

We also asked the respondents, when they were doing outcalls how did they contact their clients? By mobile phone was by far the most common mechanism of communication ($n = 20$). Although, two respondents told us that clients arranged meetings via the parlour, with another two respondents explaining that they made use of the internet and adverts (with a reference to 'Adultworks'). One respondent arranged outcalls while working on the street.

Significantly then, the locations/environments where sex work takes place are becoming increasingly varied with sex workers who are today assisted by the use of mobile phones and the internet being able to work in both on and off street locations with relative ease. Motivations for working either on street, off street or both are also varied. While the data indicates that for some sex workers off street locations are perceived to be less risky, some sex workers are driven to moving to the street in order to access more clients, to earn more money, and to be able to continue drug taking. This has important implications for service providers – particularly Outreach service providers which have traditionally targeted on street workers. Arguably, the

findings suggest that a more comprehensive service provision that reaches not only into off street establishments but also into the homes of sex workers is necessary.

3.2.3 Time Spent Working

We wanted to know how sex work was organised in terms of the amount of days spent working; the number of hours worked, as well as the time of day/evening/night the work took place.

Table 6 days, hours and time of day working

When working		
	<i>n</i>	%
Every day	6	15.0
Most days	22	55.0
Sometimes	9	22.5
Rarely	3	7.5
Total N	40	100%
Hours working per week		
	<i>n</i>	%
Over 40	8	20.0
Between 30 and 40	11	27.5
Between 20 and 30	5	12.5
Between 10 and 20	9	22.5
Less than 10	7	17.5
Total N	40	100%
What time of the day working		
	<i>n</i>	%
Day time	1	2.5
Day time and evenings	20	50.0
Evenings only	7	17.5
Evenings and night time	3	7.5
Night time	2	5.0
Day time, evenings and night time	7	17.5
Total N	40	100%

As can be seen in table 6, most of the respondents engaged in sex work regularly with the majority ($n = 22$) working most days of the week. Almost 50% of the respondents also worked over 30 hours a week with some working over 40 hours ($n = 8$). However, the majority ($n = 21$) worked part time hours with a significant number of participants working less than 20 hours per week ($n = 16$). As for the time of day worked, the majority worked day time and evenings ($n = 20$), and 12 indicated that they worked into the night. Again, this variety of working patterns suggest that Outreach provision and other sex worker support services need to be flexible in their hours of access to ensure that support services have maximum reach.

3.3 Pathways into Sex Work

3.3.1 Age Starting Sex Work

As can be seen in table 7, some respondents were very young when they first entered the sex industry while others were in their twenties or even above thirty when they sold sex for the first time. Similar findings have been presented in other research reporting on sex work in England and Wales (see, Galatowicz et al, 2005; Sagar et al, 2011; 2014), suggesting that individuals do enter sex work at different points in their lives, and as highlighted later in this section of the report, the reasons for entry into sex work can be very different.

Table 7 age starting sex work

Age	<i>n</i>
15 or younger	7
Between 16 and 18	8
Between 19 and 20	7
Between 21 and 24	8
Between 25 and 29	2
Over 30	8
Total N	40

3.3.2 Length of Time in Sex Work

Table 8 indicates that the respondents had worked as sex workers for varied levels of time. Importantly however, over 50% of our respondents had participated in sex work for over five years (*n* = 23) with some working in the industry for over ten years (*n* = 9). This finding suggests that for the majority of our respondents sex work was a long term occupation. Again, this finding is also mirrored in other studies in Wales (Sagar et al, 2014).

Table 8 length of time in sex work

Time	<i>n</i>
Less than one year	5
Between one and two years	7
Between three and five years	5
Over five years	14
Over ten years	9
Total N	40

3.3.3 Reasons for Starting Sex Work

The most common reason for starting sex work was:

- 'to support drug use' ($n = 25$)

Thus the majority of the respondents were 'drug using sex workers' (Melrose, 2009). They had taken drugs prior to entering into sex work and took up sex work to support their drug use. Those who entered sex work to support a drug habit explained:

"Because of heroin; I started when I was seventeen. Drugs have always been around in the family."

"I was addicted to heroin – I started using because my ex was using and encouraged me to try."

"I needed to buy my drugs as I have no other way of supporting it."

Two respondents also entered into sex work to support a member of the family's drug use or a partner's drug use:

"...my partner used to force me to sex work to support our habits...."

"...to help family members for their drug use."

However, respondents also indicated other reasons for taking up sex work:

- 'through a friend or personal contact' ($n = 12$)
- 'economic reasons' ($n = 9$)
- 'homelessness' ($n = 5$)
- 'response to advertisement' ($n = 2$)

Another two women explained that they needed money to support the family because they were single mothers:

"I had just given birth to my daughter; I was a single mum and needed money."

"[I am a] single mother, in need of money."

Other explanations importantly highlight how experiences of growing up, parental neglect and abuse, as well as the impact of other close relationships such as friends, partners and family can impact on trajectories into sex work.

For example two respondents were directly led into sex work by their mothers and both started selling sex before turning 15. One respondent's mother was also a sex worker and she explained that she had been around drug use and sex work growing up:

“My mother was working too, so I started when I was thirteen.”

The other respondent's mother had forced her into sex work with her drug dealer in order to get a discount on drugs:

“Heroin has been around all my life. My mother went to prison when I was twelve for six and a half years for supplying heroin and neglect. The house was bugged and she got me to sell drugs...my father had always been a heroin user, he was the first person to inject me, I was smoking heroin before. I started using because of my mother before she went to prison. I had a habit by the age of fifteen.”

One respondent explained that she had been coerced by an older man (she was under 15 and he was 30) who had offered her 'comfort':

“I didn't really know what was happening. The guy followed me around from when I was younger. He was in his thirties. He used to comfort me.”

However, some respondents did not see a clear reason, but their decisions as illustrated in the quotations below were driven simply by the need to earn money:

“I needed money. No one forced me, it just sort of happened.”

“I was homeless and needed money urgently, there was no time to apply for jobs and wait. It was a quick way to fix a problem. A boyfriend influenced me and encouraged me – but there was no gun to my head but he did strongly persuade me.”

Respondents also spoke of:

- experiences of abuse
- parental neglect
- domestic violence
- having parents who were problematic drug users
- a lack of family ties
- breaking up with a partner
- the death of a husband
- having a boyfriend who had an active role leading to sex work
- having a friend who had an active role leading to sex work

While entry into sex work is ultimately underpinned by economic reasons – whether or not the primary reason is to pay for drugs, it is unlikely that one variable in itself can result in an individual taking up sex work (see, Cusick et al, 2003). All of the reasons/events noted by the respondents (child abuse, drug using parents, broken homes, partnership breakdowns, bereavement and the inability to cope and encouragement/coercion by others) were presented as *lived experiences/conditions* that eventually led the respondents into sex work.

Thus it is impossible to say with any degree of certainty exactly what causes entry into sex work. However, as the Phase 1 literature review of this project documented, there are some key vulnerabilities and risks associated with an individual's entry into sex work which have consistently been found in sex work research *over the decades*. Given this, the research sought to explore in some detail: partner and family relationships/friendships, experience of Local Authority care and homelessness (the findings of which are documented in the following sections of this report).

3.4 Partners, Family and Friends

3.4.1 Partners

Most respondents ($n = 24$) did not have a partner. Of those who did have a partner ($n = 16$), five said that their partner had been violent to them. Two respondent’s partners were also sex workers.

Table 9 partners and violence

Having a partner			
		<i>n</i>	%
	No	24	60.0
	Yes	16	40.0
	Total N	40	100%
Has your partner ever been violent to you?			
		<i>n</i>	%
	No	11	68.8
	Yes	5	31.3
	Total N	16	
	Not applicable	24	100%

This finding does differ from previous research carried out in Wales in 2014 where violence from a partner was found to be more likely than violence from a client (see, Sagar et al, 2014). However, for those respondents who indicated their partner or a previous partner had been violent (31.3%) the levels of violence were significant:

“Every week now he kicks me down the stairs and things.”

“My previous partner was violent towards me. I suffered a fractured skull, broken nose, cheekbone and ribs - he received eighteen months.”

“...kicked my eye out, got beaten with a hammer and once when a partner was on speed, they got very angry and ruptured my spleen.”

“My partner used to hit me all the time.”

“He’s not violent anymore due to that he could be facing a long prison sentence. He’s not supposed to come into my home as he is under a court order.”

For others, partnerships appeared to be problematic, particularly where both the respondent and his/her partner were drug users for example:

“It’s an exhausting, turbulent relationship due to us both being drug users.”

Another respondent expressed her concerns in maintaining a relationship in the context of the impact of sex work and previous domestic violence:

“I feel guilty as I have sex worked, and find it hard to get close to him and still struggle with past domestic violent relationships and I flinch when he comes near me.”

Another stated:

“It’s alright but it has its ups and downs. He knows about my sex work and isn’t happy about it.”

The links between sex work and violence from partners were discussed in the literature review in Phase 1 of this project. The review also asserted that connections had to be made between sex work, substance misuse and domestic abuse in Wales. Clearly, this assertion is borne out in the data detailed here. Even so, it is extremely important that sex worker relationships with partners are not stereotyped as being always or most likely violent/abusive. When respondents spoke about their relationships with partners, some explained that the relationship was ‘good’, ‘stable’ and even ‘amazing’.

3.4.2 Family and Friends

Just over half of the respondents ($n = 23$) said that their family and friends know about their work. Again, this finding differs from other research carried out in Wales where the majority of sex workers were found to keep their sex working a secret (Sagar et al, 2011; 2014). However, for those that did keep sex work a secret from family and friends the findings were consistent with those of other research projects in that the primary reasons for not disclosing sex work revolved around feelings of shame caused by social stigma:

“I didn’t want to tell them...they would worry and because of the stigma it’s attached to.”

“It would kill them; they would assume the worst...”

“I do not want them to know as it is not something I am proud of.”

“I’m ashamed to tell them.”

“Some friends know but no family...the stigma would be negative.”

Also sex work was kept a secret due to respondents not wanting to cause a member of the family to worry:

“I feel guilty and still do, my daughter lives in my hometown and it’s a small community, I don’t want her to think of me like that.”

“My mum doesn’t understand sex work and I don’t want to worry her as she worries enough about me.”

“Some of the family know...if my dad found out it would kill him.”

Arguably, while there are many different aspects of an individual’s life that may be kept from a family member on the premise that a disclosure would cause a loved one to worry, the stigma surrounding sex work can cause shame and this far too often leads to sex work being kept a secret. Thus it is the stigma against sex workers in society that renders individuals who take up sex work vulnerable to judgemental attitudes, and consequentially social isolation. This can be particularly problematic where a drug using sex worker wants to stop using drugs because family support can really help before, during and after treatment (see, Sagar 2010). Importantly, almost half of the respondents kept sex work a secret and the majority who took part in this research indicated that they wished to stop taking drugs (see section 3.11 for further discussion).

3.4.2.1 Children

Over half of the respondents ($n = 24$) had children. Some respondents had very young children:

- child under age 1 ($n = 1$)
- child under age 5 ($n = 8$)

However, *only three of the twenty-four respondents with children were also living with their children*. Nine respondents had children that were adopted, in care or living in a foster home. Other respondents' children lived with the father, the mother or another family member. The findings indicated that:

- Ten respondents with children never saw them
- One respondent saw her children rarely
- Two saw their children sometimes
- Seven saw their children regularly
- Three had daily contact with their children
- One respondent did not provide information

Importantly, as the next section of this report (3.5) emphasises, almost half of the respondents ($n = 19$) had experienced local authority care. Similarly, over half of the respondents ($n = 21$) had children that no longer lived with them. Thus the data did indicate a cycle of parent/child breakdown. This is an issue of concern and it suggests the need for social services to become more involved with multi-agency approaches to sex work – particularly so given that children who are looked after in the care system may be vulnerable and exposed to risks of sexual exploitation as discussed in the following section.

3.5 Experiences with the Care System

3.5.1 Experience of Care

Almost half of the respondents ($n = 19$) had been placed in care. The links between sex work and experience of the care system are well known, however, the finding that just under 50% of the respondents had experienced care is significantly higher than some other studies (see, Galatowicz et al, 2005 for example which found approximately one third of respondents had experienced care). This finding also arguably highlights the acute vulnerability and to a certain extent the ongoing social isolation experienced by almost half of the respondents prior to entering sex work.

Reasons for entering care were related to:

- Parental drug use
- Family breakdown
- Domestic violence
- Parental neglect
- Parental physical abuse
- Parent's poor mental health/inability to cope
- Sexual abuse by parent/family member

Age when entering care:

- 10 years and younger ($n = 9$)
- 10 – 12 years ($n = 5$)
- 13 – 15 years ($n = 4$)
- 1 respondent did not say

3.5.2 Sexual Exploitation whilst in Care

Four respondents explained that when in care they had provided sexual acts in exchange for a variety of things – gifts, clothes, cigarettes, and money:

“An older male used to buy clothes, fags and gifts etc.[for sex working]. I was fourteen. He [didn't do] anything sexual to me, or to the other girls.”

“Someone said it was a way to earn money....”

“I was still sex working while in foster care - they were unaware.”

One respondent explained how she was groomed through a man who was known to the staff of the care home:

“Yes, grooming through a guy. He came to the care home and acted as a friend. Staff knew the guy and he worked with the children as a volunteer.”

Of course, while the care environment is supposed to provide protection and stability for those young people who are often the most vulnerable in society, it is also today recognised that children can and do experience sexual exploitation whilst in the care system. Also, as emphasised in the literature review in phase 1 of this project, grooming children whilst in care for sexual exploitation has been reported for many years (see also, Home Office, 2004).

Children who are groomed are unlikely to understand or even accept that they are being groomed and sexually exploited when encouraged into sex work. It is vital therefore that staff who work with young people who are placed in local authority care are aware of the risks. However, while this has been on the radar of statutory and voluntary agencies who are involved in children’s safeguarding for many years (Department of Health, 2000), this data indicates that the risk of sexual exploitation through prostitution should continue to be a matter of utmost concern.

3.5.3 Support when Leaving Care

Of the nineteen respondents who had experienced care, the majority left care between the ages of 14 and 18; two were 21 years old when they left.

The respondents were asked about the support they had received when they left care:

- Three respondents had a social worker or support worker (but one respondent emphasised that she had not got on well with her appointed support worker)
- One respondent was offered college and housing
- Two respondents couldn’t remember
- **Thirteen** respondents said they had received **no support**.

Two respondents took the time to explain their experiences which revolved around the end of the care period and the need for care to continue:

“I didn’t have that much support. When you are in care or in with fosters yes they look after you but when it’s time to leave it’s like for forever and you are gone.”

“I needed to say with my foster parents until I was twenty-one and ready to live on my own. My foster parents were fab, however I had to leave at the age of sixteen. I didn’t want to leave and live on my own, so I went back to live with my mum. But two days later it was not working so I left to live with my boyfriend who was physically and mentally abusive. I was then moved into [a] homelessness project.”

Respondents also spoke about the type of support they would have liked to receive when leaving care which included:

- Help with accommodation ($n = 13$)
- Counselling and a one to one specific counsellor ($n = 3$)
- Help to rebuild family relations ($n = 2$)
- Help with schooling and ‘*getting on the right path*’ ($n = 2$)
- Financial help and help with budgeting ($n = 2$)
- A befriending system, support with drug use and information on sexual exploitation ($n = 1$)

The Children (Leaving Care) Act 2000 came into effect in 2001. The Act which applies to England and Wales was brought in to ensure that young people do not leave care until they are ready and to ensure that they receive more effective support once they have left care up until the age of 21 years. Pathway plans must be in place by the young person’s 16th birthday. Local Authorities are under a duty to make an assessment of needs and to meet those needs – providing where necessary financial support, a personal advisor and there is also a duty to ensure accommodation is provided. For young people who wish to go on to further and higher education there is also a duty to assist with education costs, as well as any employment and training costs.

The majority of the respondents who had experienced care left between 14 and 18 years of age. And of course, many of our respondents were over 30 years of age suggesting that their experiences pre-dated the 2000 Act. Nevertheless, eighteen of our sample had been working in sex work less than 5 years and some of these

respondents had the experienced care system. Thus, while statutory measures have been put in place to raise awareness of sexual exploitation for 'prostitution' and of children going missing from care and their vulnerability for coercion into prostitution (Department of Health, 2000), and to provide additional support for young people leaving care, the findings nevertheless suggest that from the perspectives of our respondents, support on leaving care is still problematic. The data also emphasises the importance of advice and counselling – and very importantly, help with accommodation.

3.6 Accommodation and Homelessness

The connections between sex work and the lack of safe and secure accommodation have been reported over many decades (see the literature review – Phase 1 of this research project).

3.6.1 Current Accommodation

We asked our respondents about their current accommodation:

- Privately rented accommodation ($n = 12$)
- Local Authority housing ($n = 7$)
- Home Owner ($n = 1$)
- No fixed abode or homeless ($n = 5$)
- Living in a B & B or hostel ($n = 3$)
- Living with friends/family ($n = 4$)
- Housing Association ($n = 6$)
- (Two respondents did not provide information)

Fifteen respondents told us that they currently had rent arrears:

- Nine respondents reported arrears of less than £1000
- Two respondents reported arrears of up to £2,000
- Two respondents reported arrears over £2,000
- (No information on total sum of arrears from 2 respondents)

3.6.2 Being Forced to Leave Accommodation

We also asked our respondents if they had ever been forced to leave their accommodation and the reasons why they had been forced to leave it. The majority of the respondents had been forced to leave their accommodation. This was mostly because of:

- Rent arrears ($n = 15$)
- Domestic violence ($n = 8$)
- Drug use ($n = 6$)

- Drug users coming into the property ($n = 2$)
- Anti-social behaviour ($n = 5$)
- Violence ($n = 3$)

Other reasons included family relations, bereavement, bedroom tax, and repossession, for example:

“My gran passed away one year ago. I made my mum get clean; my mother used heroin and meow, she became paralysed from injecting meow.”

“I got evicted by bedroom tax, but I have a disability and am entitled, but at court I was told to pay £600 straight away so I was evicted.”

“It was because of repossession because of a family bereavement.”

3.6.3 Homelessness

Finding a stable place to live and holding on to it was a key issue for our respondents. The majority of respondents ($n = 28$) had experienced homelessness and even multiple periods of homelessness. For some this included having to sleep rough or in unsafe locations. The reasons for being homeless included:

- Failure to pay rent and eviction ($n = 5$)
- Domestic violence ($n = 4$)
- Drug use and associated anti-social behaviour problems ($n = 4$)
- Family conflict ($n = 2$)
- Ending a tenancy agreement ($n = 2$)
- Leaving care and having nowhere to go ($n = 2$)
- Coming out of prison ($n = 1$)

The following respondent comments illustrate some of these issues:

“[I’ve been homeless] three times. The first time my parents threw me out, second time parents again, and the third time was because of a breakdown in a relationship.”

“I’ve currently been homeless for four months because of domestic violence in the house. [I was] living with a best friend then went to live with my Dad, but the tenancy ran out and then I was homeless.”

“I have been homeless a few times, and am currently homeless, which is why I am staying with a friend. Swansea wouldn’t re-house me because they said I made myself homeless because of drug use. This has happened a few times. I then moved to Port Talbot, but got evicted from there because my boyfriend lived with me and I didn’t tell them.”

“I have been on and off homeless since I was thirteen to eighteen years old.”

“I was homeless when I left care at the age of seventeen.”

“[I’ve been homeless] twice, the last time was two and a half years ago when my daughter was taken off me.”

“Every time I came out of prison.”

Respondents also explained where they had slept while homeless. In particular it is noteworthy that out of the twenty-eight respondents who had found themselves homeless at some time, twenty-five of them had slept rough on the street:

- Slept rough on the street ($n = 25$)
- Periods of sofa surfing and or sleeping rough (both $n = 20$)
- Sleeping in a crack house ($n = 13$)
- Sleeping in a car park ($n = 11$)
- Sleeping in a shop doorway ($n = 7$)
- Sleeping in a phone box ($n = 2$)

The respondents who had experienced homelessness also explained that they had spent time in a variety of accommodation which provided them with a short term solution to their homelessness issue:

- Hostel ($n = 19$)
- Temporary/short term housing ($n = 15$)
- Bed and Breakfast ($n = 13$)

As already noted, the links between homelessness and sex work have been known for many years. Importantly however, this research continues to highlight the connections between sex work, homelessness and leaving care and prison.

The problem does seem to be particularly acute in Wales. In 2014 Sex Work Research Wales also interviewed sex workers in the South Wales area and found that out of their sample of 44 participants 31 had been homeless (Sagar et al, 2014). In this study, 28 respondents out of 40 reported periods of homelessness. This not only emphasises the need for partnership work to provide a range of options for sex workers, but also the **prioritising of housing** within any strategy aiming to meet the complex needs of sex workers.

3.7 Safety

For several years now the safety of sex workers has been a primary concern for stakeholder statutory and voluntary agencies in Wales. In particular, across the South Wales area there has been an attempt to improve partnership work between Police and Outreach agencies which has, to a large extent, been geared towards building up relationships of trust with sex workers and encouraging sex workers to report violence (see, Sagar et al, 2014). The findings from the respondents on issues of violence are encouraging in that the majority felt able to report incidents of violence to the police. However, the level of violence from clients is an ongoing concern, particularly given the varied locations sex workers work in which can leave them more isolated and at risk of violence.

3.7.1 Experience of Violence

The results showed that over 50% ($n = 21$) of the respondents had experienced violence from clients usually in the form of physical and sexual violence but also robbery.

Table 10 clients and violence

Ever experienced violence from a client?			
	<i>n</i>	<i>%</i>	
No	19	47.5	
Yes	21	52.5	
Total N	40	100%	

This violence appeared to be particularly extreme and referred to:

- Physical assault (being hit / beaten)
- Rough treatment during the sex act
- Forced into doing sexual acts without consent
- Rape
- Strangulation
- Being locked up
- Robbery

Some respondents explained their experiences:

“[I was] attacked by a client in extreme violence, he broke two ribs, beat me severely with his fists and stamped and choked me. [It was] a very bad assault. I was left for dead.”

“[I was] locked in a block of flats for three days in Bristol and I have been hit with a hammer.”

“I was raped by one client. I have also been physically assaulted three or four times by clients.”

The following statement makes it quite clear that the experience of violence can be ongoing, and it can also take part in any location:

“I’ve learnt to tolerate it and I don’t complain anymore but I’m upset. There’s not a day that goes by when I’m not sexually assaulted, they put their finger up my arsehole when I haven’t consented.

In work I had a customer who was obsessed with me, he said he loved me and I didn’t say it back. He was on top of me and had his hands around my neck and because of the music no one could hear me but everyone saw what he did.

I have experienced violence once in an outcall, once in a parlour. Once in a penthouse flat, his brother left and he wanted sex without a condom. I had to make a split second decision, I thought he was going to start without a condom so I ran out of the flat naked and found a person in a car parked randomly in the road. I thought he was going to rape me.”

3.7.2 Violence from other Sex Workers

The respondents were asked if they had ever experienced violence from fellow sex workers. The majority had not experienced such violence.

Table 11 violence from other sex workers

Has a sex worker ever been violent to you?			
	<i>n</i>	<i>%</i>	
No	32	82.1	
Yes	7	17.9	
Total N	39		
No information	1	100%	

However one respondent told us she had been attacked by two other sex workers who had punched her and pulled out her hair. Another respondent explained that she regularly had fights with other girls on the same beat – the fights revolved around competition for punters and also fights over drugs.

3.7.3 Reporting Violence

Over half of the respondents said that they would feel able to report an act of violence related to sex work to the police (57.9%).

Table 12 reporting violence to the police

Would you feel able to report an incident of sex work related violence to the police?			
		<i>n</i>	%
	No	16	42.1
	Yes	22	57.9
	Total N	38	
	No information	2	100%

Considering that other relatively recent research in Wales found that the majority of sex workers would not report violence to the police (see, Sagar and Jones, 2010; Sagar et al, 2014) this finding suggests that sex workers are beginning to slowly build up relationships of trust with the police and other services. This is illustrated in the comments of our respondents:

“Many [sex workers] do now report with help from Cyrenians.”

“I have met police in the locality of the massage parlour. They are better informed and more understanding than I expected. I have confidence having spoken to specialist services too.”

“I feel confident they [the police] would want to help rather than ignore.”

“They are the police so therefore they should help. It worked last time I reported an incident to the police.”

“They [the police] have a good relationship with StreetLife.”

“I would report via StreetLife.”

However, over 40% of our respondents still did not feel able to report to the police. The reasons for this related to:

- Feeling judged
- Not feeling comfortable to talk to the police
- Not trusting the police
- Feeling embarrassed
- Fearing that they would be charged for prostitution

Again this is illustrated through a selection of our respondent comments:

“I wouldn’t feel comfortable reporting, I would try and tell them but would feel they would judge me and belittle my claim as I would be perceived as an addict making it up.”

“I feel the police are too judgemental.”

“They would blank me.”

“It’s embarrassing, they would blame me.”

Clearly, the fear of being ‘judged’ remains a significant obstacle to sex workers reporting violence.

3.7.4 Staying Safe

Respondents were asked what could help them staying safe.

Table 13 support to keep safe

What would help to keep you safe (multiple options)		
	<i>n</i>	%
Training in self-defence	26	68.4
Drugs awareness	11	28.9
Peer support	15	39.5
Other	7	18.4
Total N	38	
No information	2	

Clearly sex workers do want to receive training in self-defence with almost 70% indicating that this could help to keep them safe. Interestingly, peer support was the second most popular choice (39.5%) and then drug awareness (28.9%).

Other suggestions raised by sex workers to keep them safe included:

- Anger management
- New laws
- Domestic violence refuges
- Being able to work in pairs
- Rape alarms
- The Ugly Mugs App
- Project work

While some of these suggestions are connected to the legal framework sex workers operate within (such as new laws and being *unable to work* in pairs in off street locations) they also indicate how sex workers perceive that the current legal framework can work against them in terms of their own safety. Likewise, the reference to the need for domestic violence refuge is a clear indicator that sex workers can feel that they fall through the gaps in terms of protection from domestic violence. On a more positive note, the reference to rape alarms, project work and 'Ugly Mugs' suggests that sex workers are aware of some of the steps services in the South Wales region are taking to help them to maintain their safety.

3.8 Mental and Physical Health

When inquiring about the respondents’ mental and physical health, the results showed that mental health issues, especially depression and anxiety, were by far more common, and also that poor mental health had a greater negative impact on the respondents’ lives as compared to physical health issues. Nevertheless, physical health issues were also common, especially dental problems and hepatitis C. Some respondents directly linked their physical health issues to their drug use while at the same time some respondents used drugs in order to cope with their mental health problems.

3.8.1 Mental Health

Respondents were asked to describe their mental health on a five-point scale going from ‘poor’ to ‘excellent’. Most respondents described their mental health as either ‘poor’ (*n* = 16) or ‘fair’ (*n* = 13).

No respondent said that his or her mental health was ‘excellent’, only one said it was ‘very good’, and nine said it was ‘good’.

The following table shows the types of mental health problems our respondents experienced:

Table 14 mental health of respondents

Mental health: Respondent suffers from... (multiple options)		
	<i>n</i>	%
Depression	35	87.5
Anxiety	35	87.5
Schizophrenia	7	17.5
Panic attacks	23	57.5
Insomnia	17	42.5
Irritability	20	50.0
Agitation	19	47.5
Confusion	17	42.5
Paranoia	23	57.5
Aggression	18	45.0
Other	4	10
Total N	40	

Importantly, thirty-five out of forty of the respondents suffered from depression and anxiety (87.5%) with panic attacks, paranoia, irritability, agitation, aggression, insomnia and confusion also being a common finding. Seven respondents also said they suffered from schizophrenia, one self-harmed and one suffered from bipolar.

Poor mental health affected their lives in many ways as illustrated by the following respondent comments:

“I’m diagnosed with manic depression, anxiety, OSD and schizophrenia. During the last three months I have had suicidal thoughts and went into Cefyn Coed.”

“I suffer with depression and anxiety and I have been self-harming due to family circumstances....”

“I have no motivation. I can’t organise my life, even something simple as making an appointment.”

“It has affected my ability to sustain housing and also caring for my children.”

“It has stopped me going out and communicating with people. It has also made me nervous around new clients because I’m paranoid.”

“It makes me scared, my everyday life is affected; even the simplest of things such as going to the shops.”

“...[It] affects me every day. I struggle to leave house and some days don’t want to get up.”

“[I’m a] shell of the person I used to be.”

3.8.2 Physical Health

Respondents were also asked to describe their physical health on a five-point scale going from ‘poor’ to ‘excellent’. Physical health was assessed overall more positively compared to mental health:

- Eight respondents said it was ‘poor’
- Fifteen said it was ‘fair’
- Fifteen said it was ‘good’
- One said it was ‘very good’
- One said it was ‘excellent’

The physical health issues suffered most commonly were:

- Dental problems ($n = 15$)
Hepatitis C ($n = 11$)
- Liver damage ($n = 5$)
- High blood pressure ($n = 4$)

Other physical health issues included:

- Kidney damage
- Bronchitis
- Blood clots
- Heart problems
- Low blood pressure

One respondent was HIV-positive. Several respondents directly linked their physical health issues to their drug and alcohol use.

The respondents spoke of back pain and tooth pain, feeling tired, poor circulation, collapsing veins, blood clots, open sores, and feeling upset. For example:

“I am ill all the time, my immune system is down, and I had a clot in my groin also.”

“I often feel poorly and constantly tired due to a leaking heart valve.”

“[It’s] draining, I’ve not a lot of energy. I pick up colds and sore throats easily, my kidney and liver aren’t great. I have back pain.”

“Blood clot, veins collapsing from injecting, especially the second blood clot. Walking has become difficult and I have bad blood circulation in my hands and my feet are numb.”

“I have open sores due to D.V.T. I also have pain in my abdominal region and my back and my left leg due to a serious physical assault.”

“I am in constant pain with my teeth.”

“I have found it hard to come to terms with having Hep C and my moods are quite erratic as I’m finding it hard to deal with.”

“I’m very upset about it.”

There has yet to be a comprehensive in-depth study of sex workers' mental and physical health in England and Wales. However, our data clearly suggests that there are connections to be made. And, unfortunately, the social exclusion that can be experienced by individuals with mental health problems due to social stigma (see, Social Exclusion Unit, 2004) can only be exacerbated by the stigma associated with sex work (see, Sagar et al, 2014).

Furthermore, given the negative impact of poor physical and mental health on the respondents who took part in this research it is apparent that health policy for sex workers in Wales must be a priority. And, in this context the findings add weight to the need for an all-encompassing harm reduction approach to assist both drug using sex workers and sex workers in Wales.

3.9 Prison and Probation

3.9.1 Experience of Prison and Probation

The findings showed that prison and probation were very common aspects of the respondents' lives with over half of the respondents having been in prison and/or having received a probation order. As the following table shows, 60% ($n = 24$) had been in prison or received a probation order.

Table 15 respondents who have been in prison and under probation orders

Have you ever been in prison?		
	<i>n</i>	%
No	22	55.0
Yes	18	45.0
Total N	40	100%
Have you ever received a probation order?		
	<i>n</i>	%
No	16	40.0
Yes	24	60.0
Total N	40	100%

Almost half of the respondents ($n = 18$) had been in prison and over half ($n = 24$) had received a probation order. The offences committed were generally related to theft but included:

- Theft
- Assault
- Robbery
- Kidnap
- Handling stolen goods
- Dealing drugs
- Arson

As can be seen from table 16, ten of the respondents who told us they had been in prison had entered prison over 5 times, with four respondents indicating they had been in prison over 10 times. Time spent in prison varied from 2 weeks to 2½ years.

Table 16 respondent offences and experiences of prison

What was your last offence?	When was the last time you were in prison?	How long were you in prison for your last offence?	How many times have you been in prison?
Arson and GBH with intent	2 years ago	3 years but served 18 months	9
Assault	12 months ago	6 months	12
Breach of license – license of probation, possession and shoplifting	2010	5 months	5
Burglary	6 months ago	18 months	6
Drugs	October 2014	2 ½ years	7
Handling stolen goods	2013	7 months	2
Non-payment of fines	2008	2 weeks	1
Possession with intent to supply Class A drug	two years ago	6 weeks	1
Possession/supply class A heroin	2/3 years ago	16 - 18 months	2
Robbery and kidnap	2 years ago	3 years	12
Shoplifting	10 years ago	3 - 4 days	1
Shoplifting	Couple of months ago	9 months	10
Shoplifting and breach of DRR and probation	December 2014	4 ½ months	3
Street robbery	18 months ago	16 months	11
Street robbery	July 2014	18 months	7
Supply Class A	1 Year ago	18 months - served 9	1
Theft	March 2013	6 and a half months	2
Theft	December 2013	2 years	6

Table 17 provides details of the offences leading to a probation order together with the duration of the order which were mostly between 12 and 18 months in duration.

Table 17 respondent offences and experiences of probation orders

If you have received a probation order, what was your last offence?	How long was your order for?
No information provided re last offence	2 years

18 months given for arson and GBH with intent	18 months
Possession and shoplifting	12 - 18 months
ABH and attempted robbery	4 months (only had it for a week and it was recalled)
Allowing my premises to be used	18 months
Assault	12 months
Burglary	12 months
Community order	12 months
Dealing heroin	24 months
DRI	12 months before prison
Supply of class A drugs	12 months
Handling of drugs	12 months
On bail at the moment for failure to attend drug testing	
Possession of class A drugs	12 months then extra 6 months
Possession of class A drugs and shoplifting	12 months
Shoplifting	12 months
Shoplifting	2 years (currently on it)
Shoplifting	12 months
Shoplifting and assault	15 Months
Street robbery	16 months
Supplying to undercover and class A drugs	1 year
Theft	12 months
Theft	1 year

3.9.2 Support while in Prison/Under Probation

Respondents who had been in prison or under probation were asked what type of support they received whilst in prison/under probation. Most respondents received multiple types of support, including:

- Drug treatment ($n = 19$)
- Help with drug and alcohol problems ($n = 18$)
- Education and training ($n = 12$)
- Help with literacy/numeracy ($n = 10$)
- Help with accommodation ($n = 8$)

- Help with benefits ($n = 7$)
- Work experience ($n = 6$)
- Careers advice ($n = 5$)
- Mentoring ($n = 4$)

When asked what type of support they needed but did not get, most respondents referred to housing and support to stay off drugs ($n = 13$) for example:

“I needed help with accommodation, to stay off the drugs, help with a women’s support group, and help with lunch.”

“Accommodation and drug help and support. [I had] no drug worker on release...peer mentoring.”

“When I came out I asked for a grant and didn’t get one because I didn’t have a property to live in. I was given £99 but I never got it.”

“I needed help for my soul, motivation to get off the drugs – no one is helping me help myself. I’m still in the same place as I was 13 years ago. No one spends time with people’s attitudes, not only those of the drug user but funding needs to be put into drugs – it’s last on the list of priorities.”

Some also spoke of help that they had needed with life skills generally, help with picking up life in the community, benefits advice and training, and mentoring:

“Accommodation and life skills and help to get back into the community; there should have been housing and money – I did it all by myself.”

“[I needed] something in place when leaving prison to fill the time.”

“[I needed] support with housing benefits and drug problems.”

Indeed, the variety of support needed – and particularly housing – is mirrored in other research carried out with sex workers in both England and Wales (Galatowicz et al, 2005; Sagar et al, 2014). This consistent finding emphasises the need for multi-agency partnership work and coordinated support to meet the needs of sex workers simultaneously and as already noted to prioritise housing.

3.10 Alcohol and Drug Use

3.10.1. Alcohol

Over half of the respondents ($n = 25$) indicated that they drank alcohol:

- Every day or almost every day ($n = 6$)
- Twice a week ($n = 7$)
- Once a week ($n = 2$)
- Once a fortnight ($n = 4$)
- Once a month ($n = 1$)
- Few times a year ($n = 5$)

When asked about the quantity over the last seven days, only six respondents appeared to be heavy drinkers, referring to drinking vodka or other strong liquor. The most common reasons for drinking alcohol were reported as:

- 'social reasons' ($n = 16$)
- 'to sell sex' ($n = 9$)
- 'depression' ($n = 7$)
- 'to relax' ($n = 7$)

It is interesting to note that the majority of respondents who drank alcohol did so for social reasons (64%); also that fourteen respondents indicated that drinking alcohol was mainly related to personal / mental emotions (i.e. being able to cope and depression). However, only nine respondents (36%) *reported that they drank alcohol to sell sex.*

Nevertheless, while the data suggests that dependency on alcohol is perhaps not an overwhelming problem for the majority of respondents who took part in this research, it is known that when alcohol is combined with drug use when sex working (whatever the reason) that the impact can be an increase in risk taking and a vulnerability to violence (see Cusick et al, 2003). Thus it is important that this issue is not overlooked – particularly given that the majority of the respondents were drug users, with fifteen respondents reporting that they mixed alcohol and drugs frequently as the next section of this report highlights.

3.10.2 Drug Use

The majority of respondents ($n = 37$) had used drugs as illustrated in table 18.

Table 18 respondents' drug use

Have you ever used drugs?			
	<i>n</i>	<i>%</i>	
No	3	7.5	
Yes	37	92.5	
Total N	40	100%	

3.10.3 Type of Drug and Frequency of Use

Table 19 reports on the type of drug and frequency of drug use for the thirty respondents (75%) who indicated that they were currently taking drugs. It can be seen that for those respondents who reported to be currently taking drugs:

- 70% took heroin almost every day
- 70% reported using cannabis (only one third using on a daily basis)
- 63.3% reported using crack (with less than 17% using on a daily basis)
- 46.7% reported using Methadone (used by about two thirds of the respondents who reported taking drugs on a daily basis) although it is not clear if this was prescribed or illicit.

Table 19 frequency of respondents' drug use and type of drug used

Frequency drug use					
Total N = 30 (7 are past drug users and 3 never used drugs) – Valid percentage					
	(Almost) every day	Once-twice a week	Once-twice a month	A few times a year	Never
Cannabis	30.0	13.3	13.3	13.3	30.0
Amphetamines	6.7	10.0	10.0	20.0	53.3
LSD	0	0	0	10.0	90.0
Ecstasy	0	3.3	3.3	10.0	83.3
Poppers	3.3	3.3	0	13.3	80.0
Tranquilisers	6.7	10.0	20.0	10.0	53.3
Heroin	70.0	3.3	6.7	10.0	10.0
Methadone	46.7	0	0	16.7	36.7
Subutex	10.0	3.3	3.3	10.0	73.3
Crack	16.7	13.3	6.7	26.7	36.7
Cocaine	6.7	3.3	3.3	26.7	60.0
Solvents	0	0	0	3.3	96.7
Ketamine	0	0	3.3	16.7	80.0
MCat or NPS	13.8	10.3	6.9	13.8	55.2
Other	16.7	0	0	0	83.3

3.10.4 'Main Drug' Taken

We asked the respondents which was their 'main drug':

- Heroin 80% ($n = 24$)
- Crack 20% ($n = 6$)
- Cannabis 16.7% ($n = 5$)
- Amphetamines 13.3% ($n = 4$)
- Tranquilisers 10% ($n = 3$)

The respondents indicated that they did NOT regularly take: LSD, Ecstasy, Poppers, Solvents or Katamine.

As already noted, heroin was found to be the most popular drug taken on a daily basis, a finding that is consistent with other research (see for example, May et al, 1999; Hunter and May, 2004; Galatowicz et al, 2005; Sagar et al, 2014). As already noted, fifteen of the respondents who used drugs reported mixing alcohol and drugs frequently, for example because it gives 'a better buzz'.

3.10.5 Method of Taking Drugs

Injecting and smoking were the most popular ways of using drugs. While injecting was said to give more 'value for money' (*a better buzz*), some respondents were forced to smoke heroin because of vein damage:

"I sometimes have to smoke heroin as I'm unable to get a vein."

"I used to inject but my veins are bad so now I smoke it instead."

Sixteen respondents indicated that they switched between smoking and injecting as the preferred method. The majority, nineteen out of the thirty respondents who reported taking drugs said that they had shared needles, syringes, spoons or filters. Thirty-three respondents had also been tested for blood borne viruses.

3.10.6 Triggers

We asked the respondents 'did anything happen in your life that triggered your drug use?' The findings showed drug use had been triggered by a variety of traumatic events but in particular abuse in childhood and having children re-homed, placed in care and adopted was reported.

Physical and sexual abuse in childhood ($n = 9$), for example:

"Abuse by my grandfather – fucked my head up."

“Being raped by three of my mother’s partners and gang raped.”

“The abuse by my uncle.”

“Needed to cope and escape abuse.”

“My dad was violent to me and my mum.”

Taking drugs to cope with loss of children ($n = 5$), for example:

“My daughter is disabled and I blame myself for this. DV, escapism and feeling lonely, one thing after another. 2010 my daughter went into care when I had a break down and I haven’t been the same since.”

“When my children were placed with my mother.”

“When my children were re-homed.”

“When my son was adopted.”

Other triggers included:

- Bereavement ($n = 4$)
- Being in care ($n = 1$)
- Being part of the gay scene ($n = 1$)
- Drugs being taken by parents in the family home ($n = 3$)
- Partner/boyfriend took drugs ($n = 4$)

It is interesting to note that in responding to the question about ‘triggers’ not one respondent indicated that sex work was a trigger which led to drug use. However, as the next section reveals, *continuing drug use* was found to be linked to a variety of reasons which included sex work.

3.10.7 Reasons for Continuing Drug Use

The findings indicated that the continuation of taking drugs was closely linked to the need to ‘relax’, ‘escape’, ‘to cope’, ‘to forget problems’, ‘depression’, ‘boredom’ and also to ‘sell sex’ far more than drinking alcohol was. The following quotations illustrate how taking drugs had negatively impacted on some of our respondents’ lives:

“I have to use drugs everyday so I am able to carry on with my everyday duties.”

“[I am] addicted – drugs are my whole life. I need drugs to function.”

“Yes, they are a problem, I’m addicted. They have ruined my everyday life and relationships and they ruined my career. I had to quit hairdressing because of my heroin addiction.”

“Yes it is a problem, as I’m addicted to drugs it affects everything in my life. It becomes your life.”

“...the financial implications [of drug use] and the fact that I have lost my children.”

Importantly, as table 20 indicates, taking drugs to ‘sell sex’ was reported by approximately 46% of the respondents.

Table 20 respondent reasons for using alcohol and drugs

Reasons using alcohol and drugs (multiple options)		
	Alcohol	Drugs
Social reasons	16 (64.0%)	14 (40.0%)
To relax	7 (28.0%)	12 (34.3%)
To escape	4 (16.0%)	22 (62.9%)
To cope	6 (24.0%)	26 (74.3%)
To forget problems	6 (24.0%)	26 (74.3%)
Depression	7 (28.0%)	22 (62.9)
Boredom	3 (12.0%)	15 (42.9%)
To sell sex	9 (36.0%)	16 (45.9%)
Total N	25	35
Not applicable	15	3
No information	0	2

The complex motivations surrounding sex work and drug use – taking drugs to sell sex, selling sex to fund a drug habit and taking drugs as a sex worker to cope is perhaps best explained by our respondents:

“I don’t think I could sell sex for any length of time without drugs. It was a barrier to reality and helped me to cope, although I sold sex to buy drugs at first.”

“I will take drugs to help me to sex work and cope with everyday life.”

“If I don’t have heroin every day I am not in control of myself. I need to fund my habit and I only work when I am on drugs. This has been the case since I was fifteen years old. I come off drugs when I move away from Swansea, but I start again as soon as I come back – it’s all I know in Swansea. I have stopped four times, the longest for a year and a half and I would love to stop again.”

“Yes, drugs is a big problem for me as I have to sex work to be able to buy drugs, and I also buy for my sister because she has got a habit.”

Also, importantly, although the majority of respondents indicated that their drug/alcohol use did go up at different times – the findings indicated that this was not necessarily brought about by sex work; rather increased use was brought about by a variety of life events which included family problems, mental health, an increase in money, lack of money, as well as sex work:

- Family issues and problems with accessing children ($n = 4$)
- Mental health including feeling low and depression ($n = 3$)
- Having more money to spend ($n = 15$)
- Financial pressures leading to ‘going on a bender’ ($n = 1$)
- Sex work ($n = 3$)

3.10.8 Drug Use with Partners and Friends

The findings suggested that the use of drugs tends to take place mostly in a social context with the thirty drug using respondents indicating that they took drugs with other people.

- Of the sixteen respondents who had a partner, twelve said that their partner also takes drugs and the majority ($n = 13$) use drugs when they are with their partner. Importantly however, eleven out of the sixteen respondents indicated that their sex work paid for their *personal drug use only*. Therefore it cannot be said that sex work is necessarily driven by the need to pay for the drug use of a partner.

- Eighteen respondents used with family members
- Thirty used drugs with friends
- Twenty-six used drugs with fellow sex workers.

The findings suggest that drug using sex workers' close social networks are also drug using networks.

3.10.9 Sex Working and Drug Use

Despite respondent perceptions of their motivations for using drugs being varied, the data clearly indicates that for a significant percentage of our respondents (45.9%) sex work was found to be closely linked to drug use – as table 21 illustrates, seventeen respondents had exchanged sex for drugs but only 16.7% ($n = 4$) had exchanged sex for alcohol.

The findings also indicated that both drug and alcohol consumption had increased after becoming involved in sex work. In this respect it is particularly noteworthy that twenty-nine respondents (80.6%) indicated that sex work had led to increased drug taking.

Table 21 respondents' use of drugs and alcohol while sex working

Exchange of sex for alcohol/drugs		
	Alcohol	Drugs
No	20 (83.3%)	20 (54.1%)
Yes	4 (16.7%)	17 (45.9%)
Total N	24	37
Not applicable	15	3
No information	1	0
Increase in drinking/drug use since becoming involved in sex work		
	Alcohol	Drugs
No	17 (68.0%)	7 (19.4%)
Yes	8 (32.0%)	29 (80.6%)
Total N	25	36
Not applicable	15	3
No information	0	1

Also some clients provided drugs for sex and some respondents took drugs (or drunk alcohol) during the sexual transaction itself as indicated in table 22.

Table 22 respondents' use of drugs and alcohol with clients

Do clients provide you with alcohol/drugs?		
	Alcohol	Drugs
No	26 (72.2%)	18 (46.2%)
Yes	10 (27.8%)	21 (53.8%)
Total N	36	39
No information	4	1
Do you drink alcohol/take drugs with clients during the sexual exchange?		
	Alcohol	Drugs

No	25 (69.4%)	17 (44.7%)
Yes	11 (30.6%)	21 (55.3%)
Total N	36	38
No information	4	2

The most popular drug use with clients included:

- Heroin ($n = 8$)
- Crack ($n = 7$)
- Coke ($n = 2$)
- Cannabis and NPS ($n = 1$)
- Valium ($n = 1$)
- Alcohol, cannabis, crystal meth, GHB and MCAT ($n = 1$)

Interestingly, one of our respondents explained that taking drugs during off street sex work was not acceptable to establishment managers:

“Can’t do this [drugs] off street – it’s very different. The boss knows I’m on a prescription and was caught once and girls would glam you up. It’s a bitchy industry so no – drugs are far away from work.”

However, another respondent explained:

“...clients do target in the rooms and ask to swap crack for a service. A lot of dealers spend money in parlours.”

Therefore, while off street establishments often have ‘house rules’ which prohibit the consumption of drugs and/or alcohol on the premises this does not mean to say that off street premises are necessarily drug free environments.

3.10.10 Withdrawal and Sex Work

Most of the drug using respondents ($n = 28$) indicated that feelings of withdrawal impacts on their sex work. Negative impacts included:

- Irritability/agitation
- Not wanting to be touched
- Feeling ill
- Sweaty
- Aching body

- Finding it difficult to ‘perform’

One respondent explained for example:

“You are trying to give a service and you are dripping sweat. So like if you are giving oral sex you feel sick but you have to finish to get drugs to make you feel better.”

Some respondents also told us that withdrawal and the need for money to buy drugs can also lead them to take risks:

- Having sex without a condom ($n = 17$)
- Working for cheaper prices ($n = 1$)
- Performing sex acts they do not want to do ($n = 1$)
- Being less picky about which client to accept ($n = 3$)
- Sharing needles ($n = 3$)

Risks for sex workers who are withdrawing can also be multiple, and the respondents were quite aware of the risks they took, for example as one respondent explained:

“[I have performed] oral without for extra money, and I’ve done lone work – outcall work for clients for extra money in homes and hotels.”

Obviously, accepting clients that they would not usually puts sex workers in a vulnerable position with regard to issues of safety. It is also extremely worrying to find that over half of those respondents who used drugs indicated that they were more likely during periods of withdrawal to have sex without a condom and in doing so putting at risk their sexual health.

3.10.11 Purchasing Drugs

We asked the respondents who were drug users where they purchased their drugs from. The vast majority ($n = 29$) referred to purchasing drugs from a dealer. Other answers included:

- Anywhere and everywhere ($n = 1$)
- Shop ($n = 1$)
- Associates ($n = 1$)
- Friends ($n = 4$)
- Different people ($n = 1$)

With regard to how much the respondents paid for their main drug we received varying responses, likewise the amount the respondents spent daily on their drug varied greatly as outlined in table 23.

Table 23 cost of main drug and daily amount spent

How much do you normally pay for your main drug?	How much do you spend on this/these drugs in a day?
No information provided on main drug	£25
No information provided on main drug	£50 - £160
No information provided on main drug	£170
No information provided on main drug	£20 -£30
£10 a bag, 1 gram	£20 - £30
£10 bag, depends	£40
£10 per bag	£50- £70
£100 a week	£30
£100- ounce of speed- lasts a month	£10
£20 - 0.2 grams	£60 - £80
£20 - lasts a few weeks	
£20 a bag	£10
£20 a day of each	
£20 crack, £20 heroin	£400
£20 per stone, £45 on tenth of Heroin	£60
£25 half gram	£50
£25 per ounce	£15
£260 heroin and crack cocaine	£260
£30 = 3 bags	£30
£50 for a tenth	£100
£50 heroin, £60 crack, £25 benzos, 100 valium	£100 - £200
1 oz - £700 – 28g heroin, Cannabis – 1oz £150-200, Valium - £25-100	£100
1.75 grams for £60 a day.	£60
£10	Up to £100
£10	£60 - £70
£30	£10
£60	£200
Alcohol £7.50 half a litre of vodka a day	

Amphetamine £20 lasts 3 days, Crack - £3-£400 per fortnight	
Buy a t-shirt – it weights 1.75 grams for £45	£50
Heroin – 1 gram £60, Crack - 1 gram £100	£400
Heroin £30	£30
Heroin, £30 half gram	£30 - £60
Lump £60	£30

As reported in table 23, the majority of respondents who used drugs spent less than £30 per day on their main drug ($n = 11$). However, nine respondents spent between £30 and £70 per day, with another nine respondents indicating that they spent £100 and over (up to £400) each day on drugs.

3.10.13 Offending to Pay for Drugs

While less than 50% of the respondents took drugs specifically to sell sex, twenty-three respondents indicated that they funded their drug use through sex work. Also funds for drug use were obtained by using benefits ($n = 3$), and lending money from family/borrowing money elsewhere ($n = 4$).

Over half of the respondents had also offended in order to pay for alcohol or drugs:

- Shoplifting ($n = 25$)
- Dealing ($n = 5$)
- Street robbery ($n = 4$)
- Handling stolen goods ($n = 2$)
- Theft ($n = 2$)
- Burglary ($n = 1$)
- Stealing drugs from place of work ($n = 1$)

3.10.14 Buying and Selling Prescription Drugs/Prescription Opiate Drugs

The majority of the respondents had some experience with either buying and/or selling prescription opiate drugs:

- Eleven respondents told us that they had found it easy to buy prescription opiates

- One respondent spoke of how ‘diazepam was easy to get hold of in Swansea’ and another explained that it was quite easy to buy and sell methadone and subutex
- Three respondents stated that it was easy to buy valium with one respondent saying she found it difficult to buy valium
- Three respondents indicated that they had sold prescription opiate drugs

The danger however of mixing prescription drugs/prescription opiate drugs with other drugs was evidently clear to some of the respondents, for example:

“It’s easy to get hold of but easier to overdose if mixing with other drugs.”

Another respondent explained that she had purchased valium on the street and would continue to do this until she got a prescription

“I’ve bought valium from the street and I will keep doing it if I can’t get a prescription.”

3.10.15 Summary

Given the wealth of detailed data collated from the respondents on drug use it is perhaps helpful to summarise the respondents’ experiences of drug taking at this point. As already noted **the majority of respondents** who were currently taking drugs at the time of the interviews:

- Took heroin almost daily
- Purchased their drugs from a dealer
- Switched between smoking and injecting
- Shared needles, syringes, spoons and/or filters
- Had exchanged sex for drugs
- Funded their drug use through sex work
- Spent less than £30 per day on their main drug (but that did rise for significantly for others and for some reached up to £400)
- Had bought and/or sold prescription drugs/prescription opiate drugs
- Had offended to pay for drugs

- Experienced feelings of withdrawal that negatively impacted on their sex working leading to increased risk taking (sex without a condom for example)
- Had increased drug taking after becoming involved in sex work

However, the data did indicate that the increase in drug use after becoming involved in sex work could be due to the respondents having more money to spend on drugs rather than taking more drugs to enable them to cope with sex work. **The majority** were found to:

- Take drugs for emotional reasons for example to help them relax and cope (with less than half indicating that they took drugs to enable them to sell sex)
- Increase their drug use when faced with events such as family issues and inability to access children but also when they had more money to spend on drugs (with only 3 respondents indicating that drug use increased because of sex work although the majority did sell sex to fund their drug use)

The findings do help to foster a better understanding of the complexity of sex work and drug use which can be mutually reinforcing. Clearly the data suggests that drug use is problematic for the majority of the respondents – whether or not sex work is carried specifically to fund drug use. While drugs predominantly appear to be taken in a social environment for a variety of reasons, the connections with sex work and the inherent risks in terms of personal mental, physical and sexual health as well as physical safety is very concerning.

Importantly, as discussed at 3.11 of this report, almost all of the respondents who were taking drugs at the time of interview *expressed a desire to stop*. And, indeed, a life free from drugs would go a long way to assisting sex workers to be able to tackle some of the many risks and vulnerabilities they face. Unfortunately, the respondents also perceived that there are many obstacles to achieving this.

3.11 Stopping Taking Drugs

3.11.1 Desire to Stop Taking Drugs

As indicated already, respondents explained that drug use prevented them from doing day to day things for example:

- Preventing them from finding a job
- Leaving them unable to take care of their children (some respondents had lost custody of their children)

Also as noted, the negatives of drug use were also wide ranging and included:

- Ruining a career before getting into sex work
- Custodial sentences
- Financial problems
- Impacting on personal relationships
- Damage to health
- Needing to do more sex work in order to fund a habit

Therefore, unsurprisingly, out of the thirty respondents who were using drugs the vast majority ($n = 28$) told us that they wanted to stop taking drugs as highlighted in table 24.

Table 24 desire to stop taking drugs

Do you want to stop taking drugs?		
	<i>n</i>	%
No	2	6.7
Yes	28	93.3
Total N	30	
Not applicable-already stopped	7	
Not applicable-never took drugs	3	100%

3.11.2 Experiences with Stopping

Respondents were asked about their experiences with getting off drugs and what they had found helpful in the past. The respondents reported that they had been helped to stop taking drugs in the past through:

- Accessing methadone prescriptions ($n = 10$)
- The support by family and friends ($n = 4$)

- Access to drug treatment services ($n = 4$)
- Access to counselling/someone to talk to ($n = 3$)
- Going to prison ($n = 3$)
- Their own personal motivation / self-determination ($n = 3$)
- Thinking about their children ($n = 2$)

The respondents also told us which services they had accessed when trying to get help to stop taking drugs:

- IOIS ($n = 11$)
- CDAT ($n = 5$)
- Prison services ($n = 3$)
- Cyrenians ($n = 2$)
- Safer Wales StreetLife ($n = 2$)
- WCADA ($n = 2$)
- SANDS ($n = 2$)
- Inroads ($n = 1$)
- EDAS ($n = 1$)
- Cross Borders ($n = 1$)

It is clear that the majority of sex worker respondents who took part in the research accessed drug treatment services through the criminal justice system. As already noted, the majority of the respondents who had experience of the criminal justice system reported that they had committed offences relating to theft and drugs rather than prostitution related offences.

Notwithstanding this, as the data documented in this report makes clear the connections between sex work and problematic drug use are apparent. Thus it is extremely important that criminal justice system drug treatment services have a good awareness of sex work related issues and that processes and systems are in place to ensure that advice and support can be provided by specialist sex worker focused services as well as other services as required. This need is emphasised through the respondents' own perceptions of the obstacles that prevent them from stopping taking drugs.

3.11.3 Obstacles to Stopping

We asked the respondents what would help them to stop taking drugs for good. The respondents indicated that this would necessitate a variety of things including the need to:

- Move out of the area and the inability to do so
- Have an 'entire change of life'
- Feel motivated personally
- Have more life skills
- Be able to see their children
- Have a partner who doesn't use drugs and who is against drug taking
- Have drug treatment at the same time as a partner received drug treatment

In particular however, the main obstacles that were reported fell into four categories:

- Being approached/encouraged to take drugs by others while trying to stop
- The length of time it took to get a prescription
- Drug treatment service provision
- Lack of counselling support

Being approached / encouraged to take drugs by others while trying to stop

Seventeen respondents who wanted to get off drugs said that they were approached by dealers, friends or family who know that they are trying to stop. Dealers approached the respondents by phone (or text messages) or directly on the street. Respondents explained:

“Dealers text that they have stuff and family offer or mention it in conversation.”

“It's a big communal exchange – you know who has got good shit.”

“[I receive] text messages from dealers and sometimes friends/associates.”

“[I am approached] on street, by phone, when picking up my prescription.”

“People come up to me in drug services.”

Dealers approaching drug using sex workers while they are picking up prescriptions and when attending drug services is extremely problematic. This needs to be recognised by all of the services that sex workers may seek to access support from to enable services to formulate preventative strategies to address drug pushing activity taking place on or outside their premises.

Also, as noted, problematic drug use can be a feature of family life / personal relationships. One respondent explained to us that it was difficult to stop taking drugs because her partner was also a drug user and they had yet to receive a prescription at the same time – thus they kept influencing each other. This respondent said that ideally they should be treated simultaneously. Such an approach has been recommended for over a decade (see, Hunter and May, 2004; Hester and Westmarland, 2004). ‘Open Doors’ a London based project adopted this approach to sex workers and their partners a few years ago and the results have been very encouraging in putting couples on the road to stabilisation, with sex workers being much more likely to make use of support services and complete drug treatment programmes (see, Bury, 2011).

Getting a prescription

Nine of the respondents said that they felt they had to wait too long and/or attend too many appointments before getting a prescription. The time that respondents had to wait to get a prescription varied greatly:

- Less than 2 weeks ($n = 5$)
- Less than 3 weeks ($n = 4$)
- Less than 4 weeks ($n = 1$)
- Between 1 and 3 months ($n = 3$)
- Between 3 and six months ($n = 2$)
- Over six months ($n = 3$)
- Some respondents did not provide an exact period but stated it took months ($n = 5$)

It was clear from the respondents’ comments that the quickest route to getting a prescription was on entering and leaving prison / under a court order:

“When I was in prison they put me on a prescription the day after I arrived.”

“I left prison and went straight to IOIS and got a next day prescription sorted out.”

“When I was in prison. That was the quickest prescription.”

“It always took weeks/months so I never had one... [I have] only got one now through offending [through] probation and IOIS.”

The different times between getting a prescription through the criminal justice system route in comparison to receiving a prescription through drug treatment community service providers is worrying. This issue has already been raised in Wales by the *Sex Work Research Wales* report (Sagar, et. al, 2014) which also found that women who took part in that research perceived that going to prison was a better option for them because it would enable them to get a prescription quickly and get clean.

Once again, the findings in this research project highlight the continuing gap on the ground with regard to the timeliness of drug treatment outside of the criminal justice system – an issue that needs to be addressed as a priority given the multiple risks (highlighted throughout this report) which are associated with sex workers who are problematic drug users. Additionally and equally importantly, the respondents who took part in this research also spoke of how having a prescription at the same time as receiving other forms of support would help them, for example:

“[I need] a prescription quicker, I need mental support and a support worker, going to groups, training to help deal with difficult situations and day to day life and life skills.”

“A prescription and support. I feel that it would not work with just one approach.”

“A prescription and moving out of the area.”

Again, this suggests that not only should prescriptions be available more quickly for drug using sex workers, but that drug treatment has to be part of a wrap around support package that is tailored to individual need.

Drug treatment service provision

Other obstacles reported by the respondents related to drug treatment service provision and included:

- A lack of relapse prevention from drug services
- Long waiting lists to access drug services
- Waiting too long while at drug services
- Inconvenient opening hours
- Inflexible appointments
- Difficulty in reaching services by public transport
- A lack of consistent support workers
- Having to mix with other drug users at drop in centres
- Services not understanding '*how it is in reality*'

The need for shorter waiting lists and flexibility in service provision for drug using sex workers as well as difficulties in reaching services has been a recurring finding in Welsh research over several years (see, Sagar and Jones, 2010; Sagar et al, 2014). Similarly, while sex work academics and governments have been calling for more wide ranging support including practical assistance and counselling support for many years (see for example, Hester and Westmarland, 2004; Home Office 2006) the respondents emphasised to us that there was a need for greater professional support from counsellors and support workers. Respondents told us that they needed greater support including:

- More counselling ($n = 4$)
- One to one support ($n = 3$)
- A constant support worker ($n = 2$)
- More professionals ($n = 2$)
- Professionals with personal experience of drug use ($n = 1$)

Counselling

Out of the thirty respondents who were drug users, only sixteen (43.2%) had received counselling to help them stop taking drugs. Those who had received counselling and who thought it was helpful referred to:

- Having somebody to talk to and who would not judge them
- Maintaining enthusiasm for staying in recovery
- Assistance in dealing with surrounding issues
- Providing some structure to their day (it gave them something to do outside the house away from fellow users)
- Getting some perspective
- Learning how to stay clean

Some respondents however also reported being dissatisfied with the counselling they had received referring to counsellors/counselling being:

- Too pushy
- Too invasive pushing them into talking about their past which only made them wanting to use more
- Too sporadic ('one appointment a month and it lasts 5 minutes')
- Lacking personal connection

One respondent said that counselling worked only temporarily but she started using again as soon as it ended. Another respondent explained that she had found that the sessions did not work because they brought back too many memories – “...every time I have scored after”.

Some respondents reported that shorter waiting lists for counselling were needed with one respondent stating that she had been on a waiting list for counselling for over six months.

It was also clear that getting on a prescription and accessing counselling need to be provided simultaneously:

“I needed counselling and substitute prescribing. I feel that it would not have worked with just one approach.”

Importantly however, combining getting on a prescription and access to counselling will often need to be supported by other forms of assistance:

“[I need a] prescription, constant support and contact with family.”

As noted in this section of the report, the respondents perceived that there were several obstacles to them stopping taking drugs. Some of these obstacles referred to being unable to access the services that they believed they needed (for example due

to long waiting lists and the length of time it took to get a prescription). However, the findings also emphasise once again that drug treatment is one of many issues that need to be tackled simultaneously given the myriad of emotional and practical difficulties sex workers can face. The respondents spoke of obstacles on a personal level such as addiction, the lack of self-motivation, the need for counselling, as well as support and assistance with housing for example to help them. All of which re-enforces the need for a wrap around service provision for sex workers that can address multiple needs simultaneously.

Although holistic wrap around support has been recommended for many years now (see, Hester and Westmarland, 2004; Sagar et al, 2014) – an approach that is also strongly encouraged in the context of drug using sex workers (see, Hunter and May, 2004), it appears that from the perspectives of some of our respondents that a comprehensive care/support plan that is socially inclusive and tailored to individual need remains under-developed in Wales.

3.12 Services

3.12.1 Services Accessed

Most respondents had experience accessing a wide variety of social and support services. Such access tended to take place over many years – particularly so for those respondents who had experience of being in care. Thus the duration of accessing services ranged from one month to many years.

The services used by the respondents in order of frequency were:

- Housing ($n=29$)
- GP and Drug Services (both $n = 28$)
- Police ($n = 25$)
- IOIS/DIP and Outreach Sexual Health Nurse (both $n = 24$)
- Social Services ($n = 22$)
- GUM clinic and Probation (both $n = 20$)
- School or College ($n = 16$)
- Cyrenians ($n = 25$)
- StreetLife ($n = 14$)

As indicated above, the respondents clearly had the need for and had accessed several different services with housing, drug treatment, the police and sexual health being the services that were most accessed. Importantly, this also highlights the need for housing as a priority for the respondents (74.4%) suggesting once again the importance of housing in multi-agency support for sex workers.

Access to services mainly happened through:

- Self-referral ($n = 21$)
- Referral from another service ($n = 20$)
- Through a court order ($n = 13$)

The data also suggested that while the respondents had sought in the first instance the support of statutory services such as housing and the police, they did rely on the services of Cyrenians and StreetLife in particular to help them pass a difficult point in their life and this had provided assistance in a variety of crisis situations:

- Homelessness
- Having no food
- Drug use

- Debt management
- Sexual health issues
- Violent assaults

Some of the respondents told us that Cyrenians were particularly supportive where they had experienced difficulties in accessing housing for example:

“The Cyrenians have helped me through lots of crisis – when I was homeless they helped to find accommodation for me.”

“Cyrenians [helped me] when I was at my lowest, they helped to house me.”

Others spoke of how StreetLife had assisted them with debt as well as helping to make important appointments:

“[I needed help with] debt management. StreetLife helped to make an arrangement with bailiffs so they stopped calling.”

“Streetlife is great when there is a crisis. They helped take me to appointments and with the clinic.”

However, the use of services was not limited to crisis situations and the majority of respondents told us that that they accessed services on a daily or weekly basis – indicating the necessity of service provision in their lives:

- Daily ($n = 9$)
- Weekly ($n = 19$)
- Fortnightly ($n = 5$)
- Monthly ($n = 2$)
- As much as possible ($n = 1$)
- When needed ($n = 1$)

3.12.2 Most Helpful Services

The respondents indicated that they found Cyrenians and StreetLife the most helpful services. Considering that both offer specialist sex worker focused services and that both were highlighted as being supportive in crisis situations it could be suggested that this is perhaps unsurprising. However, the data clearly indicated that there are

certain qualities that they appreciate from a service which Cyrenians and StreetLife were held up as providing. These *qualities* include:

- A personal approach
- Quality workers
- Accessibility
- Good atmosphere
- Approaches tailored to personal need
- Support that can 'really help'

Respondents were asked to explain to us what they found *most helpful* about the services they accessed, responses included:

- Having a one to one worker
- Always having the same worker
- Getting a non-judgemental and empathic treatment
- Being listened to
- Being treated as a full person
- Having access to the service at hours that suited them
- Easy access
- Getting a quick service
- Receiving hope
- Receiving help with getting and attending appointments
- Being there whenever there is a crisis
- Being honest and direct
- Getting practical help with letters, bills and debt
- Getting help with medication
- Working with staff that are nice, warm and friendly
- Getting help with drug use
- Getting help with housing
- Having all sorts of different help at one place (Cyrenians)
- An open atmosphere
- Getting support to keep seeing children
- Not being intrusive
- High confidentiality
- Having a group setting and the support of peers
- People willing to give you a chance
- People who are willing to take the time to get to know you as a whole person

This is illustrated in the following respondent comments:

“Cyrenians have helped a lot with lots of issues – always polite, warm and welcoming.”

“Some help you actually achieve and get what you want.”

“They give good advice, they are nice people and they aren’t judgemental.”

“They listen and provide help I need.”

3.12.3 Least Helpful Services

The police, educational institutions, housing and probation were considered to be the *least helpful*.

Respondents that made use of these services reported that they:

- Did not feel they had been treated well
- The services were not as accessible to them
- Felt they had not really received any help

The reasons why services were considered to be unhelpful included:

- Being blamed for the experience of violence (by the police)
- Reluctance to help
- Reluctance to give a prescription
- Getting different workers all the time instead of having one same contact
- Unreliable workers
- Being rude
- Not really listening
- Long waiting lists
- Not being treated as a person
- Lack of support
- Lack of flexibility
- Being judgemental
- Not caring
- Feeling bullied into decisions they did not want to make
- Breaking confidentiality
- Abuse of trust
- Failing to help with housing

3.12.4 Services Most Needed

When asked for the type of service that would be of most help to them the respondents indicated that they needed a variety of services:

- Accommodation ($n = 7$)
- Counselling ($n = 7$)
- Drug treatment ($n = 6$)
- Help with benefits and financial resources ($n = 5$)
- Debt advice ($n = 3$)
- Outreach vehicles ($n = 3$)
- Help to attend appointments ($n = 2$)
- Drop in provision ($n = 2$)
- GUM drop in ($n = 1$)
- A Sexual Health Nurse ($n = 1$)
- Education and training ($n = 1$)
- Long term prescribing ($n = 1$)

3.12.5 Failure to Access Services Most Needed

Importantly, housing, counselling and emergency funding/food provider services were flagged up as the services most needed but which the respondents had failed to gain access to as reported in table 25.

Table 25 services respondents needed but failed to access

Service needed but failed to access (multiple answers)		
	<i>n</i>	%
Outreach vehicle	5	17.2
Women only drop-in	4	13.8
GUM drop-in	3	10.3
Counselling	11	37.9
Benefits advice	10	34.5
Debt/arrears advice	8	27.6
Emergency funding/Food vouchers	11	37.9
Advocacy/Accompaniment to appointments	9	31.0
Accommodation	11	37.9
Access to drug treatment services	9	31.0
Education/training	8	27.6
Other	6	20.7

Total N	29
No information	11

The things that **discouraged** or prevented respondents from accessing services included:

- Opening hours
- Transport costs
- Having to travel long distances
- An inability to understand the information given
- Services being judgemental
- Staff being rude and patronising to sex workers
- Former bad experiences
- Lack of confidentiality
- Fear of getting into trouble
- Too many other drug users in the same place at the same time
- Men attending the same service
- Lack of money
- Lack of credit on phone
- Being pushed into stopping sex work
- Low motivation
- Depression
- Embarrassment and pride
- Feeling that it would be a waste of time
- Being under influence

The things that would **encourage** respondents to make use of services included:

- Accessible location
- Flexible opening hours (evenings and weekends)
- Mutual support groups and activities
- Not being made into feeling unworthy of help
- Transport to services
- Reminders of appointments
- Less stigma around sex work and drugs
- Professionalism
- People being more aware of the services that are on offer
- Outreach and carer workers on site
- If a partner could go to the same places

- A community feel and being able to come to a service and chat openly without being judged
- Friendly staff and feeling comfortable
- Different specialist services in the same place
- Having the same worker every time
- Getting a prescription quicker
- Contact numbers that were free to phone

Clearly the flexibility of the service, its location, its atmosphere, the friendliness and expertise of its staff as well as consistent support workers is highlighted as being extremely important to the respondents – elements of which are highlighted in the following respondent comments when they were asked what they want/need from a service:

“A community feel, being able to come to a service and talk and chat as yourself and openly and not being judged.”

“Friendly staff and feeling comfortable... information on how to access services...having all services and information in one place...specialist staff.”

“Positive people in my life...appointments more flexible and having a flexible worker. Also having the same DU all the time rather than changes. I need consistency.”

“Friendly workers, someone I can trust and talk to.”

“Specialist drug workers, sex worker specialists.”

“Services being friendly, having time for me, having empathy...getting to know me, knowing that they are confidential and non-judgemental.”

3.12.6 Disclosure of Sex Work Activities

Most respondents ($n = 29$) said that they had disclosed their sex work activities to the services they used. Respondents told us that they had disclosed their sex work to services because:

- They believed it was better to do so in order to get the support they needed
- It was the right thing to do ('better to be honest', 'no point lying')

- They had felt comfortable and didn't feel judged
- The staff who spoke to them were non-judgemental

This finding is encouraging given that research in Wales in recent years has highlighted that sex workers are fearful to disclose their work to services (see for example, Sagar et al, 2014). However, the reasons why some did not disclose were either due to the feeling that there was a need for disclosure (not being relevant) or due to a fear of being judged and stigmatised.

3.12.7. Changes Respondents Would Like to See in Service Provision

Respondents told us that they would like to see the following changes to service provision:

- Better housing assistance
- Fast tracking for long term prescribing
- Shorter waiting lists for drug treatment
- Quicker prescriptions
- More Outreach services and more Outreach staff
- More motivational support
- Easier access to counselling
- The police to be more understanding

3.12.8 Help that Respondents Need 'Now'

We asked our respondents what help they would most like now? The most popular requests for help are detailed as follows:

- Securing accommodation ($n = 6$)
- Securing accommodation 'on their own' ($n = 2$)
- Drug treatment/getting on a prescription ($n = 6$)
- Employment/training ($n = 5$)
- Getting back into work/getting a career ($n = 3$)
- Help to manage finances/debt ($n = 3$)

4. Conclusions and Recommendations

This research fulfils the Welsh Assembly Government's 2004 commitment to client consultation/participation within the Substance Misuse Treatment Framework. While providing some important socio demographic information, the research opens up a much needed window into the lived experiences of sex workers who are substance users and their needs (physical, emotional, situational and economic) from their own perspectives, as well as their views and opinions on service provision and service provision improvement.

4.1 Key Conclusions

4.1.1 Harm and Need

- ❖ The key vulnerabilities connected to sex work and drug use are well known. This research confirmed that sexual abuse in childhood, experience of local authority care, homelessness, poverty, violent partners and violent clients also featured in the respondents' lives. Indeed it is true to say that the majority of the sex workers who took part in this research could be said to have experienced a wide range of physical, social, emotional, situational and economic situations which singularly or in combination increased their vulnerability and exposure to risk and harm.

- ❖ It appears drug availability in the cities of Cardiff and Swansea provides sex workers with relatively easy access to heroin and other Class A drugs. Although the causal relationship between drug use and sex work is very difficult to demonstrate in any precise way (May and Hunter, 2006), this research substantiates that there are links between sex work and problematic substance use. The research found that the majority of sex workers were drug using sex workers – that is sex workers who took up sex work in order to fund drug use. Others who were engaged in sex work took drugs to help them to cope with a variety of negative feelings and situations that they found themselves in (often which were beyond their own control). It is also true to say that drug use was problematic for the majority of sex workers who took part in the research whether or not they were engaged in sex work specifically to fund their drug use. Furthermore, for the majority of sex workers who took part in the research problematic drug use and sex work were re-enforcing and this impacted extremely negatively on their lives in a wide variety of ways –

bringing sex workers into the criminal justice system, causing poor physical and mental health, leading to heightened risk taking whilst sex working.

- ❖ Like other research carried out with sex workers who work predominantly on the street, this research also found that substance misuse is one issue (although an extremely important issue) that needs addressing alongside several others. The research emphasised how situational and economic vulnerabilities (such as homelessness and rent arrears) can significantly increase the risk of a person becoming ‘trapped’ in sex work and continuous substance misuse. From their own perspectives, the respondents wanted to stop taking drugs and also to attain the basics in life, including the chance to feel safe and secure in their own home. They also wanted debt advice and counselling in particular to help them move on to attain some stability in their lives. The respondents’ desire for life skills assistance – up-skilling, training and education was also evident.

4.1.2 Barriers and Obstacles to Accessing Support

- ❖ Importantly, the majority of respondents who took part in the research were problematic drug users and equally importantly the overwhelming majority of problematic drug users wanted *to stop taking drugs*. From the respondents’ own perspectives there are several obstacles to them accessing the support that they feel that they need.
- ❖ First, the respondents believed that there is a need for service improvement – they want to see reduced waiting times for prescriptions, more flexibility in service provision and particularly drug treatment services, more professional staff, the opportunity to receive treatment away from other substance users, staff not to judge and stigmatise them, and perhaps most importantly, multiple issues to be addressed simultaneously.
- ❖ Nevertheless, there were some positive findings. In particular, that the majority of sex workers who took part in the research felt that they could report violence against them. Also, sex workers really appreciated the specialist support provided by sex worker focused services, especially Cyrenians and StreetLife. Respondents valued friendly services that had professional staff who were experts and who had empathy and understanding for their situations and needs. This type of service approach is vitally important to sex workers who are members of the community but who are too often marginalised, and who face stigma and judgement and social isolation.

4.1.3 Meeting Need

- ❖ The respondents wanted to take control of their physical, social and economic environments. However, none of the respondents indicated a belief that they were in a position to stop taking drugs or make positive changes to their lives without substantial and wide ranging support.
- ❖ The majority of the respondents had come into contact with the Criminal Justice System and therefore it is perhaps unsurprising that policy and practice continues to be steered by criminal justice interventions. However, none of the respondents had entered the criminal justice system for 'prostitution' related offences but they had committed offences predominantly in the pursuit money to maintain their drug use. It is however extremely worrying that some respondents believed that going to prison would be a path to quicker prescriptions and drug treatment assistance, particularly so given that the respondents also indicated that they had required additional help and support when leaving prison and in this context securing housing was emphasised.
- ❖ Sex workers who find themselves excluded from society, in temporary accommodation or homeless and who feel unsafe are exposed to a physical environment where drug use is more likely to take place. For years academics and practitioners have raised awareness about the dangers of the revolving door for sex workers (where sex workers are fined for prostitution related offences but then return to prostitution to pay off their fines), and arguably the system at the moment can create yet another revolving door – where sex workers who are seeking treatment or who are receiving treatment are housed within high risk environments. The data suggests that there is a need for service coverage which provides transitional housing, emergency accommodation and permanent housing which are situated outside of high risk environments to facilitate stability and drug rehabilitation.
- ❖ It is widely recognised that a multi-agency approach is required to meet sex workers' needs. However the data in this report suggests that this is not translating into practical strategies which provide wrap around support. Sex workers' needs are interconnected and this demands that service provision meeting different needs are interconnected – thus for example equal attention needs to be paid to their social and situational needs in the context of reducing drug use.

4.1.4 Reducing Harm

- ❖ Interconnections between substance misuse and sex work bring to the surface key issues in terms of drug treatment strategies and sex work focused support strategies. The complexities of sex work as well as the multiple vulnerabilities and risks sex workers face indicate that there is a need now in Wales to formulate a strategy for sex workers specifically which also provides for drug treatment.
- ❖ In accordance with the 2008-2018 'Substance Misuse Strategy for Wales' harm reduction approach to substance misuse, the Welsh Government has committed to developing a range of services in Wales which are underpinned by a harm reduction approach. The findings suggest that focusing on 'harm reduction' and providing wrap around support is a good fit with the needs of sex workers who are problematic drug users - rather than coercing sex workers (particularly through the criminal justice system) towards exiting sex work. The respondents who took part in this research needed some stability in their lives and stopping drug use was a vital step towards achieving this. Arguably, given that the majority of sex workers were selling sex to fund their drug use and committing offences to fund their drug use, a harm reduction approach rather than an exit focused approach (assisting women to step out of sex work) is more likely to offer greater support to sex workers – this has however to be tailored to individual need.
- ❖ The research findings provide a clear evidence base for the need to develop drug treatment service provision and policy in Wales but also, very importantly, to strategically set out at the national level a more comprehensive joined up approach to meet the multiple needs of sex workers. Any such strategy must take into account in particular the management of risk, the need to minimise barriers to treatment, investment to ensure there are coherent and 'fast track' pathways into joined up support systems that are designed to provide wrap around support and care.
- ❖ In the development of any such national strategy it is important that sex workers are not treated as victims. Each individual has a different lived experience, and each sex worker has different needs. Likewise, not all sex workers are exposed to the same vulnerabilities or experience the same risks. It must be remembered that the majority of sex workers who took part in the research were at the time of the research working on the street or moving from the street to off street work and vice versa. Street based sex work represents only a small percentage of the overall sex markets and it is well recognised in the literature that sex workers who work on the street are likely to be substance users and that street based workers are some of the most vulnerable individuals in society. However, there are many others working off street who are engaged in legal occupations and who do not have the same

needs as street based workers and who are not exposed to the same vulnerabilities. Therefore, any strategy must acknowledge these important differences and make the distinction between those who might require a comprehensive harm reduction support package and those who do not, but who may from time to time require access to specialist support. It is also important for services to be able to reach out to those who are less visible and who use the internet, social media and mobile phones to contact clients and who are working from their own homes/doing outcalls, and this is likely to entail financial investment.

4.2 Key Recommendations

A number of recommendations arise from the findings of the research:

4.2.1 Improvements to Services

The following recommendations are drawn from the perceptions of the respondents with regard to service provision.

Drug treatment

- Reducing the waiting times for drug treatment and the length of time it takes sex workers to get a methadone prescription was highlighted as extremely important to the respondents – drug treatment for *all sex workers* who are problematic drug users should be fast tracked.
- More flexibility is required in drug treatment service provision (for example, extended opening hours).
- Drug Treatment services should make provisions for sex workers to have a consistent support worker and to provide in this context ongoing one to one support (before/during/after treatment).
- Steps should be taken to ensure that sex workers who are problematic drug users are treated away from other problematic drug users.
- Drug treatment services should develop holistic approaches that offer treatment to partners/family members of drug using sex workers.

Outreach

- Outreach projects should be properly resourced to enable them to expand their service provision to identify, locate and reach out to sex workers who are less visible and work off street from their own homes/participate in outcall work.

Counselling

- Solution focused therapy and counselling should be more accessible to sex workers.

Housing

- Transitional housing, emergency accommodation and permanent accommodation must be prioritised for:
 - sex workers who are problematic substance users
 - sex workers who wish to step out of sex work
 - sex workers who experience domestic violence
- It is vital that accommodation is situated outside of working/drug taking/violent environments.

Education and training

- Education and training opportunities must be provided to assist those sex workers who wish to step away from sex work.

Crime prevention

- A programme of safety focused crime prevention initiatives for vulnerable sex workers is required: including self defence, peer support programmes, rape alarms, and mechanisms for reporting of concerns from sex workers.

All service providers

- All service providers should be trained to enable them to better understand:
 - sex work issues
 - the risks associated with sex work (physical, social, situational and economic)
 - the interconnected needs of sex workers and those sex workers who are problematic drug and/or alcohol users
 - the impact of stigma and judgement on sex workers
 - the impact of problematic social networks and the need for positive influences/role models in their lives
 - the importance of 'befriending' and providing an empathetic and friendly service
 - the importance of preventive work to identify child sexual exploitation at an early stage

4.2.2 Multi-Agency Collaboration

The findings report on the respondents' needs which are identified through their own opinions and experiences. Specifically the following recommendations for multi-agency collaboration would go a long way to meeting the needs identified.

Housing

- Housing representatives should be part of multi-agency strategy development.
- The housing needs of sex workers should be prioritised in multi-agency work.

Counselling

- Multi-agency collaborations need to extend to include counselling experts and access to counselling needs to be prioritised for sex workers.

Social Services

- Social services should:
 - Be aware of the risks and vulnerabilities associated with sex work
 - Take an active role in multi-agency strategies to assist drug using sex workers
 - Assist sex workers to re-connect with their families and children

- Focus on early identification and intervention where child sexual exploitation is suspected (especially when children are in the care environment)

Police

- There is a need for continued liaison between the police and other service providers (especially Outreach) to develop trustful relationships with sex workers to increase the reporting of violence and sexual assault.
- Ugly mugs reporting should be encouraged and information on incidents of violence should be shared across regions.

Education and training

- Education and training opportunities for sex workers should form a key part of multi-agency initiatives which seek to provide longer term support for sex workers who wish to step out of sex work.

Strategy development

- Sex workers who are problematic drug users require comprehensive assistance – wrap around care and support. This means that strategies must adopt an approach that is tailored to the individual – ensuring that all needs are addressed **simultaneously**. For a drug using sex worker, achieving stability in their lives is likely to include:
 - Access to emergency food and other essentials (furniture for example)
 - Access to emergency accommodation and domestic violence refuge/safe housing
 - Fast track drug treatment
 - Intensive one to one support while receiving drug treatment/post treatment with access to counselling
 - Physical, sexual and mental health support
 - Secure housing away from other drug users
 - Advice on benefits and debt

Follow on assistance is likely to include:

- Training and education
- Assistance to find alternative work

- Multi-agency partnerships must be proactive in the development and implementation of preventative strategies employed to protect children from sexual exploitation and grooming – with a particular focus on those who are in looked after care.
- Where a sex worker is identified by any agency as being at ‘high risk’, information should be shared as far as possible with other stakeholder agencies.

4.2.3 Policy Development

Sex workers slipping through the policy net

- The review of policy in Wales documented in the literature review (phase 1 of this research project) emphasised how sex workers were slipping through the policy provision net in Wales:
 - Strategies which focus on domestic violence in Wales do little to support women who ‘are in’ sex work and tend to focus instead on those who are ‘leaving’ sex work
 - The ‘Wales Reducing Reoffending Strategy 2014 – 2016’ (IOMC, 2014) emphasises that in reducing offending, pathways out of offending behaviour must be integrated however, support for women who are trafficked, exploited and who ‘have been’ in the sex industry rather than ‘who are’ in the sex industry is prioritised
 - Since the literature review which formed phase 1 of this research project was compiled, sex worker safety and exploitation have become key features of the anti-slavery agenda in Wales. However, not all sex workers are sexually exploited or trafficked (as the findings documented in this report and the Sex Work Research Wales report indicate see, Sagar et al, 2014). Research that has focused in Wales on *direct* sex work (the provision of intimate sexual services) which takes place on street also confirms that the majority of sex workers are White, British and local – predominantly working in the areas within which they also live
 - Strategies which focus specifically on sex work tend to focus on ‘exit work’, substance misuse treatment and the need for *criminal justice* interventions. However, research has consistently emphasised (including the research documented in this report) that given the complexity of sex workers’ needs,

strategies should adopt a harm reduction approach and not an exit focused approach

The need for a comprehensive national ‘sex worker’ strategy

- The policy documents ‘Working Together to Reduce Harm’, ‘The Right to be Safe’ and the ‘Reoffending Strategy’ fail to make clear the connections and complex realities between sex work, violence and substance misuse; the strategies consequentially fail to offer sufficient guidance to enhance partnership work in this area. However, given the specific and wide ranging interconnected needs of some sex workers – it is suggested here that Wales seeks to develop a comprehensive strategy for sex workers rather than integrate sex work into multiple policies in Wales.
- The findings documented in this report clearly emphasise the need for a comprehensive harm reduction approach – which particularly aims to meet the needs of sex workers who are problematic drug/alcohol users, and which includes support for those sex workers who wish to leave sex work.
- While only the most vulnerable sex workers may require intensive wrap around support, it is also important to ensure that services are available to ***all*** sex workers. It should be remembered that not all sex work is problematic, nor is all sex work illegal; not all sex workers are exploited, nor are they all problematic substance users. Instead, a strategy for Wales should aim to provide a wide range of services to meet the needs of those who are occupied in both direct and indirect sex work occupations – physical and sexual health, mental health, situational, emotional, and economic.
- A strategy is important to provide guidance and consistency across Wales and to put in place systems and mechanisms to ensure:
 - Training for professionals who engage with sex workers
 - Information sharing across Wales for those who are most vulnerable/at high risk
 - Information sharing across Wales on violence and sexual assaults
 - Participation is widened in multi-agency work to meet the needs of sex workers. Representatives from housing, solution focused therapy and counselling, debt advice and access to education, training and employment opportunities should all be involved in multi-agency work

- The identification of children and young people who are at risk of sexual exploitation and effective interventions
- The provision of seamless support for young people leaving care
- The provision of continuous support for sex workers who are problematic drug and/or alcohol users who are released from prison

4.2.4 Further Research

- The findings of the research illustrate that family breakdown for some respondents was cyclical. Further that not being able to see their children could have a devastating impact on their general wellbeing. There is a need for research in Wales that specifically focuses on:
 - The impact of parental/family drug use on children and entry into sex work/problematic drug use
 - The links between child sexual exploitation (including exploitation in the care environment) and routes into sex work and substance misuse
 - The potential impact of maintaining contact with their children on the wellbeing of both sex workers who are problematic drug and/or alcohol users and their children
- There is also need for a closer examination on the links between sex work and domestic abuse to inform strategies and enhance protection and support in Wales.
- The respondents put great importance on the need for professional role models in their lives including professional workers, befriending by professionals and the need for positive peer networks. How and in what ways this kind of assistance can help sex workers is not yet fully understood. Thus research into the development of positive social networks and their impact is also recommended.
- The data in this report highlights risk from the respondents own perspectives. However, if we are to help sex workers to reduce their risk of harm then we need to carefully consider service provider experiences of sex workers who are problematic drug and/or alcohol users.

- Research should also focus on how 'vulnerability' and 'risk' is also perceived and managed by all stakeholder service providers. In particular, research should focus on how risk and sex work is managed from a multiple needs perspective; how individual services providers can improve on multiple risk management; how risk is managed collaboratively across the sectors. This research is vitally important towards the development of a national harm reduction strategy for sex workers.

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