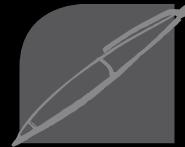


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UK NETWORK OF  
SEX WORK PROJECTS

## GOOD PRACTICE GUIDANCE



# Working with Sex Workers: Exiting

# Acknowledgments

As part of work funded by The Big Lottery Fund, the UK Network of Sex Work Projects (UK NSWP) undertook to produce a series of good practice guidance documents for sex work projects and agencies working with sex workers. As with all resources developed by the UK NSWP, members from across the UK have played a critical role in identifying the issues to be addressed and in developing the materials. The good practice guidance is based on the collective experience and knowledge accumulated by the working group, which was drawn from the UK NSWP membership.

The working group comprised Trudy Hannington (Streetreach, Doncaster and Board of Directors UK NSWP), Dionne Reid (Women's Work, Derby), Rachel Searcey (Women's Work, Derby), Sian Kilcommons (Lifeline Kirklees/The SWEET Project, Huddersfield), Clare McKenzie (One25 Ltd, Bristol), Melissa Fulton (Associate Member UK NSWP, University of Bristol); supported by Geraldine Flanagan (UK NSWP).

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## UK NSWP aims

*To promote the health, safety, civil and human rights of sex workers, including their rights to live free from violence, intimidation, coercion or exploitation, to engage in the work as safely as possible, and to receive high quality health and other services in conditions of trust and confidentiality, without discrimination on the grounds of gender, sexual orientation, disability, race, culture or religion.*

## Disclaimer

The content of this publication is for information purposes only. Some of the legislation and terminology may not be applicable across the whole of the UK. Whilst the authors have made every effort to ensure the accuracy and comprehensiveness of the text, we accept no legal liability for any errors or omissions.

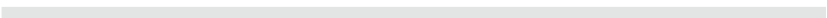
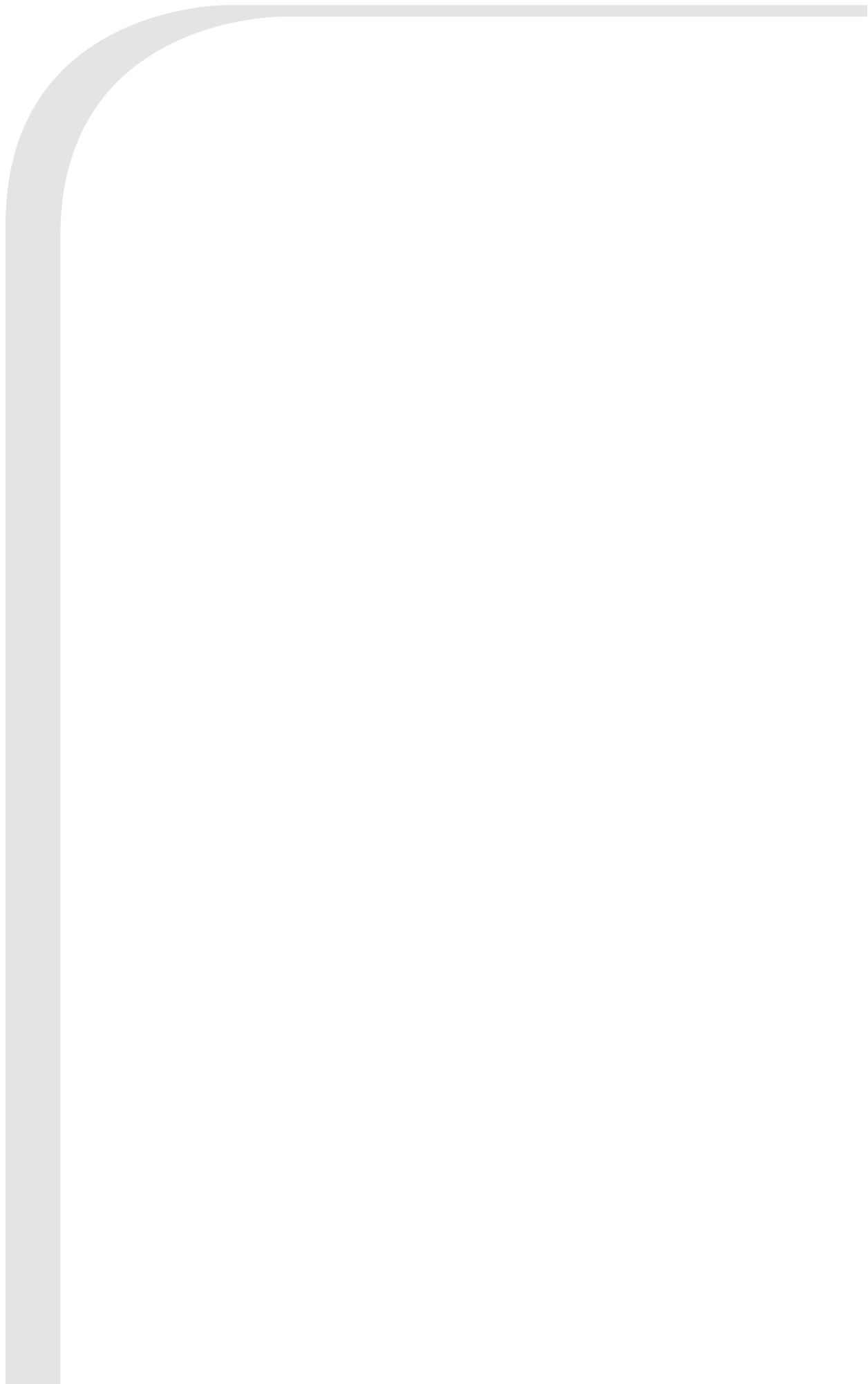


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# Introduction

The concept of 'exiting' or 'routes out' refers to the decision to leave the commercial sex industry and has been particularly applied to street-based sex work. Selling sex is an active economic choice for some people such as indoor workers, escorts and those providing specialist sexual services. But for others, social exclusion and risks to health and personal safety currently associated with street sex work in particular, mean that 'exiting' may be desirable.

Women's lack of economic choice is a key reason for entry into 'marginalised' lifestyles including street-based sex work and associated issues of homelessness and problematic poly drug use (McNaughton & Sanders, 2007).

'Exiting' is not a linear (Hester & Westmarland, 2004), one-off process but rather a journey which can yo-yo, often over many years.

In moving out of lifestyles associated with street sex work, problematic drug use and homelessness, people face many barriers. However, changes in external circumstances alone are not enough. Changes to internal worlds are required to sustain these. This makes the 'exiting' process complex and lengthy.

Having a coherent 'exiting' strategy is useful in focusing resources; identifying gaps in resources; and in having a cohesive service response to those who want to move away from selling sex. Exiting services should be

provided as part of a holistic needs-based approach along with prevention and harm reduction. Providing exiting /routes out support is a key element of UK government strategies on sex work.

This booklet provides guidance for projects on the key factors involved in the exiting process; identifies common barriers and possible solutions; and introduces the concept of a 'gold standard' service. It can also be used as a basis for local area agreements on support services for sex workers.

## Terminology

We have tried to use language that is universally understood and have used the terms 'exiting' and 'routes out' interchangeably. The term 'routes out' is often preferred to 'exiting' as it seems to reflect the multi-faceted nature of leaving and the many ways this may be accomplished. It also seems to better reflect the yo-yoing nature of the journey.

The focus of this guidance is on female sex workers and those presenting as female. Projects which work with men who sell sex to men should use this guidance alongside the Good Practice Guidance, Working with Male and Transgender Sex Workers, published by UK NSWP. All projects should read this guidance alongside the UK NSWP Good Practice Guidance, Working with Migrant Sex Workers.

The guidance recognises the diversity of sex work styles within the UK NSW and can be used by projects working with people who sell sex from street and indoor sex markets. There are some common issues shared by those who choose to move away from selling sex. When referring to service users we have used female pronouns, as women make up the majority of service users in this context.

We use the term 'social exclusion' to describe an individual's ability to participate in the established events and culture of their community. We use the term 'marginalised' to refer to individuals who feel alienated from mainstream society (see Levitas, 1998, for a detailed discussion of social exclusion and policy). In line with the aims of the UK NSW, the guidance recognises and supports the rights of individual sex workers to self-determination. This includes the right to remain in sex work or leave it.

# Reclaiming exiting

Sex work in the UK is a hugely varied and diverse area, and sex workers are not a homogenous group. So, options for exiting sex work should be tailored to each individual's needs rather than an inflexible 'one size fits all' approach.

The UK NSWP 'exiting good practice working group' does not represent the variety of experience within sex work in the UK. Its main knowledge is of street and sauna-based sex workers, the majority of whom are female, white and British. In this document, we 'reclaim' the definition of 'exiting' so that all UK NSWP member projects can use it.

Most projects already do work on 'exiting'. This guidance aims to consolidate current good practice into a documented 'gold standard'. The term 'exiting' is often presented as a structured, rigid and coercive approach isolated from harm minimisation services. However, these good practice guidelines redefine it as an option within a range of non-judgemental, holistic, harm reduction services offered to sex workers. Sex workers must first be in touch with flexible, crisis-led, harm reduction services if they are ever to be engaged with a process of more substantial change.

An 'exiting strategy' is a lengthy, non-linear process (Hester & Westmarland, 2004, Sanders, 2006). Changes for most sex

workers are incremental, much like the domestic violence model. Opportunities for intervention often present at times of crisis (Hunter & May, 2004) and many sex workers come in and out of sex work as a part of this process.

To ensure success, exiting processes should be offered as a voluntary option led by service users. This is already the approach of many projects, and provides the context in which this good practice guide discusses 'exiting processes'.

If the services and professionals involved dictate the process, sex workers will feel alienated from it, particularly if they are struggling to comply. Sex workers may then feel isolated from the essential harm reduction services that they should be entitled to, and become more invisible and marginalised.

By reclaiming definitions of success in this way, we hope that services funded to work with sex workers on exiting processes will develop monitoring systems which capture this in a relevant and meaningful way. Projects measured by their success in 'exiting' sex workers from the sex industry can provide funders or other stakeholders with targets which everyone understands and can work towards.

# The cycle of change and its impact on exiting

'The cycle of change', a model developed by Prochaska et al, 1998, has influenced drug treatment services in the UK for many years. However, it was originally developed to describe the process that people go through when attempting to give up smoking. Its basic principles are applicable to other forms of behaviour, particularly those which can be problematic and addictive.

The model has six stages which individuals move between. How long an individual stays in a particular stage or the speed at which they move from one stage to another is influenced by many external factors. The process is very individual: one person could take years and another could take minutes or days to reach the decision-making stage (for example if there's a crisis). However, both could have the same 'success' in how far through the cycle they go.

Often, individuals attempting to make major lifestyle changes move smoothly through the various stages only to fall back to the beginning. Failure to recognise and understand this process often leads to demotivation and unwillingness to start the process again because it seems too difficult. This creates a barrier to exiting. However, each attempt can be a benefit and can increase the success of future attempts.

## The stages of the cycle

- **Pre-contemplation:** the person does not see any problem in what they are doing
- **Contemplation:** the person is ambivalent and in two minds about what they want to do
- **Decision:** the person has decided to do something and are getting ready for change
- **Action:** the person has made the change and it is all-consuming
- **Maintenance:** the changes have been integrated into the person's life
- **Lapse/relapse:** full return to old behaviour

There are many barriers to exiting street sex work, which in itself can involve behavioural elements such as risk-taking. Like the cycle of change, the process of exiting can be a cycle within which individuals can become trapped for years at different stages. They may progress rapidly through the various stages, only to fall out completely or go back to stage one. This means that support services and information should always be available to avoid missing opportunities when an individual reaches the decision stage. This indicates the value of sex work projects working holistically, rather than being preoccupied with exiting, and offering both generic support services as well as exiting programmes.

Understanding this cycle is important for any workers who are helping people exit street sex work. They should be able to recognise the different stages and know the interventions which are appropriate at each stage. This will influence people's success in exiting. For instance, motivational interviewing is particularly helpful for people who are at the contemplation stage, and relapse prevention strategies are very useful if implemented at the decision stage.

Unless individuals are ready and adequately prepared during contemplation, the next steps may be less successful. Workers also need to understand client-centred working to ensure that any intervention is well placed, and to minimise the risk of making things worse.

**Note:** the UK NSWP does not approach all sex work as problematic. This model is one that has been found to be useful for some projects working to provide exit support to women involved in street sex work who have problematic drug and /or alcohol use.

## How to identify the stage an individual is at

### Pre-contemplation

May admit to enjoying substance use; does not report any health problems; accepts current circumstances; occasionally uses facilities of drop-in or outreach but does not engage further with workers; avoids in-depth conversation; does not join in with group activities/discussion; may be in denial; may find it difficult to accept responsibility for personal circumstances.

### Contemplation

Accesses services more frequently; starts to disclose personal information and reports dissatisfaction with current circumstances; starts to think and talk about the future more than the past; begins to show excitement about possible change.

### Decision

Makes decisive statement about initiating change, for example, "I have had enough"; contacts service and requests help to deal with a specific issue; fully engages with key worker; makes their intentions public; has already made some small changes, for example moving from injecting to smoking or only works at certain times or with particular clients.

### Action

Completes care plan and is proactive in its development; attends scheduled appointments and meetings.

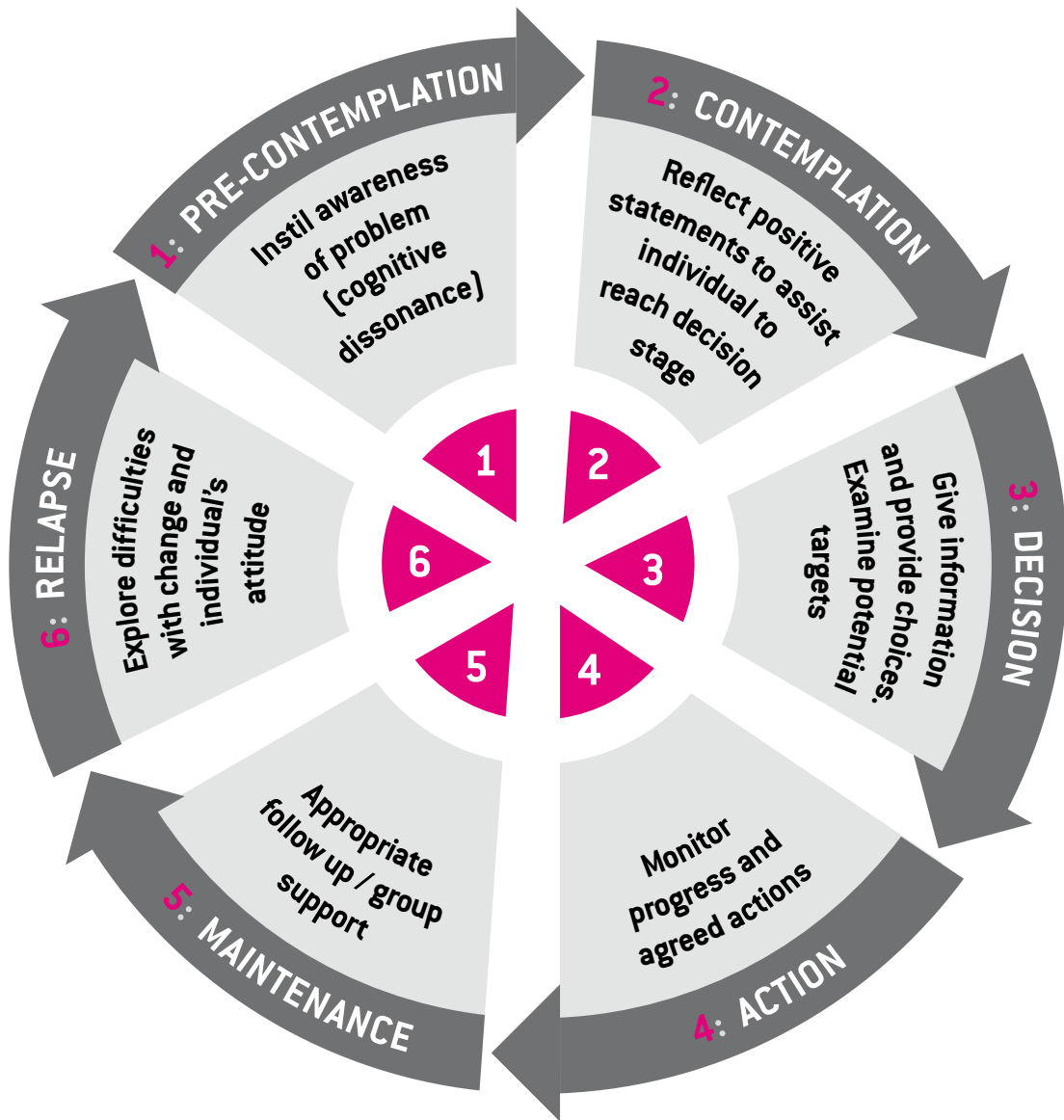
### Maintenance

Regularly attends appointments; is optimistic; becomes more proactive in care plan; personal health and hygiene improves; maintains contact with support worker but may move away from initial intensity of support.

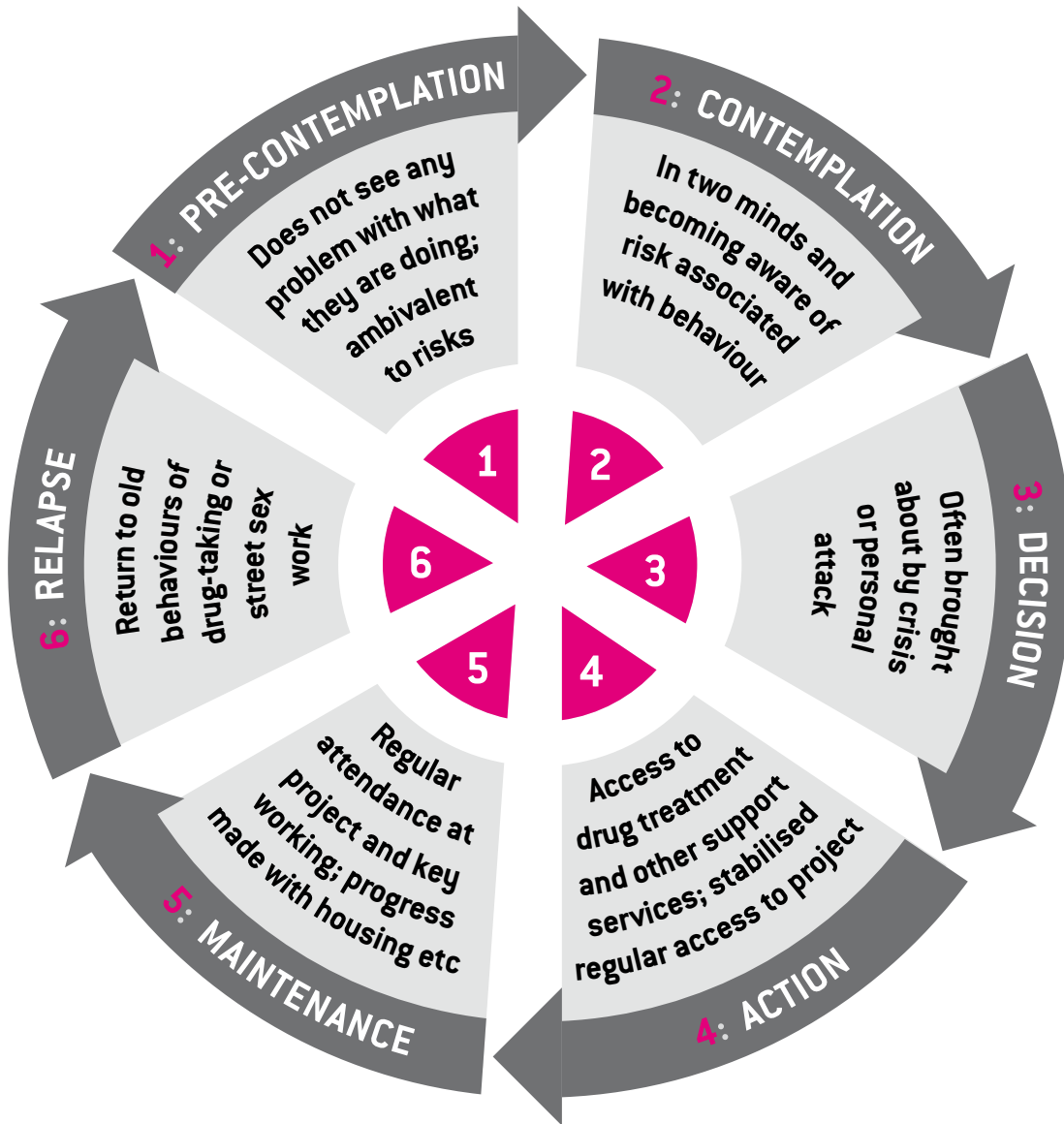
### Relapse

May report sporadic drug use and occasional sex work; disengages and starts to miss appointments and key working sessions; returns to street sex work and chaotic drug use; worker has difficulty contacting individual.

## The cycle of change and worker actions



The cycle for exiting



# Strategies to facilitate exiting

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Challenges exist at different levels – individual, community and structural – and can be both direct and indirect.

How much influence projects can have over these challenges is variable. But it is important to be aware of and acknowledge their impact. Some may be taken up locally through collaborative working and having a clear strategy incorporated within the local area agreement. Others need to be addressed nationally or internationally, and may involve lobbying for changes in legislation.

The following strategies and challenges have been identified by the projects involved in producing this good practice guidance and their service users. Challenges are individual and changeable and the list could be endless. However, this guidance gives

some ideas for achieving a ‘gold standard service’ for supporting women wanting to exit. It also discusses possible solutions for addressing common challenges locally. Its principles are relevant whether your project is well established and highly resourced or consists of one worker based within another organisation. It may also be useful for those commissioning services.

The following are suggested areas to cover with service users when undertaking comprehensive assessments and preparing care/support plans. An example of an assessment document (kindly supplied by One25 Ltd Bristol) is in appendix 2. Case studies illustrating service users’ journeys and some of the challenges faced when attempting to exit sex work are in appendix 1.

## Access to drug treatment

### Gold standard service

A gold standard service should offer a comprehensive, harm reduction drug treatment programme, which would include a range of drug service options from tier 1 to tier 4 (see appendix 3). Qualified drug workers and prescribing doctors would be based within the local sex work project, and would offer various services. These could range from immediate and non-appointment based prescribing (acting as harm minimisation and engagement tools), through to more therapeutic, structured work and referral into residential rehabilitation.

Whilst working towards this, projects could develop partnership working with local drug agencies, agree secondments or negotiate specific sessions within drug agencies. Projects could also raise awareness within drug services and advocate on behalf of sex workers requiring these services.

Whilst the clinical aspect of drug treatment is important, drug treatment programmes should be based on philosophies of social inclusion and exist as part of a holistic package of care to address complex needs.

### Challenges

Lack of access to a range of drug treatment services represents a significant barrier to exiting street-based sex work. Often appointments are inflexible: for example, early morning appointments which don't take into account lifestyles. Another barrier is that most drug services are mixed-gender services. Drug services should be working towards addressing the needs of diverse groups, including the specific needs of female, male and transgender sex workers. Projects need to lobby tirelessly to see a broad range of accessible prescribing and treatment facilities for sex workers and their partners.

**Note:** Hunter & May, 2004, produced guidance for partnership working on street sex markets and drugs markets. This includes guidance on drug treatment for those involved in sex work.

## Criminal records

Many service users from this group have criminal records, not only for prostitution but also offences including possession, supply of drugs, violence and fraud. This can have serious consequences in the longer term for education, training and employment. For example, many social work courses no longer accept applicants with serious criminal convictions. Prostitution-related offences on a criminal record carry stigma when disclosed to employers. Sexual offences must be considered when applying to work with children.

### Gold standard service

A gold standard service would ensure staff are trained on how to disclose criminal records positively. This needs to be accompanied by self-esteem and confidence-building work to help overcome stigma. Whilst working towards this, projects should make links with other projects which can offer such training or provide sessional staff in your drop-in facility.

### Challenges

Some of the challenges need to be addressed at policy and legislative levels. However, some inequalities can be challenged locally.

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## Education, training and employment (ETE)

Supporting service users to access ETE may include running awareness-raising workshops with local employers, organisations and agencies.

### Gold standard service

In working towards a gold standard service, projects could agree service level agreements or contracts with employment and training agencies, for example arranging for an agency to be based within a sex work project for a minimum of one session a week. Service users are likely to come from different starting points, and many may not be ready for formal, structured ETE programmes. Sex work projects running in-house activities/workshops should keep records of attendance and achievement and record and collate these within a personal development file. This is an excellent introduction to more formal ETE opportunities and fits with capacity, skill and confidence-building which are all desirable and necessary steps towards more formal ETE.

### Challenges

The challenges are considerable, and many projects report disappointingly low numbers of people moving back into legal forms of employment. In most towns and cities, there are training and employment agencies which work specifically with people who are marginalised. It is important to have a plan with clearly marked stages or goals, which can be celebrated when reached to maintain service users' momentum and motivation.

## Housing

In the short term, a range of crisis accommodation needs to be available. Some of this should be for women only because of the high levels of bullying and intimidation in mixed emergency accommodation. This service user group should be recognised as a priority within the local housing and homeless strategy, and if it is not this needs to be challenged.

### Gold standard service

A gold standard service would be a move-on house for women exiting street-based sex work with trained staff (24 hours) to offer intensive support such as the Alabaré Christian Care Centre – The Well – in Bristol.

Best practice would be to have an in-house specialist housing worker who would offer a service from referral to crisis accommodation through to longer-term tenancy sustainment. This worker would need to have good local knowledge and connections and be proactive in negotiating service level agreements and contracts with housing providers.

In the meantime, projects could arrange for housing workers to visit their drop-in sessions; develop partnerships to conduct assertive outreach to homeless populations; provide awareness-raising in homeless departments about issues faced by this vulnerable group.

### Challenges

Challenges include rigid policies about curfews, visitors, drug use and children, all of which adversely affect this service user group, especially if there is a history of domestic abuse.

## General health and wellbeing

Women consulted about this good practice guidance highlighted difficulties with general health and wellbeing as a major barrier to exiting sex work.

### Gold standard service

Service users should be registered with a GP to establish general medical care. Projects could offer presentations/workshops at GP in-house training and area training events to raise awareness of the realities of street-based sex work; the difficulties of exiting; and the role of GPs.

In-house community-based health provision, such as primary health care clinics, can be useful for service users. Nursing and other health and social care professionals, employed within or seconded to specialist services, can provide practical health advice, care and referral to other specialist health services. Forging other partnership arrangements with health agencies, such as fast-track arrangements, can provide access to a wide range of health care, for example dentistry, sexual health and contraceptive services.

Dental care is important. Projects should know about the local emergency dental system or as a 'gold standard' develop links with sympathetic dentists so women can be fast tracked into treatment.

Sex workers often have issues with their bodies and appearance. This is an important factor for projects to take account of. For example, putting on weight when in recovery for drug addiction can affect the exiting process. Small grants or bursary schemes may be available, for example clothing grants or materials for returning to work, or basic furniture. It may be useful to contact local businesses which could give a day free of charge or at minimal cost to do hair and beauty. This could be part of a project's

education programme incorporating social skills, developing confidence and self-esteem. Other businesses may be willing to donate end of lines such as hygiene products and clothing and so on. Make links with local colleges as students often need models to practice on! Adverts asking for donations on local authority/health authority websites can be a great way of getting donations from items of furniture to toiletries and clothing. If your project needs help or particular skills, you could advertise for volunteers in your local Council for Voluntary Services newsletter.

### Challenges

Poor dental health is a common side effect of drug use. Difficulty in finding dentists is a huge problem. Many women report severe toothache and abscesses and, in some cases, need to have all their teeth removed because of damage caused by heroin. It is important to think about this before exiting, not only because of the pain involved and the temptation to use drugs to numb the pain and therefore having to return to sex work to fund the drugs, but also because of how women feel about themselves and their appearance.

Health services must address the specific health inequalities experienced by sex workers. For example, one woman described how multiple injuries sustained as a result of violence experienced during sex work developed into severe arthritis when exposed to the cold while working on the streets for long hours. This severely disabled her and restricted reintegration into society.

## Mental Health

Some sex workers, particularly those who work on the streets, struggle with mental health issues. The high levels of violence and abuse faced by street-based sex workers and witnesses can severely traumatise them. Surviving this by self-medication, including street drugs, is common and inevitably leads to more complex mental health issues. On leaving sex work, mental health services should be available to support individuals with any psychological damage they may have sustained whilst in the sex industry.

### Gold standard service

A gold standard service would include quality crisis counselling delivered from a sex work project on a drop-in basis for those still living with chaos or unable to commit to a structured appointment system. It would also offer structured appointment-based counselling for those wishing to move away from this chaos. This would be a comprehensive service delivered by a mental health professional able to deal with trauma and abuse. There would be a care pathway established with the local statutory mental health crisis team to ensure it could offer an efficient response to any severe mental health issues. Shared protocols would also be established with both statutory and voluntary mental health services to facilitate referral onto more long-term or specialised counselling. For those services which cannot resource a mental health professional within their organisation, it is recommended that a representative from the sex work project offers advocacy to the service user when they are dealing with mental health services. This can help ensure that the individual's voice is heard and that assumptions based on prejudice do not inform any mental health diagnosis.

### Challenges

Lack of understanding of the complexities can be a huge obstacle. For example, women are often diagnosed with 'Borderline Personality Disorder' simply because many of the activities relating to sex work can be found within this diagnosis (such as criminal activity). Some would argue that this pathologises the experience of sex workers.

For many disempowered individuals, selling sex can sometimes represent an element of control in a history of little control. For them, when exiting sex work, the need for an element of control may manifest in different ways. This sometimes brings with it specific mental health issues, such as eating disorders or self-harm which the individual does not understand or know how to deal with. This may add to them thinking of themselves as 'disordered'.

## Access to benefits and financial advice

Women exiting can face large debts and financial difficulties including credit problems, which have built up over many years. Their chaotic lifestyles may mean that they have ignored or not been aware of these. Some women will have limited knowledge of the benefits system and their rights, including support available for those wishing to enter training and education.

### Gold standard service

Access to good financial and debt management advice is important. A gold standard service would have a debt counsellor based in sex worker drop-ins at least once a week to advocate for women with creditors and to work out budgeting plans. With attendance at a weekly session, budgets could be kept under review and adjusted accordingly.

A session from a benefits adviser would also be useful so that advice about entitlement and applications for benefits could be completed with service users in a friendly and familiar environment. This may help to reduce the stigma women feel about having to disclose personal information to benefits advisers in what can be experienced as a hostile and judgemental environment.

Whilst working towards a gold standard service, good links with local benefits offices, welfare rights advisors and debt advice services are important. Project staff can then signpost women accurately to the relevant services. Staff should also know about other financial services such as local credit unions, which offer a banking and low interest loan service to those on low incomes.

Training and awareness raising for benefits agency staff is important so they treat such service users with empathy and understanding.

### Challenges

On leaving prison, for example, the small grant is not sufficient for more than a few days' living expenses, and the Benefits Agency can be notoriously slow in sorting out benefits. The temptation to return to sex work is very high as women often have no other means of earning money. Family relationships are often disrupted and families may not be a feasible means of support.

The pressure of managing the finances of a home as well as addressing debt on a very low income can at times be overwhelming. The attraction of returning to sex work at any point during the exiting process in order to meet a financial commitment is strong as there are few other options, and the initial taboo associated with sex work has already been overcome.

## Families and relationships

Many women end up in street-based sex work to fund a drug habit. They are often estranged from families possibly because of breakdown of trust or family members unable to deal with what their loved one is doing. Their children are often cared for by a family member, and these relationships may be strained because of chaotic lifestyles.

### Gold standard service

A gold standard would be to have a family liaison worker in the project working as an advocate to make initial contact with a family or verify progress to date. Often families need support to understand 'what went wrong' and to learn to trust again. Family therapy may sometimes be beneficial. There may be negotiations to be made to facilitate contact between children if they live apart from one another, particularly if the long-term aim is to renegotiate parental orders.

If it is difficult to find accommodation, families may be willing, with support, to accept their daughter/family member back home, offering stability, a change of environment and safety.

Projects should develop strong links with local authority Children and Young People's Services (CYPS) (formerly known as Social Services) to advocate for service users and their children. Workers should be proactive with service users on prevention work, for example raising awareness of risks and consequences of chaotic lifestyles; positive parenting; and child protection. They also need to work closely with CYPS as a part of care plans, sharing information and attending core groups and case conferences.

### Challenges

By the time service users start to fund a drug habit through street-based sex work, their life choices will have already been severely reduced. This results in them becoming entrenched in this lifestyle very quickly, and they often feel a strong sense of identity and belonging. This is a powerful draw as they will have been socially excluded for some time already.

The removal of children is very distressing, and it is important to work with clear child protection guidelines and not collude with poor parenting nor create a blame culture around CYPS. However, it is also important to educate and challenge CYPS decisions based on prejudice.

## Domestic abuse and sexual assault

Some women involved in sex work have experienced domestic abuse. For some, domestic abuse will be one factor preventing them exiting and this will need to be addressed alongside their other issues. Similarly, some women involved in sex work may have experienced childhood abuse within the family. Some women may need help to address rape and sexual assault, recent or historical.

### Gold standard service

Projects could employ staff (including counselling staff) with specialist knowledge and experience of working with victims of domestic abuse, rape/sexual assault and childhood abuse. Gold standard would be an independent sexual/domestic violence adviser located in the support project or a project counsellor with specialist experience of working with victims of domestic abuse and childhood abuse.

Projects can form partnership arrangements with local specialist domestic abuse and sexual assault services, for example Sexual Assault and Referral Centres, Rape Crisis Centres, Women's Aid, helplines for victims of domestic abuse and survivors organisations. This can enable fast track to specialist support, counselling and accommodation. Specialist counsellors or support workers can offer sessions within the sex work project. Specialist agencies can provide training to support staff to develop staff awareness and capacity for supporting victims of domestic abuse, rape/sexual assault and childhood abuse.

### Challenges

Some organisations offering refuge accommodation do not take women with problematic drug and alcohol issues, or have limited capacity to accommodate them. So projects need to raise awareness and work with local partnerships to address the accommodation and support needs of sex workers who are victims of domestic abuse.

There may not be a specialist service for rape and sexual assault or for supporting victims of childhood abuse in your area. Some of those specialist services may not understand particular issues and concerns for people involved in sex work. If this is the case, reciprocal training may be useful.

# Partnership working

Given finite resources, partnership working with key agencies is the basis of good practice in routes out work.

The principles of working together need to be enshrined in policy and not left to personality. Individuals move on and change but the need for good practice in working together remains.

Working parties or strategy groups are useful forums for such work to begin and to develop. Working documents can result from them. The agencies controlling access to main services need to participate with a clear purpose for the group. The absence of one key player can make the difference between success and endless frustration. Strong chairing and holding each other to account are important for success, as well as commitment and shared goals.

Competition among agencies can be a factor. It is important to guard against this as it is detrimental to service users and inhibits the trusting, open working relationships which benefit service users.

This document could be used as the basis for partnership working. Projects could encourage key stakeholders to sign up to it as a strategy for working with street-based sex workers. It could inform or supersede existing council 'prostitution strategies'.

The process of exiting is not a one-time linear progression and may take years and any number of attempts before lasting changes are maintained. Most funding is short term and not therefore in tune with the reality of this process or the timescales involved. Agency partnerships, especially between statutory and non-statutory agencies, can act as a buffer for service users against changes of agenda and funding priorities.

Partnerships are useful for sharing knowledge and raising awareness of the issues facing women who sell sex. Often services which say they are open to sex workers actually exclude them through lack of awareness of how their policies act as hidden barriers; for example, curfews on night shelters and hostels that don't take account of the hours women work. The lack of women-only emergency night shelter provision and early pick-up times on scripts also negatively affect sex workers.

Training and awareness-raising sessions with statutory and other agencies help to break down stereotypes and stigma. Attending local forums can provide opportunities for encouraging agencies to take up training.

# Staff care and training

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Working with chaotic and socially marginalised people can be emotionally and mentally exhausting. Staff care is important to achieve continuity of staffing; building expertise through staff retention; and modelling healthy living.

One pitfall for organisations working with chaotic and marginalised service users is in not managing the transference of the user group's chaos and experience of marginalisation. This can lead to poor organisation, poor time management, stress and worker burnout.

Managers and trustees should be aware of the impact of marginalisation. Staff can feel excluded and marginalised themselves, leading to an inability to deal with issues objectively and constructively.

Good quality workload supervision, training and professional development opportunities are starting points. Clear policies, boundaries and organisational direction help to keep focused in the face of chaos.

External supervisors who offer more of a counselling/therapeutic role are beneficial to staff who deal with high levels of violence, assault, trauma and death. All of these affect workers at some level and will eventually adversely affect their practice if not dealt with routinely.

If resources are limited, you could consider peer supervision across local organisations or enter a reciprocal arrangement with colleagues from another sex work project. The UK NSWP regional forums are an excellent resource for mutual support.

# Theory base

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A coherent theory base is helpful for providing a clear framework and structure to this work and giving confidence to staff.

As voluntary sector projects in the marketplace of social care, it is useful to be clear about the basis for our work. It also encourages clarity and transparency, and encourages a reflective and thoughtful approach. Reading the subject extends knowledge and encourages staff to keep up to date with relevant practice and legal and research evidence.

Ideas from social work, drugs work and mental health practice are the main basis for this guidance. The process of developing a theory base can simply begin by circulating and reading articles/chapters and then discussing the relevance of the idea or technique to practice. This can be done

regularly in team meetings and reviewed annually. Notes may be taken, discussions written up and a theory base is born.

Suggested areas for discussion and development might include ideas from social work e.g. crisis intervention; task centred casework; the ecological approach; reflective practice; and needs-led assessment. From the mental health arena: the recovery model and dual diagnosis. From drugs work: motivational interviewing; relapse prevention; and the community reinforcement approach. In this guidance, we have referred to several models (Prochaska et al, 1998, Hester & Westmarland, 2004, and Sanders, 2006) which may be useful for projects to inform their exit support work.

For suggested reading see page 27.

# Theoretical discussion of exiting issues

## Stigma

Stigma has been described as an undesired differentness, which is underpinned by a conviction that the person is less than human, and results in discrimination and a reduction of life chances (Goffman, 1963). Evidence suggests that stigma has a huge, negative impact on people's lives in terms of housing, access to health care and employment opportunities (Link & Phelan, 2001). In our society, sexual activity is linked to emotional investment (such as monogamous relationships). Sexual activity such as sex for money, which rejects these values, is perceived by mainstream society as deviant, and the people who engage in such activities, either by selling sex or buying sex, are stigmatised. Street sex workers experience extreme stigma because of their visibility on the street.

It is a challenge to resist internalising such levels of stigma, which lead to low self-worth, guilt and hopelessness. Providing a truly non-judgemental service, consistently challenging discrimination and working to a service user's 'exiting' agenda (not yours!) will encourage service users' sense of hope and self-esteem.

## The role of class in the helping process – a brief overview

Questions which projects should consider are:

- Who needs to exit?
- What are they exiting from?
- What are they exiting to?

These questions are fundamental if projects are to avoid colluding with society's stereotypes of street-based sex work as deviant. The questions prompt us to look at the context of the individual sex worker to avoid presumptions about the need to 'exit'.

It is useful to locate any discussion of exiting and the questions posed above within the history of the relationship between sex workers and the 'helping' professions. The concept of exiting can be seen as part of the moral debate about people involved in the commercial sex industry and their need of 'reform'.

Agustín, 2007, asks whether helping is about middle class women 'reforming' working class women into acceptable notions of domesticity. The 'prostitute' and description of the activity of 'prostitution' itself reflect a moral discourse which merely acts to re-stigmatise those who sell sex (Agustín, 2007). She explores how the desire of middle class women to be 'usefully' employed outside the home in 'acceptable' work contributed to the rise of philanthropic enterprises, in which better

educated and 'respectable' women sought (and perhaps seek) to 'help' or 'rescue' women who are perceived to be trapped in 'deviant' and 'destructive' lifestyles or employment. There is a constant need to guard against these attitudes creeping into what projects or more generic services for women are seeking to achieve. There is perhaps a need to recognise that selling sex is not an identity for women but an economic choice that may only be used for short periods of time. Agustín argues that migrant women particularly may make this choice, and the problem becomes that they are defined purely by their choice to sell sex and not by any other aspect of their lives or skills. Hence she argues that their roles as mothers, breadwinners and people with a desire to travel and see the world is ignored in favour of a focus on, or even morbid fascination with, their choice to sell sex as a mode of economic survival.

This may appear a very academic argument for this guidance, but it is important to be aware of the history of ideas, labels and work in order to encourage a reflective and anti-oppressive way of working. The rest of this chapter considers resources and routes in and out of marginalised lifestyles.

### Access to resources

Several key concepts relate to social welfare provision and its distribution:

- The nature of entry into marginalised lifestyles and the nature of those lifestyles tend to determine whether service users are seen as 'deserving' or 'undeserving'
- Explanations offered for entry into 'marginalised' lifestyles can at times verge on pathologising the individual for their circumstances (Pleace & Quilgars, 2003)

- Service users are seen as 'rational actors' by service providers and therefore able to modify behaviours in order to access the required/needed service (McNaughton & Sanders, 2007)

This is clearly not the case for people with very complex needs who are entering services and treatment from very traumatic backgrounds with high levels of social exclusion. Services are often provided in a very rigid way, and the inability or failure to comply with the regulations governing the distribution of resources is viewed as 'disengagement' by professionals within these organisations. Rather than seeing the behaviour as 'normal' to those individuals and the rigidity of access as the problem, the behaviour, and often the individual, are pathologised. McNaughton & Sanders, 2007, say that both homeless and sex working women find the 'rules, bureaucratic systems, tight timelines and conservative protocols' very difficult to adhere to or even comprehend given the traumas and other problems they have experienced and that 'the most vulnerable women often were excluded from the very services that could assist them' (p891).

### Routes in and out of marginalised lifestyles

Entry into marginalised lifestyles such as street-based sex work is influenced by many factors common to other forms of marginalisation including homelessness, violence, unemployment, familial abuse and breakdown, childhood abuse, care system, debt, low levels of academic qualification, mental and physical health issues, substance misuse and poor social networks.

Exit and the desire for change are triggered by well documented factors: violence, increased competition and low prices often

due to the intense policing of the beat areas, increased risk of arrest, health crisis, drug crisis, loss of children and pregnancy. Also age and what Harris, 2007, calls 'decade shifts' can lead to a desire to change as these factors cause disparity in our own expectations of our lives. These are listed by McNaughton & Sanders, 2007, and are borne out by the experiences of all the projects represented in this guidance. Women wanting to make changes face a long and hazardous journey with many barriers to overcome on the way, and projects can usefully work to minimise barriers and maximise opportunities for their service users.

External changes alone are not enough, as maintaining a drug-free life requires profound internal change as well. McNaughton & Sanders, 2007, refer to this as 'ontological security'. They go on to make the important point that whilst stable housing is an absolute key to the routes out process, it also brings with it some profound problems for women exiting street-based sex work and homelessness generally, in that they are catapulted from a strong and intense social support network into a situation of extreme isolation. This in itself is often enough to precipitate a relapse: the 'strong networks and routines associated with that lifestyle were both negative and supportive' (p 891).

As 'helpers' we can sometimes underestimate or even forget that just as we are connected to our environment and rely on our social networks, so too are the women we work with. To leave all of that behind is isolating and frightening. Street-based sex workers constantly internalise society's views of them and of their place in society. A volunteer at a project, who

was formerly a street-based sex worker, described how she knew her place in society quite clearly when she was working, and her behaviour and relationships reflected that understanding and her 'place'. One of the difficulties of exiting and 'cleaning up' was that she was suddenly adrift not knowing who she was or where she fitted in any more, and finding herself with a set of behaviours and responses that no longer seemed to fit. She described this as a very painful and frightening experience and one that had, on previous attempts to exit, contributed to relapse.

The lack of secure and appropriate housing and opportunities to fill one's time in a meaningful way are key factors in relapsing. Increased poverty or perceived poverty are also problematic as women try to manage a property and live on a very low income often with significant debt and other financial problems. This can make working on the streets and all the associated dangers seem preferable to trying to manage on such low incomes in such isolated circumstances.

McNaughton & Sanders, 2007, refer to women exiting as having 'precarious new lives' (p896). Often, we professionals feel the 'need' to see women move from 'disordered' to 'ordered' lives, especially where babies and children are involved. This can blind us to the precarious nature of the changes made and the possibility of tipping back into 'disordered' living. This can be seen when professionals focus on external world changes such as a little bit of clean time and a new flat, without looking at the internal world changes required to sure up those changes and stave off the likelihood of relapse into drug misuse and working. McNaughton & Sanders, 2007, observe

that exiting is not a linear process, rather a 'yo-yoing' back and forwards between 'disordered' and 'ordered' living. They comment that policy models that focus on the 'characteristics' of each stage of exiting reflect a very limited understanding of the complexity of the process and the significant internal changes that need to accompany external changes. They sum this up in the following way: 'policy models and priorities for regulating behaviours do not account for the transformations in identities from 'pre' to 'post' marginalisation or 'deviance' and the tensions that identity shifts create when moving from an exclusive to an inclusive status' (p 897).

We have already outlined one model, developed by Prochaska et al, 1998, which some projects may find useful to inform their exiting work. We now summarise two other models based on research which some projects have drawn on to help them understand exiting and the support clients may need.

Hester & Westmarland, 2004, propose a model relating to street sex work. They also stressed that exiting is a non-linear and long process, which requires a range of holistic support to be made available at all stages. They identified three key general stages of sex work: entry, ongoing involvement and exit. They identified five phases that women move between: vulnerability, chaos, stabilisation, moving on and post exit. They identified crisis turning points which, for some people involved in street sex work, can be part of a shift from 'chaos to stabilisation', for example near-death overdosing, losing children into local authority care, extreme violence and pregnancy. They recommend that exit support should be linked to ongoing

outreach and support for sex workers so that they are accessible at the points, including crisis points, when an individual wants and is motivated to make change.

Sanders, 2006, approaches exiting from the experiences of both ex-street workers and ex-sauna workers, and outlines the processes of change in leaving sex work she found in her research interviews. Her model gives an understanding of some of the differences for people in different sectors of the sex industry, which is important for support services to be aware of. She explores the triggers and barriers that women encounter, taking into account personal, agency as well as structural disadvantages. Her in-depth interviews focus upon: routes into sex work, money, relationships, education, career planning, mainstream employment, involvement in the criminal justice system, drug use, housing, mental health and self-esteem, stigma, triggers and life events that led to leaving, support services, returning to sex work, changes in identity and role, and coping strategies. The ex-indoor workers interviewed were currently employed in the media, office work, counselling, graphic design, teaching, researching, and social services, and three women were taking higher degrees. The ex-street workers were working in manual unskilled jobs, shop work as well as office work, and some women were taking courses in information technology, beauty therapy, hairdressing, and access to higher education. Sanders proposes a typology of transitions with four dominant ways out of sex work: reactionary, gradual planning, natural progressing and yo-yoing (see table overleaf).

## Typology of transitions

TYPE OF TRANSITION	TRIGGER FOR STREET WORKER	TRIGGER FOR INDOOR WORKER
Reactionary	Violence, ill health, significant life events (eg pregnancy/child removal, imprisonment)	New relationship, being discovered, violence
Gradual planning	Drug treatment program, rehousing, welfare support, therapeutic engagement	Timed transition alongside alternative career and financial planning
Natural progression	Desire for a new, safer lifestyle that is drug free; concern about working conditions	Age, natural career length, disillusionment with working conditions / lack of regulation
Yo-yoing	Failed drug treatment and support package, drift in and out, criminal justice involvement	Unplanned exit, psychological strain, working 'on and off' / 'career break'

Sanders, 2006

Reactionary routes out had been the process for half of the women across the two markets. Here, leaving sex work is described as being a reaction to a significant life event, for example responding to a violent attack or becoming pregnant. Health crisis for street sex workers usually temporarily took them out of sex work. Indoor workers often described leaving quickly in response to a personal and intimate reason such as falling in love and this conflicting with working or being 'discovered' working by a partner or family member. Reactionary reasons were often not permanent. Gradual planning involved a conscious, planned transition that happened during a period of time. For many of the women who worked indoors, gradual exit involved clear financial planning to prepare for the possible significant reduction in earnings. Sanders found indoor sex workers used different language to describe how they planned leaving compared to their street-working counterparts. Those with lucrative earnings spoke of 'retirement' plans. They had concerns about income tax and lack of national insurance and pension

contributions for old age. [**Note:** this shows how projects supporting indoor sex workers may have to cater for different support and advice needs/priorities.]

Street sex workers who did gradual planning often started by reducing the number of times they spent on the beat or only working occasionally. This often coincided with starting methadone treatment or other support from specialist projects working intensively with them. Suitable rehousing was central to successful planned change. Changes in both sectors of the industry were often referred to as reasons for prompting plans to leave gradually, with concerns about violence being more to the fore for street sex workers. Natural progression occurred in both markets when there was a process that involved sex workers thinking that their 'time was up' and their time in sex work was naturally coming to an end. Yet the triggers were different for indoor and street sex workers. For the ex-street workers, women reached a natural point of change based on a history of failed drug treatment, violence,

and chaotic lifestyle. This all became too much and a strong desire for another lifestyle was a catalyst for change. Ex-indoor workers describe coming to a natural point in their working career when it was time to stop and do something else. The key triggers were getting older (with some very conscious of how age was a determining factor in retirement from sex work), and a realisation that new plans for the future needed to be made that did not rely on sex work and aspirations to do other work. In the indoor sector, there was also a view that there was a natural length of time that individuals can work, and that the psychological strain and stress of sex work in relation to emotional labour is something people want a change from. Sanders, 2006, uses the 'yo-yo pattern' to describe how leaving sex work was often frequently preceded by frequent movement in and out of sex work for both street and indoor workers. Whilst women

in both sectors experienced this yo-yoing effect, the 'trapping' factors that returned people were different. Street sex workers with no planned transition were attracted back to earn money for drugs, with parallel movements in and out of the criminal justice system for soliciting and other offences. In contrast, indoor sex workers often had temporary breaks due to occupational stress before returning, often because a job in the mainstream labour market could not substitute for their earnings in sex work. Hence a more planned transition, which addressed earnings, was needed. Rickard, 2001, also reports on findings from research with indoor sex workers reflecting on their jobs, the future and open 'retirement'. This is helpful in providing projects which want to support indoor sex workers with an understanding of some of the priorities and concerns of women in the indoor sector.

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## APPENDIX 1

# Case studies

All names and places have been anonymised to protect confidentiality.

### Case study 1: Penny's story

Eighteen months ago, Penny was a heroin addict and street sex worker. After accessing a sex work drop-in facility, and with support and encouragement from her key worker, she began a methadone programme and eventually entered residential rehabilitation. This is her story so far...

*"It has been 18 months since I last used heroin or crack. It seems like a lifetime ago, almost as if I was another person then, which I suppose is close enough to the truth.*

*I was happy enough to complete a rehabilitation programme and then to move into my own flat. It seems strange that the only person I'm now avoiding is the television licence man rather than a handful of dealers I owe money to! It's good to be able to walk down the street and not have to turn away every time a police car passes just on the off-chance there's a warrant out for me.*

*I try and keep myself busy; so far I've gained health and hygiene, first aid and drama certificates. I've also completed a course on working with the deaf using sign*

*language skills and mediation between disputing neighbours. I also worked at Tesco supermarket over the Christmas period. Last September I started a full time access course in art and design, and have every intention of completing this.*

*When I left the city I lived in, I had to cut off from everyone with whom I'd had drug-related relationships. Some of the people I was in rehabilitation with have returned to using drugs so I've had to cut off all contact with them.*

*My support worker has been one of the very few contacts that I've continued to keep and I have appreciated that. I am a stranger in a strange city so it's good to hear from someone familiar to me. I've got friends from college so my social life has improved vastly.*

*I wouldn't say I've got what I want, but I would say I've got what I need and that's what I call progress!"*

Penny  
Service user

## Case Study 2

27-year-old Katie's initial engagement with the sex work project was in November 2004. She had moved to a new city and continued sex working. She attended our drop-in service and started to access one-to-one support regularly. She moved into a hostel and started a drug treatment programme to deal with her five-year addiction problem.

In March 2005 Katie discovered she was pregnant. This was her second pregnancy; her first child had been adopted through social services at Katie's request. She continued to engage with the project, having regular key-working sessions. She attended all of her ante-natal appointments and started to access formal counselling sessions at the project.

Katie had her baby in September 2005, and was sharing a flat with her partner who was also an ex-heroin user and the father of her child. Katie had made the flat homely and it was always clean and tidy; she had also found herself a part-time job. She appeared to be progressing very well and stayed in contact with support workers at the project. Katie was still on a drug treatment programme and had not used any substances or worked on the street during her treatment.

In December 2006, Katie's partner suffered a nervous breakdown and was admitted to hospital. This had a cataclysmic effect on Katie, which resulted in her returning to heroin use. Katie's lifestyle soon deteriorated and this began to have a negative effect on her child whom she felt she was neglecting. His development slowed and other support agencies grew concerned for his wellbeing. Katie was finding it increasingly difficult to cope with her child and asked the local social services to have him fostered on a temporary basis. Katie's use of substances increased, and she was working on the street more regularly. Within a few months, Katie had been evicted from her property and was declared homeless.

At the end of February 2007, it was confirmed that Katie was expecting another child. She was now living at another hostel, and had met a new partner who was not the father of the child she was carrying. Concerns were raised with social services and a decision was made that the child would be taken into foster care as soon as it was born. Katie's second child is now in the process of adoption and the social services are hoping that both children will be placed within one family unit. Katie is homeless after leaving the hostel and is asking for a placement in a women's refuge.

### Case Study 3

Approximately 16 months ago, Elana (from Eastern Europe) began working on the streets of our city. A few months later she was joined by Petra from the same country. Elana spoke very little English; Petra spoke more.

Initially, neither of them smoked or had a drug habit. They used the outreach van regularly but did not come to the drop-in although Petra said she knew about it. We got a translation of sandwich fillings and hot drinks from the internet to facilitate communication with Elana, and information about their rights to live and work in the UK. Petra told us that they were working on the streets because the jobcentre had told them that they were not entitled to work here. This was not true, however they needed to register.

Through contacts in two local churches, we managed to secure part-time paid employment for both women, and a grant to fund their worker registration.

Progress was slow as communication was extremely difficult and we found out later that Petra was not communicating the information we thought she was to Elana. They continued to resist all encouragement to use the drop-in where we were hoping to engage the services of an interpreter in order to be able to help more accurately.

Petra was seen less and less often as she had secured other work. Both women's health began to deteriorate, and soon our fears were confirmed that they had begun using heroin to cope with life on the street. Our contact with Petra lessened and, since then, Elana's situation has gone from bad to worse with her being unable to hold down the paid employment she had and losing her home with Petra and her family.

Working together with a woman at one of the churches who befriended Elana, and the local drug agency outreach worker, we managed, in the autumn, to get her into the drop-in and to use an interpreting service to try to ascertain her situation and help her to access services she wanted. She got a script through a local GP but lost it on becoming homeless. In December, we helped her to find emergency B&B accommodation through the city council with Adult Services picking up the bill as she was not entitled to benefits because of her status.

Her current position remains unclear as no one seems to know who is paying the accommodation bill or how to move Elana on as she is not entitled to Supporting People funds.

We have learned the importance of having interpreting quickly and flexibly and the need to widen our volunteer base to include people who speak other languages. The telephone interpreting service has not been particularly useful as Elana has been so distressed that she hasn't used the opportunity to talk more widely about her situation and the support she would benefit from. The interpreter has not known about the field of drugs; has not understood some of the language; and is very impersonal. These factors may have contributed to her not discussing anything more than necessary. Given the stigmas and the difficulties, face-to-face interpreting may be more effective.

With hindsight, if we had managed to get the information about their work status directly to both women in the first instance, had not relied on one to pass it on to the other, and had been able to get them to services more quickly, it may have been possible to prevent the slide into heroin addiction which will now compound any exit from street-based sex work.

## Case study 4

Jill started selling sex on the streets at 17 due to financial hardship. Two years later, she decided to work indoors in a house, which she was 'fine with'. After becoming pregnant a year later, and being a single parent, she made an active decision to make a career out of sex work, because she could work part-time hours, be a full-time mum and earn 'professional women's' wages. However, Jill was also very aware that as she got older there was a time limit on her sex work. She recognised the time would come 'to hang up her stockings' and that it was necessary to lay foundations for this time.

Jill wasn't sure what she wanted to do after sex work, so she started different courses at college. She was fine in class but found it hard to interact with the other students during breaks because she could not disclose her sex work career. She felt like a fraud when others asked what she did for a living; she felt like she was living a double life. Attending college part time was difficult when working under a parlour manageress because of the shift system. She didn't want to lose her job at a good establishment and end up working somewhere less reputable.

Another time, Jill fell in love, and decided to become a cleaner but when her employer asked some general questions, she felt overexposed and gave up the cleaning job. She then decided to 'put the stockings back on' and return to sex work, this time from

home. She attended an evening course in counselling skills, and really enjoyed it because it felt safe to disclose her sex work career and not feel judged. She then applied for voluntary work, and reduced her sex work to one day a week. This made her feel more comfortable still as she could talk about voluntary work when at college. She commented that voluntary work was like dipping her toe into the mainstream.

Jill carried on working on a reduced basis from home for a couple of years, which enabled her to 'save a nest egg', so she was able to subsidise the financial transition from sex work salary to voluntary sector worker salary. The financial rewards of sex work were difficult to leave and were the main reason for staying; the financial aspect of another job 'worried Jill sick'. As well as having spent a long time in the sex industry [15 years], Jill described a 'deviant lifestyle' as her norm.

Jill then got a job part-time for a couple of years because she didn't feel quite ready to work full-time. Although she felt her skills were very transferable, at 32 she felt like a 16-year-old YTS person, and was worried about other workers' expectations of her skills. Overall, the transition to her current full-time job took around five years. Jill says she has no shame about her sex work career as it made her who she is today and she loves that person.

## APPENDIX 2

## Sample assessment tool

## Information gathering

1 DETAILS			
Name		Also known as	
Date of birth		Ethnicity	
Address			
		Phone	
NI number		Prison number	
Referred by		Case worker	
Date		Date file opened	

2 CHILDREN			
Name	DoB	M/F	Location
Name	DoB	M/F	Location
Name	DoB	M/F	Location

3 SIGNIFICANT OTHERS		
1 Name	Relationship	Phone
Address		
2 Name	Relationship	Phone
Address		

4 IN CASE OF EMERGENCY		
Contact	Relationship	Phone

5 GP	
Name	Phone
Address	

6 OTHER AGENCIES	
1 Org. name	Phone
Address	
2 Org. name	Phone
Address	

**Assessment areas**



## Assessment form

<b>1 PROJECT NAME</b>		
<input type="text"/>		
<b>2 ASSESSMENT DETAILS</b>		
Completed:		Review date:
Completed by (please tick): Client      Worker      Client & worker		
<b>3 PLAN</b>		
Area	Plan	Review date
Housing		
Substance misuse		
Physical health		
Spiritual health		
Mental health		
Relationship + family		
Relationship + friends		
Relationship + agencies		
Living skills		
Personal responsibility		
<b>4 ASSESSMENT SCALE (please circle)</b>		
1: Going very badly    2: Not doing very well    3: Okay    4: Doing well    5: Doing very well		

## Consent to store and release personal information

### 1 I give permission for information about me to be stored by

which may include, if relevant, information about my health, sex life, religious or political beliefs, race or ethnicity, offences and convictions.

### 2 I give permission for relevant information held by

to be released to other agencies, including the following: (tick as appropriate)

- |  |  |  |                                     |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Social Services   | <input type="checkbox"/> Police              | <input type="checkbox"/> DSS               | <input type="checkbox"/> Solicitors |
| <input type="checkbox"/> Housing offices   | <input type="checkbox"/> Education / schools | <input type="checkbox"/> Drug services     |                                     |
| <input type="checkbox"/> Utility companies | <input type="checkbox"/> GP / Health         | <input type="checkbox"/> Housing providers |                                     |

### 3 I DO NOT give permission to release any information to the following people

Name	Relationship
------	--------------

Name	Relationship
------	--------------

(This wish will be respected unless any of the special circumstances, below, apply)

### 4 I understand that there are some circumstances where confidential information WILL be released by ; these are if:

- A A child is at risk of abuse
- B There is risk of physical harm to another adult
- C A vulnerable adult is at risk of abuse
- D I am at risk of serious self-harm
- E I have given permission for  to share information about me with another agency or its representative.
- F  is forced by court order to divulge this information
- G It is absolutely necessary to maintain 's reputation for the benefit of everyone

### 5 I know that I can request to see the information held by

about me by asking a member of staff or by writing to the Project Co-ordinator at

and that an appointment will be made for me to look at it within 21 days of the request being received.

### 6 I have understood the above and give permission for my details to be held by

and disclosed as described.

Signed	Date
--------	------

PRINT NAME	Date of birth
------------	---------------

## APPENDIX 3

# Explanation of the drug treatment tier system

from the National Treatment Agency website ([www.nta.nhs.uk](http://www.nta.nhs.uk))

## The different types of drug treatment services

### Advice and information

Advice and information is provided by non-specialists such as GP surgeries and accident and emergency departments. This should include:

- information about drugs and alcohol, and their effects
- advice on reducing and giving up drugs and alcohol
- information on reducing the potential harm from drug misuse, such as injecting more safely and preventing overdose
- how to get help for drug problems
- how to get help for other problems, such as housing and sexual health
- information for carers, partners and families of drug users.

### Harm reduction

Most harm reduction is about preventing diseases passed on by contaminated blood (particularly HIV and hepatitis infections), and preventing overdose and drug-related death. All drug treatment services, whether residential or based in the community, should provide this as a core service. Examples of harm reduction are:

- needle exchange services, which distribute and dispose of needles, syringes and other injecting equipment (such as spoons, filters and citric acid)

- advice and support on injecting more safely, injecting less and preventing other people from starting to inject
- advice and information on preventing infections associated with drug misuse, particularly hepatitis A, B and C, and HIV (blood-borne viruses)
- testing, advice, information and counselling around hepatitis and HIV
- vaccination for hepatitis A and B
- access to treatment for hepatitis B, C and HIV infection
- advice and support on preventing overdose and drug-related death
- assessing clients and referring them to other treatment services if necessary.

### Community prescribing

Community prescribing is specialised drug treatment in the context of a care plan. It is provided as part of primary care, by a GP with an interest in drug misuse or a doctor in a specialist drug treatment service. Where clients receive the treatment may depend on the seriousness of their problems, how long they have been in treatment or how stable they are. Community prescribing can include:

- stabilising a client on substitute drugs
- prescribing substitute drugs, such as methadone and buprenorphine, for a sustained period (maintenance prescribing)

- prescribing for withdrawal (community detoxification)
- prescribing to prevent relapse
- stabilisation and withdrawal from sedatives, such as Valium and Temazepam
- prescribing for assisted withdrawal from alcohol, where appropriate
- treatment for stimulant users, which may include prescribing to help relieve symptoms
- non-medical prescribing (by nurses or pharmacists).

### Counselling and psychological support

Counselling is not to be confused with basic advice and informal support. It should be carried out by a trained and competent professional and be included in a client's care plan. Counselling needs to be formal, structured – with clearly defined treatment plans and goals – and regularly reviewed. Psychological therapies can include cognitive behaviour therapy (CBT), coping skills, relapse prevention therapy, motivational interventions and family therapies.

### Structured day programmes

Structured day programmes usually run a set series of activities for a fixed period of time (for example 12 weeks). Clients attend these services according to a set attendance level (usually 3-5 days a week), as set out in their care plans. There is a timetable of activities which will either be the same for everyone, or be set individually for clients according to their needs. Programmes often include group work, counselling, education and life skills, and creative activities.

### Detox

This is known medically as 'assisted withdrawal' and involves a stay as an inpatient. Most people receiving detox are given medication to help clear their bodies of drugs. The inpatient treatment can also include stabilisation on substitute medication, emergency medical care for drug users in crisis, and in some cases treatment for stimulant users. As well as the inpatient treatment itself, other services may be available, such as preparation for entering inpatient treatment, counselling, help with alcohol problems, harm reduction and treatment for blood-borne viruses. Inpatient treatment is provided in:

- general hospital wards (usually psychiatric wards)
- specialist drug inpatient units (a whole ward or unit specifically for drug treatment)
- residential rehab units with attached detox units to help people come off drugs before entering the main rehab programme.

Clients are normally admitted into inpatient treatment through community drug services. It is important that people leaving inpatient treatment receive proper support to maintain the positive changes they have made and prevent themselves relapsing.

### Rehab

Residential rehabilitation (rehab) usually involves clients staying in a facility for weeks or months and a complete break from their current circumstances. Rehabs normally have a mixture of group work, counselling and other practical and vocational activities. There are several types of facilities:

- traditional rehab units, with programmes to suit the needs of different service users. Different units have different

approaches, for example therapeutic communities and the 12-Step programmes used by Alcoholics Anonymous and Narcotics Anonymous. Most of these take clients from all over the country

- crisis intervention units (usually in urban areas) that help people in drug-related crisis. These are generally shorter stay units
- residential treatment programmes for specific client groups, for example pregnant women, people with liver problems and clients with mental illness. These may require joint initiatives between specialist drug services and other specialist inpatient units
- 'second stage' or 'move-on' supported accommodation, where some clients go to after rehab
- other supported accommodation, with the rehabilitation interventions (therapeutic drug-related and non-drug-related interventions) provided at a different nearby site(s).

As with inpatient treatment, clients will generally access rehab through community services. People entering rehab will usually have gone through detox before entering. This detox could be somewhere else – for example in a hospital, or in the community – or at the rehab itself, if it has an attached detox unit.

### Aftercare

Aftercare is support that is planned for when clients leave structured treatment. The aim is to maintain the positive developments clients have made in their treatment, and help them return to normal life. Examples include help with housing, education, employment, general health care and relapse prevention.

## Explaining the tier system: What are “treatment tiers”?

In Models of Care, the NTA groups treatment into four ‘tiers’ or levels. These reflect increasing intensities of intervention.

### Tier 1

This level mainly involves interventions from general healthcare and other services that are not specialist drugs services, for example hospital A&E departments, pharmacies, GPs, antenatal wards and social care agencies. Tier 1 services offer facilities such as information and advice, screening for drug misuse and referral to specialist drugs services.

### Tier 2

This is open-access drug treatment (such as drop-in services) that does not always need a care plan. Tier 2 covers things like triage assessment, advice and information and harm reduction given by specialist drug treatment services.

### Tier 3

This is drug treatment in the community with regular sessions to attend, undertaken as part of a care plan. Prescribing, structured day programmes and structured psychosocial interventions (counselling, therapy etc) are always Tier 3. Advice, information and harm reduction can be Tier 3 if they are part of a care plan.

### Tier 4

This is residential drug treatment – inpatient treatment and residential rehabilitation. Treatment should include arrangements for further treatment or aftercare for clients finishing treatment and returning to the community.

