Drugs: education, prevention and policy,
August 2009; 16(4): 355–363

informa
healthcare

Sex work, substance misuse and service provision: The experiences of female sex workers in south London

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Abstract
Background: Observations suggest that patterns of drug use may be changing among sex workers and that service provision may be failing this group. The aim of this study was to investigate life, substance-related, and service-provision experiences of women who are both substance users and involved in sex work.
Methods: The study was carried out using unstructured recorded confidential interviews and analysis of the themes arising from them.
Results: Twelve women were interviewed. Most of them came from an abusive background. There is a vicious circle between sex working and taking drugs—sex work generates funds and drugs facilitate continuation of work. The emergence of crack cocaine was consistently significant.
Conclusion: Experiences of the women discussed here are not new and confirm existing knowledge. Important issues related to service provision were discussed. Flexible services are necessary to attract, engage and support this vulnerable group.

Introduction

Several studies of drug use and sexual behaviour among street-working prostitutes have been carried out in UK cities over the past ten years (Green et al., 1993; Morrison & Ruben, 1995; Morrison, Ruben, & Wakefield, 1994). The emphasis of these studies has been on the impact of drug use and sexual

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ISSN 0968–7637 print/ISSN 1465–3370 online © 2009 Informa UK Ltd.
DOI: 10.1080/09687630701579679

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behaviour on the spread and risk of HIV and AIDS and not on the women themselves. In a series of studies Gossop and co-workers (Gossop, Powis, & Griffiths, 1994; Gossop, Powis, Griffiths, & Strang, 1993a, 1993b, 1995) interviewed injecting female prostitutes. They reported that 37% said they started working to pay for drugs, 59% said that drugs were their main reason for working at the time (Gossop et al., 1994). There was also an association between the severity of dependence and a range of riskier sexual behaviours (Gossop et al., 1993a, 1993b, 1995). Reed (1995) investigated prostitution as a women's health issue, and addressed women's inequalities with men, and the imbalance of power demonstrated by limited access to healthcare. May, Edmunds and Hough (1999) interviewed sex workers, drug workers and police officers. Crack cocaine use was seen to be on the increase in some areas, and the already well-documented co-existence of sex working and drug use was endorsed, particularly among street sex workers. Relationships were complex, but the message conveyed was that more outreach services, workers who understood both sex work and drug use, and specialist crack services were needed. A study examining vulnerability factors predisposing young individuals to sex work identified that those involved in sex work at a younger age were more likely to have been 'looked after' by local authorities, have been involved with street work and have been problematic drug users mostly continuing to prostitute to fund their drug problem. Ceasing problematic drug use was identified as the most important intervention to reduce vulnerability (Cusick, Martin, & May, 2003). The importance of provision of drug treatment was highlighted in the Co-ordinated Prostitution Strategy introduced by the Home Office in 2006. Collaborative work between support projects and drug treatment services (statutory and voluntary) in order to provide access to treatment in crisis situation and to overcome barriers such as planned appointments and childcare arrangements were recommended (Home Office, 2006).

The present study attempts to explore the experiences of a group of women who are or have been sex workers and drug users, with the aim of building a picture of the types of early experiences that lead women to this lifestyle. It also attempts to portray what it is like to be a drug user who works on the streets, with the aim of informing appropriate and effective healthcare provision and service development. It was carried out from a non-positivist, feminist perspective with the hope that the women involved, while telling their stories, would set the agenda for changes that are needed in attitudes or service provision.

Method

This study was carried out in Lambeth and neighbouring areas in south London. A phenomenological approach with unstructured interviews was used, because of the limitations posed by questionnaires and structured interviews with women whose lifestyles are both chaotic and, of necessity, hidden.

Study design and setting

Twelve women who both were, or had been, sex workers and were, or had been, drug users were interviewed using a self-definition of women who recognize themselves as both working in prostitution and as drug users.[1] This removes questions as to whether women are working for money or working for drugs. The interviews took place in four agencies working with women drug users involved in prostitution. Unstructured interviewing was employed for data collection, and data were analysed using Grounded Theory techniques. Women with whom the researcher (BM) had an ongoing professional relationship were excluded from the study.

Procedure

The interviews were carried out over a 6-week period at the beginning of 2000. Individual interviews took place in a private room, and lasted between 30 minutes and 1 hour. The study was approved by the Local Research Ethics Committee. Project staff approached women and explored their willingness to take part in the study. Confidentiality was discussed with all participants, and written consent was obtained. The interviewees were then asked to tell their story, starting from wherever they wanted. No specific questions were asked, and prompting was minimal. All interviews were tape recorded, the tapes were transcribed.

Data analysis

The interviews were coded and concepts were generated from the data by the first author. These concepts were then discussed with the second author and used to generate more abstract conceptual categories with a view to synthesizing, explaining, understanding the data, and identifying patterned relationships within it (Strauss, 1987). To confirm their credibility, the categories identified were discussed with staff working in the four agencies involved.

Results

Family and significant relationships

Most women described an early family life that involved abuse, violence, insecurity, mental-health problems, and substance misuse, especially alcohol, although positive experiences of parents and family life were also described. Most of the women left home early.

> E: Mum was an alcoholic. My older brother used to beat me up all the time.
> F: My family background was violent. My dad and mum were always fighting. Not so much drugs, but a lot of drink, a lot of fighting, a lot of violence.

Seven of the 12 women described violent and abusive partners. Some had had several violent partners. Almost all the partners described were or had been substance users. Some of the women had coped with the death of their partners,

again sometimes more than once. There seemed to be dependence and also some exploitation in the relationships.

> L: I went into an abusive relationship with a guy who, unbeknownst to me took heroin. He was in control of me. I ceded my control to him. That's why I used to let him hit me.

Introduction to drugs and subsequent drug-use patterns

All 12 women described how they first started using drugs.[2] The age at which the women became involved with drugs varied and most started by smoking cannabis. Most were introduced to drugs by partners or friends. The drug used seemed to depend on what was available at the time. The amount used at times depended on income, but in most cases the time came when income had to depend on the amount used. The women used a variety of drugs, but heroin and subsequently crack cocaine were part of each woman's story. The increase in use of crack is clearly seen in all but one woman's story.

> E: I started injecting heroin when I was 13. I had been on cannabis from about 10 and smoking before that. A boyfriend started me on it—some friend!
> M: [H]e used to inject it. I watched him and saw the different effect he got from injecting. It made me think I'd like to see what that was like. I finally talked him into it and he used to inject me with it.
> Y: I used to sell a lot of drugs. I started using needles when I was 27. I used to take a lot of crack cocaine, which initially I smoked, but I ended up IV-ing [injecting intravenously] a lot of that as well. Drugs was a lifestyle . . . .

Involvement with sex work

Of the 12 women, 8 spoke only of their own experiences, whereas 4 spoke also about the experiences of close friends or family. The most consistent feature of the stories was the use of crack, even if it was not the reason for sex working in the first instance. Five of the women though noted that the reason was the use of crack, and its extremely addictive nature. Heroin was the main affordable drug, but crack was a must. Some women became involved in sex working to earn money to support their own, and often also their partner's, drug habit. A number of the woman were on a methadone prescription to substitute for heroin, but still worked to pay for crack.[3] The desperation of women addicted to crack was described, both by the women interviewed and by those that they see on the streets. The women had different views but most did not regard street sex work as what they wanted to be doing. Two women described the need to take drugs to be able to work on the streets. Several of the women talked about their experiences of violence while working, and some talked about multiple rapes and attacks.

> M: The way I was doing it, I couldn't go more than ten minutes without a pipe. Basically it was for crack.
> F: I had more money than I'd had in my life and it gave me self-esteem.
> E: I was drinking a lot to make it possible to go out on the streets . . . . If I hadn't been on the drugs I wouldn't have done it.
> M: I've been raped, attacked, God knows how many times.

Y: There was a lot of violence . . . when I was sick and needed money for drugs I'd do anything. I've been raped 7 times. I got strangled once in a bin shed.

Relationship with children

Experiences about children are categorized into experiences of pregnancy and antenatal care, and experiences of childcare and social services involvement. For most, this brought them into an often-unhappy relationship with social services. Seven of the 12 women had children. The two who described their pregnancy did not receive any antenatal care. Both were only recognized as users when the babies started withdrawing, however, they spoke of the caring, non-judgmental attitudes of midwives and others, once the problem was identified. They felt that they and other women in their situation might not go to clinics out of fear of being judged, having the baby taken from them and feeling guilty.

The women above, and the remaining 5 with children, described their experiences. For these and the women who did not describe their pregnancies, or who were not using when they were pregnant, their relationship with their children was bound up with their relationship with social services. Keeping their children was an incentive to come off drugs and progress well in their own treatment. Only two of the women had all their children living with them. For three of them, their parents were caring for their children, and some found this manageable but distressing. One woman described a relationship with social services and the care system, which she felt contributed to her own mental state.

O: She was 10 days old, [baby daughter suffered from withdrawal symptoms for 10 days], and then she was fine. I took her home two weeks after I had her. There was a lot of guilt with that [baby suffering].
L: My children are still with my parents. Any time I arranged to meet them, my mum would go out with them [meeting cancelled] . . . . And you get there and you have no come back—because they're looking after the kids [can't complain].
M: The social services found out I'd been to a [drug treatment] clinic and came and took the children away. You know it's really wrong in my eyes, because I was doing better. I fought 6 years to get my children back. When I got back they told me the children had been taken into foster care. The foster carers abused the children and I had a breakdown. It makes me really angry. I accept some of it's down to me because I took the drugs in the first place—but you have to live with that guilt as well.

Housing

For 8 of the women interviewed a significant factor in their lifestyle instability was problematic housing. One had been homeless and others described unstable accommodation, including living in squats, which had led either to relapse to drugs or prostitution, or exposure to violence. Although for some women unstable housing represented freedom from authority at first, it was acknowledged that subsequently it became an obstacle in their effort for recovery.

M: Then I ended up going back to Brixton and seeing old friends and started to get back into my old way of life. I started to go back on the streets and working.

> Y: I'd go and sleep at 'The Passage' in Victoria, a place for the homeless .... I remember getting hit by a road sweeper with his broom. I went to the police station and the police just laughed at me, because I was a junkie, because I was a homeless prostitute it was like—you haven't got a right ... it was like I didn't exist.

Experience of treatment services

All 12 women had some experience of treatment services. The overall view of support services and street projects was positive. Keyworkers had been particularly helpful, and often had been their only consistent source of support. Those that had been involved with women-only groups found them helpful and approachable, especially if they could bring their children. The observation with these groups is that women continued to come even when they were drug free, because this provided part of the support network they needed to prevent relapse. Narcotics Anonymous (NA) was an important source of ongoing support for many women too.

Nine of the 12 women described experiences of in-patient drug services. The overwhelming impression was that there were not enough, they were not there for long enough, and that it took too long to be offered a place. The other repeated comment from those with children was about the lack of facilities for parents and children. The services were criticized for discharging people without enough support to manage alone.

Many women were wary of GPs, felt that doctors looked down on them, and did not want to be bothered with them. Many felt that they were regarded as drug addicts, and that the other healthcare problems they experienced were put down to this. One woman described a positive relationship with her doctor. There was recognition that part of the problem was that doctors were lacking in specialist knowledge and needed to be educated about it. The other part was their attitude to them, especially if they were sex workers.

> Z: If you register with a doctor about something to do with your health and go along for a few weeks and then tell them you're using heroin—they don't want to know.
> G: I'm taken seriously by some doctors but they can't do enough because they are not trained.

Suggestions for appropriate help

All 12 women had ideas and suggestions about what might have made a difference for them or for other women. Some of these suggestions contradicted one another. Most women felt that services should be aware of the needs of sex workers. Drop-in facilities with flexibility, lack of reliance on appointment times and easy accessibility were seen as very important elements of a service for people with hugely chaotic lifestyles. On the other hand, consistency and development of a trustful relationship was seen as equally important. There was also a call for greater availability of rest places for the increasing number of homeless women crack users. A 24-hour drug helpline and an emergency phone line for women who had been assaulted were suggested. Centres where mothers could meet and spend time with their children when in care, in-patient facilities for mothers with

children, as well as rehabilitation facilities were also referred to as needed. Those who had had negative experiences with social services wanted a more humane service where people were treated with respect as individuals. Those who had had mental-health problems felt that it was very important for these problems to be properly diagnosed and treated.

> Z: [I]t's almost like they're [women users] afraid to take the first step, but if there was someone there—like a keyworker that they could contact any time—that they could contact when they needed it; not make an appointment or come back in six weeks time.
> F: There's a lot of shame around when using and working. Health workers are sometimes embarrassed and are unprepared to talk. People don't have a clue about drugs or lifestyles.

Discussion

This study had the objective of directly exploring the issues arising from the complex relationship between substance use and prostitution. There is often discussion about whether women work for their drugs or take drugs so they can work. In this study it was most commonly the former case, and the views of those interviewed was that this would almost always be the case in this part of south London, particularly because of the desperation often caused by crack addiction. The descriptions of their families given by women fit with the patterns of family life often seen in substance misusers, and were consistent with the social learning and family interaction models of substance misuse. Violence has been recognized as a subtext of family homelessness in substance-misusing women (Bassuk, Buckner, Perloff, & Bassuk, 1998) and this also appears to be true of those who become involved in prostitution. Violence against women on the street is well recognized. The need for police protection, the difficulty of obtaining the trust needed, and the time needed to take action against those involved in violence is an ongoing dilemma for women and those who seek to support them through this process.

A further objective of this study was to explore the nature of experiences of treatment services for this group of women. The more chaotic the person's lifestyle and the less support they have in their own networks, the more helpful ongoing support can be in improving outcome, both in terms of substance use and social functioning. Suggestions made by the participants concerning the availability of outreach and sex-worker-specific services echoed the findings of previous research (May et al., 1999) and supported recent policy development (Home Office, 2006). Flexibility of approach by professionals is clearly necessary; recognition of the difficulty of the lifestyle, difficulty beyond what most professionals can imagine, is important. It is widely recognized that more child-friendly services that will allow mothers to bring their children with them are needed and can be more effective (Marsh, D'Aunno, & Smith, 2000). Women involved in prostitution who are substance users, often mothers, and frequently homeless clearly come into the category of those with multiple needs. Stable accommodation and support to maintain tenancy has been acknowledged as an

important factor in exiting the cycle of prostitution and drug use (Home Office, 2006).

This research clearly had its limitations. The numbers interviewed were small, but enough to observe some clear patterns and themes. The study only looked at women already engaged in treatment services. Codes were developed by one researcher only but discussed with the second author. In addition, categories raised were discussed with professionals from the agencies working with women.

Acknowledgements

The authors express their gratification to the Stockwell Project, especially Lorraine Hewitt, The Women's group, The SMART project, CLAS team, Streatham Streetlink, and most of all to the twelve women who generously agreed to share a little of their lives with us and without whom this research would not have been possible.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

Notes

[1] The age range of the women was 25–40.
[2] All had been using illegal drugs for at least 10 years.
[3] Since they had been in treatment most were on methadone scripts (there was no buprenorphine then). Previously all had used heroin, all but one crack, about half alcohol and most cannabis.

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