

Sex Workers Addressing Treatment

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KEYWORDS: SEX WORKERS, SUBSTANCE MISUSE, ADDICTION,
TREATMENT, STIGMA

Substance misuse among women sex workers is a complex issue, given the heterogeneity of both substance misusers and sex workers and the stigma they both bear. Media depictions of drug-addicted prostitutes fuel the notion that sex work and substance misuse are inextricably and problematically linked in the urban environment. Hallgrimsdottir et. al., (2008, p. 129) surveyed the Victoria Times Colonist from 1980 to 2004 and see sex workers being positioned as “vectors of contagion (medical, criminal, and moral).” McNaughton and Sanders (2007) note the predominance of discourses supporting the elimination of street sex work to ensure ‘clean streets’ and ‘safe communities.’ Kantola and Squires (2004) describe the role of public nuisance discourse in the UK in constructing substance-misusing sex workers as health and social problems that must be removed or moved. This discursive environment constrains sex workers’ access to health services and safe working environments (Bellis et. al., 2007; Jeal & Salisbury, 2004). Accessing and successfully completing substance misuse treatment presents a particular challenge for sex workers, given the stigmas attached to substance misuse and sex work, the interrelationship between substance use and sex work, and the sometimes addictive quality of sex work itself (Casey & Paterson, 2008). This paper explores these barriers and challenges by reviewing the literature and reporting on recent research conducted with Canadian sex workers. It describes the development and evaluation of an innovative sex-worker-specific treatment model that shows promise for reducing the harms incurred through substance misuse and sex work. The research was conducted by the Canadian National Coalition of Experiential Women (CNCEW), which also developed the treatment program and contracted with an independent researcher (Rutman) for the program evaluation. All activities were funded by Status of Women Canada. CNCEW is a consortium of women activists committed to the advancement of equality and human rights for sex workers. All members have direct experience in sex work and/or as sexually exploited youth.

Dimensions of the Issue

A sex worker is a person who earns money by providing sexual services. The term is sometimes used as a synonym or euphemism for ‘prostitute,’ but most scholars define it to include all individuals who perform sexual or sexually-oriented activities in the sex industry, such as exotic dancers, erotic massage therapists, adult film actors, phone sex operators, and participants in live sex and webcam shows (Weitzer, 2000). Street sex work is different from other forms of sex work and usually involves a combination of sex work for money and the exchange of sex for food, drugs, or a place to stay. Survival sex workers primarily exchange sex for food, drugs, or a place to stay. Research conducted on sex work and substance misuse and their affects on health has been conducted primarily with street sex workers and focused on illicit drug use, sex-related illnesses, disease and violence (see, for example, Farley et al., 1998; Pyett & Warr, 1997). Street sex work represents the smallest, though most visible, sector of sex work; Alexander (1987, cited in Arnold, Stewart & McNeece, 2000) estimated that 10-20% of sex work was street sex work. More recently Dalla (2002) estimated that about 15% of sex work occurs on the street, with the other 85% conducted in inside venues such as escort agencies, massage parlours, and exotic dance clubs. HIV/AIDS dominates the research conducted in Canada, which cites sex work as a major contributor to the spread of HIV/AIDS and other sexually transmitted infections (Spittal et. al., 2003). Ninety-five

percent of Dalla's (2002) research participants, primarily street sex workers, reported drug dependency. But research with participants from both street and non-street venues paints a more complicated picture of the relationship between sex work and substance misuse.

In Farley, Lynne and Cotton's (2005) study with 100 Vancouver workers, which included some massage parlour workers and escorts as well as street workers, 82% identified addiction as a problem. In Ward and Day's study (2006) of 130 women drawn primarily from escorts and massage parlour workers, 64% reported current or past addiction. Church et. al. (2001) found that street sex workers tend to use highly addictive drugs such as crack and heroin and that they use drugs more frequently than workers in indoor venues. When Jeal and Salisbury (2007) compared street workers with massage parlour workers, they found less drug use, both in terms of frequency and quantity, among massage parlour workers than among street workers.

Although these differences merit consideration for policy and program development, it is clear that in many instances sex work and substance use are mutually reinforcing. As Nuttbrock et. al. (2004, p. 233) note, drugs and alcohol are readily available in most sex work venues, places "where norms regarding the virtues of abstinence may be diminished" and in common with other studies they found extremely high levels of substance use and dependence for street sex workers. Vulnerabilities to substance misuse are reinforced most effectively in street or survival sex work as opposed to indoor and entrepreneurial work (Cusick & Hickman, 2005). Inciardi and Surrat (as cited in Cusick, 2006, p. 6) make the point that "open, street-based and low status sex markets... are often so entangled with street drug markets that continued and escalating drug use is virtually guaranteed." The overlap between drug markets and sex markets creates special vulnerabilities for Indigenous women and other women of colour. As Golder and Logan note, "[t]he geographical contexts of urban drug markets place poor women of color in greater proximity to drugs, specifically crack, than middle class women, regardless of ethnicity" (2007, p. 629).

Much of the research literature suggests either that sex workers use substances to cope with having to prostitute themselves, or that they were misusing substances prior to entering the sex industry and turned to sex work in order to support their addiction (Farley, 2004; Inciardi, Lockwood & Pottinger, 1993). The image created by these studies is of an inseparable link between sex work and victimization (Lowman, 1991); they overlook the possibility that some women might both choose and enjoy sex work. The co-trajectories of substance misuse and sex work are much more complex than the literature indicates and, as such, depend on a number of other dynamics such as the structural conditions underlying sex work and substance use, and significant contextual factors of race, gender, and class. We suggest that a recursive rather than a causal relationship exists between sex work and substance misuse. Sometimes substance misuse, especially of cocaine or crack cocaine, may precipitate involvement in sex work and sometimes involvement in sex work may precipitate substance misuse (Nuttbrock et. al., 2004). Only 37% of Dalla's (2002) participants reported that they entered into sex work to support substance misuse. Most were propelled into street level work first by financial need while 19% reported that entry substance misuse and entry into sex work occurred simultaneously. As Graham and Wish (1994, cited in Dalla, 2002) note, substance misuse does not always precede sex work involvement. In Potterat et. al.'s 1998 (cited in Dalla, 2002) study, 66% of sex workers used drugs prior to entry, 18% began drug use and sex work concurrently, and 16% began drug use following entry. Moreover, drug use was not the primary precursor to entry, as 44% were precipitated into sex work out of economic necessity. We agree with Golder and Logan who state that "[t]he intersections of race, class, and gender combine to heighten the vulnerability of women of color, particularly poor, urban women of color, to substance use (and HIV/AIDS) and subsequently increase their probability of entry into sex work" (2007, p. 629).

Evidence of the disproportionate representation of racially and economically marginalised women in sex work, particularly in street and survival sex work, is irrefutable. Of Shannon et. al.'s (2008) 46 participants, 57% were Indigenous. In Butters and Erickson's (2003) study with crack-using survival sex workers in Toronto, a disproportionate percentage (43%) were

women of colour, including 25% who were Indigenous. Farley, Lynne and Cotton (2005) noted that Indigenous women comprised 52% of their 100 Vancouver research participants, drawn from three different sectors of sex work (street, massage parlour, and escort). Similarly, Benoit and Millar (2001) found that 15% of the exited sex workers they interviewed, drawn from throughout the sex industry, identified as Indigenous although the Indigenous population of Victoria is estimated at 2%. Benoit and Millar (2001: iv) defined an ‘exited’ sex worker as someone who had been entirely out of sex work for a minimum of two years at the time of interview. Valandra (2007) also notes the disproportionate number of African-American women involved in sex work in the United States.

Finally, as previously noted, most female sex workers enter sex work under economic duress (Benoit & Millar, 2001; Carter & Walton, 2000; Jeffrey & MacDonald, 2006). In this context, Ward and Day (2006) theorise that treatment programs that emphasise exiting have limited impact because sex work provides important economic opportunities for women, including a living wage. As Scott, London, and Myers (2002) note, welfare time limits and meagre assistance payments create the conditions in which vulnerable women, especially those marginalized by race and class, come to see sex work as their only option. These findings suggest that varying personal and contextual factors affect individual sex workers’ entry into and continued involvement in sex work.

Although substance use may occur prior to entry into sex work, substance misuse is a significant factor in maintaining sex work involvement, given that “[s]ubstance use is woven into the sex work life-style in multiple respects” (Nuttbrock et. al., 2004, p. 233). Once addiction develops, continued involvement in sex work is required to support it (Nadon, Koverola & Schluderman, 1998). Not surprisingly, most sex workers struggling with substance misuse want to or have attempted to access treatment. In Butters and Erickson’s (2003) study of female crack users in Toronto, women identified drug abuse counselling as a significant need and vital to improving their health. In Farley, Lynne, and Cotton’s (2005) study, 82% of their research participants wanted addiction treatment and 95% stated they wanted to leave sex work. Almost all of the 23 street sex workers in Arnold, Stewart and McNeece’s (2000) study expressed a desire to stop drug use. Nuttbrock et. al. (2004) found that a significant number of sex workers in their study had entered, though not always completed, some form of substance misuse treatment, most often detoxification. However, detoxification did not often serve as an entry to treatment and rehabilitation, which suggests either that there need to be improvements in the link between detoxification and treatment, or that experiences in detoxification facilities discourage sex workers from proceeding with treatment.

Although sex workers may want substance misuse treatment, they are often unable or unwilling to access or complete it for both individual and systemic reasons. For example, in Kuyper et. al.’s (2005) large-scale study, the majority of the 565 participants reported that they had sought treatment but were unable to access it. Yahne et. al. (2002) note that although street sex workers are at high risk for substance misuse and frequently express a desire for treatment, they are underserved in treatment facilities. Belcher and Herr (2005) note that all of the 15 women in their study had been in treatment multiple times without success. Smith and Marshall (2007) suggest that these difficulties may be attributed to the substance-misusing sex worker being positioned as the most reckless and contagious type of client, vulnerable to double stigmatization.

The provision of health care services, including substance-misuse treatment, to sex workers is inhibited by the proliferation of bias and moral judgments against sex work (Sanders, 2007). Sex workers describe a variety of negative experiences with mainstream social services, including being blamed for their involvement in sex work; being treated as helpless victims; and being eroticised, sexually objectified, and isolated from other program participants (Rabinovitch & Strega, 2004). Nuttbrock et. al. (2004) describe three main barriers to sex workers’ accessing treatment: the illegal status of sex work, alienation experienced by sex workers, and sex workers’ fear of stigmatization. In Butters and Erickson’s (2003) study,

women believed that health care workers would be judgmental and insensitive toward them, concerns that reduced the likelihood of their seeking treatment. Similarly, the women in Arnold, Stewart, and McNeece's (2000) study wanted treatment programs specific to sex workers for three primary reasons: their belief that they had little in common with addicts who were not sex workers, feelings of shame and stigma, and fears of being judged and embarrassed because of their status as sex workers. Barriers to treatment for street-entrenched women are likely more complicated and challenging than they are for women in other kinds of sex work, given the "discourse of disposability" that encourages "blame, marginalisation and violence" (Sanders, 2007, p. 793) towards these women.

Research & Program Development

In order to redress the situation for sex workers seeking treatment and in response to its members' identifying addiction as a key issue of concern, the Canadian National Coalition of Experiential Women (CNCEW) investigated these issues with Canadian sex workers through a mixed methods study. Fifty anonymous questionnaires addressing barriers in accessing substance-misuse treatment and other social services were distributed to current and former sex workers through Canadian sex worker organizations and thirty-two (64%) were completed and returned. Questionnaires included standardized items (for example, participants were asked for non-identifying demographic information, types of sex work they had performed, etc.) and qualitative questions (for example, respondents were asked to describe any barriers they had faced in accessing services and to comment on why they thought those barriers existed). Respondents ranged in age from 23–54 years old. At the time of survey, four women were regularly working in sex work, twenty three (71%) were no longer working, and five women were attempting to transition out. All of the women reported past or present substance misuse, with cocaine identified as the primary drug of choice, followed by alcohol. All respondents reported that while their initial entry into sex work stemmed from financial need, they eventually became addicted to drugs and/or alcohol. Very few ($n=3$) women had accessed detoxification or substance misuse treatment. Women cited shame, fear, and long waitlists as primary access barriers.

The survey results were used to develop questions for focus group interviews, conducted through sex worker organizations in three provinces (BC, Ontario, and New Brunswick). Focus groups are an excellent means of collecting qualitative data in situations where a one-shot collection is necessary (Berg, 2004) and focus group interviewing is an established method of qualitative data collection (Edmunds, 1999; Krueger & Casey, 2000; Morgan, 1997), allowing a researcher to access substantive and relevant content efficiently. Because the research was community-based and conducted under the auspices of CNCEW, no formal institutional ethical review was undertaken, although CNCEW members familiar with institutional ethical review requirements were consulted. A CNCEW member with institutional research experience served as research coordinator and data analyst. Participants were recruited through purposive sampling (Creswell, 1998) to ensure that all participants were sex workers with substance misuse issues. Given that some of the participants were illiterate and that all participants were concerned about preserving their anonymity, a verbal consent process was used. The right to withdraw from the research at any time was emphasised and research assistants made clear to prospective participants that their participation or lack of it would not in any way affect any services that they might be receiving. Participants had the opportunity to ask questions about the research prior to consenting to participation.

CNCEW members, all current or former sex workers, facilitated the focus groups and CNCEW members or other experiential women (i.e. current or former sex workers) were employed as note-takers. Training was provided where necessary. Nine focus groups were conducted in five Canadian cities, with a total of 79 participants. Various forms of data recording were employed, including note-taking, recording information from participants on flip-chart sheets, summaries from facilitators and note-takers, and evaluations completed by the

participants at the end of the focus groups. A research assistant collated the data from all focus groups. Theoretical thematic analysis (Braun & Clarke, 2006) was employed to analyse the data. Thematic analysis centres the experiences and meanings of those who are the main focus of the study, giving voice to participants who are often silenced (Luborsky, 1994), and has been successfully employed in other research with marginalized women (Benoit, Carroll & Chaudry, 2003). In theoretical thematic analysis, data are coded in relation to specific research questions. Data were read and re-read to elicit themes in three main areas: experiences of substance use, misuse, and addiction; barriers to accessing and/or completing treatment; and sex-work-related issues missing from traditional treatment programs.

All focus group participants stated they wanted to leave the sex industry but were having difficulty doing so and that they were addicted to drugs and/or alcohol. Cocaine was identified as the predominant drug. Notably, every participant had entered sex work initially for financial reasons rather than to support substance use or addiction. Over time, however, substance and/or alcohol use became ‘part of the scene’, as one participant described it, eventually resulting in misuse. For many participants, working in the sex industry was as addictive as drugs or alcohol. Participants identified five factors as particularly addictive: sense of independence, ability to make significant amounts of money quickly, sense of power and control, admiration and attention from clients, and excitement associated with ‘living on the edge.’ Many women reported that they found it difficult to transition out of sex work because it required them to break the habits of having access to fast money and working whenever they wanted to: One of the hardest things is the addiction to money. [Leaving meant] cutting my losses, walking away with nothing but my life and children and asking: where did it all go?

Participants identified barriers to entering and remaining in treatment similar to those found by other researchers: shame, stigma, and marginalization. Almost all participants were reluctant to enter or remain in traditional treatment programs, primarily because of stigma; most stated that they would not open up in a group for fear of being judged. As one participant stated, “I feel really ashamed because they [other treatment centre clients] call you a drug ho, needle poking ho, or crack whore.”

Long waiting lists and lack of services appropriate to sex workers also discouraged participants from accessing or completing treatment. The most commonly recurring theme in the focus groups was the need for treatment services specific to sex workers and to gender. Women identified experiences of violation while in treatment that precipitated their leaving prior to completion.

There’s a lot of discomfort by being in a meeting and you’re sitting across from someone you’ve sucked off. [I] would run into johns... at [treatment centre] a lot of girls were hit on a lot by other people in recovery meetings—because we are known sex workers.

Focus group participants expressed a strong preference for working with experiential counsellors and facilitators:

I think the best help is from people that have had that experience themselves...they have gone through it, too. When someone says I’ve read the books, that’s not enough. It’s really powerful what you’re going through. It’s only what you experience yourselves.

The consistency of themes elicited in the surveys and focus groups, coupled with a review of related research, led CNCEW to collaboratively develop and pilot a specialized addiction treatment model for sex workers. The SWAT Program (Sex Workers Addressing Treatment) (Casey & Paterson, 2008) was informed by three critical principles during development: a harm-reduction approach, honouring experiential knowledge, and a reliance on peer support. The model attends specifically to the complex issues sex workers face with substance misuse and when leaving the sex industry and incorporates those areas identified by focus group participants as missing from existing treatment programs. It was initially piloted with sex workers in an outpatient format at a sex worker agency as a series of workshops including sex work issues,

loss of identity, triggers, FASD (Foetal Alcohol Spectrum Disorder) and sex work, sex work and Indigenous healing, transition, and aftercare. Feedback from pilot program participants informed revisions and further development of process and curriculum. Subsequently, an inpatient version of the SWAT model was piloted with three separate client cohorts in an existing residential treatment centre with separate gender-specific treatment streams. Women were admitted to the treatment centre and to the SWAT program simultaneously. The twenty SWAT workshops were provided five days a week, two hours each evening over a four-week period as an addition to the regular therapeutic and psycho-educational treatment centre programming.

Program Description & Evaluation

Fourteen of the fifteen women who participated in the three initial inpatient programs consented to share their demographic information, allowing us to develop a profile of the group. Participant ages ranged from 28 to 50, with about half (n=7) in their 30s at the time of admission. Three participants were Indigenous. All participants self-identified as street and/or survival sex workers. Nearly all the women were living in highly transient and potentially high-risk circumstances at the time that they entered the SWAT program. The description of the inpatient SWAT program and presentation of evaluation findings are drawn substantively from the *SWAT Pilot Program Evaluation Report* (Rutman, 2008).

Many described themselves as homeless; some lived in low-rent hotels or motels; several were in transition or safe houses; a few were living, short-term, with relatives. Only one woman reported that she currently had a spouse or partner. All of the SWAT participants reported being poly-substance users. For the majority, the drug of choice for which they sought substance-use treatment was cocaine and/or crack cocaine, though for some, their drug of choice was heroin or opiates, often accompanied by cocaine. A number of participants reported that they also had problems with prescription drugs and/or alcohol, along with cocaine and/or heroin use. The majority of participants (n=9) were receiving methadone treatment for opiate addiction, which continued while they were in treatment. The amount of 'clean time' prior to admission varied considerably: some women had been drug and alcohol-free for at least one month, others for only a few days, prior to commencing the SWAT program (Rutman, 2008).

Slightly more than half of the participants reported that substance use and/or misuse preceded their entry into sex work. Participants who reported that their entry into sex work came first included a woman who began living on the streets as a young teenager and a woman who started doing sex work because she needed money to support her family. Slightly over half of participants self-identified as survival sex workers. For example, one woman shared this story of becoming involved in sex work:

"I started using heroin and became addicted. I needed money to get heroin, and I needed heroin to do the work. I made \$800 a day and gave \$500 of that to my pimp. So yes, I was a survival sex worker. To pay my rent and to pay for my heroin, I did sex work."

Participants reported having been involved in a range of indoor and street-related work in the sex industry, and the duration of their careers in sex work varied considerably. Most participants reported that they no longer worked in the sex industry, in particular on the street, though at the same time, several participants noted that they still engaged in sex work with their 'regulars' (Rutman, 2008).

Workshops were designed to inform participants about health, legal and safety issues related to sex work, including issues associated with transitioning out of sex work. Another important component of the curriculum related to women's identification of their strengths and the transferable skills they obtained from working in the sex industry. Accordingly, a number of exercises in several of the workshops focused on having participants brainstorm and enumerate their strengths and skills. A central aim of the SWAT workshops was to provide information and stimulate discussion regarding the relationship between women's substance use and their involvement in sex work. Because the program facilitator was not experiential, she received three days of intensive training as well as ongoing supervision and consultation with the

program developers to facilitate working with these issues.

Workshops presented the idea that working in the sex industry is at least as addictive as drugs and alcohol. For example, the draft curriculum for the very first workshop, devoted to sex work issues, stated:

When an individual is seeking recovery from working in the sex industry, it must be noted that the actual working, making money, and lifestyle associated with working in the sex industry are necessary components of addiction that need to be addressed. The addiction to money, power, independence, and admiration/self-esteem experienced while working make it extremely difficult to stop working in the sex industry (CNCEW, 2007).

Particular issues facing Indigenous women were another essential component of the curriculum. Materials for ‘Sex Work & Indigenous Healing’ were informed by consultations with Indigenous women and included information about the Medicine Wheel, Indigenous teachings, and ways of healing. Given that Canada has many Indigenous peoples and nations, the intention is that this particular workshop be facilitated by Indigenous elders and people with knowledge of traditional ways of healing who come from the traditional territory where the treatment centre is located. During the initial inpatient program, the ‘Sex Work & Indigenous Healing’ workshops began with offering a smudge in the traditional grass of the area, following by thanking the nation of the traditional territory. Animal cards were sometimes used to assist participants in gaining a sense of self. Medicine Wheel teachings emphasised walking the earth in a peaceful and good way, assisting women to seek healthy minds (East), strong inner spirits (South), inner peace (West), and strong bodies (North).

Throughout program delivery, the CNCEW program developers and the program facilitator engaged in an iterative process of delivering a given workshop, reflecting on its perceived effectiveness, and revising process and content as needed, based on participant and facilitator feedback.

Evaluation Methodology

A formal evaluation was conducted to obtain additional information. This comprised both a formative or process component and a summative or outcome component. Formative evaluation examines issues related to a program’s implementation (Patton, 2002) and addresses questions such as: What are the program’s activities? How is it working? What are the program’s strengths and challenges? How might the program be improved? Summative evaluation examines outcomes of a program for program participants and for stakeholders or program partners (Patton, 2002).

The evaluation plan involved a qualitative, time-series design whereby semi-structured interviews were conducted with SWAT program participants, program staff, and other key informants at two separate points in time. Qualitative methodologies are rooted in the belief that participants’ experiences and perspectives are the starting point and core of the inquiry (Barnsley & Ellis, 1992). These designs rely on in-depth analysis of text-based data—often generated through in-depth interviews structured as guided conversations—that are systematically collected in order to understand how a program operates, how participants experience the program, what types of affects have been observed and/or experienced, and how and why program interventions achieve anticipated outcomes. In addition, these designs feature gathering qualitative data from multiple sources and perspectives; triangulation of data ensures rigour in the study. Data also may be gathered over time (e.g., baseline, follow-up, etc.) to assess changes for participants in conjunction with program involvement.

A total of eleven interviews were conducted with SWAT participants. These focussed on participant satisfaction with the workshops (e.g., perceived sense of safety, accessibility, responsiveness to sex-work-related issues), and on areas of their life related to anticipated early and intermediate outcomes of the SWAT program (e.g., current involvement in sex work, extent of current substance use, perceived strengths and skills, sense of self-efficacy and self-esteem, and current housing or

living arrangements). In addition, key informant interviews were conducted with a variety of people knowledgeable about the program and its creation and/or delivery, including the SWAT program developers, a senior manager at the treatment facility at which the SWAT program was held, the SWAT program counsellor, and a program volunteer. These interviews focussed on aspects of program implementation, including the program's activities and milestones, strengths and successes, challenges, and suggestions for program improvements (Rutman, 2008).

Findings From the Program Evaluation

The SWAT program was guided by empowerment and peer-education principles emphasizing that participants' experiential expertise be recognized as the starting point of the endeavour (Rutman, 2008). This meant that sex workers themselves developed, tested, critiqued, and revised the curriculum for the SWAT workshops. In this respect, the SWAT program was a peer-based model: a sex-worker-specific substance-use treatment program for sex workers developed by sex workers. At the same time, the rapidly evolving nature of the pilot program meant that the program model needed a degree of flexibility. For example, while in an early evaluation interview the program developers expressed a preference for the SWAT facilitator to be experiential, the facilitator who was hired had considerable experience as a clinical counsellor yet was not experiential. Similarly, while developers recognized the importance of aftercare, when implementation of the program commenced there were no formal program activities related to aftercare, nor was case management (e.g., having dedicated time for staff to assist participants in securing post-program housing or addressing other anticipated day-to-day post-program needs) built into the program (Rutman, 2008). Interestingly, program participants developed their own weekly support group, still ongoing at the time of writing, an endeavour supported by a donation of space and facilitator time from the treatment centre. The group expanded beyond the SWAT program participants to include other women who were or had been involved in sex work and were looking for support in not returning to that work.

Participants in two of the three groups reported that their time in the SWAT group was the best time of the day, in part because of their feelings of safety and the opportunities that the SWAT group presented to talk about what was important to them. One participant stated: "In SWAT we work as a group; we are tight knit and everyone has something to say" (Rutman, 2008). Similarly, women in all three groups identified aspects of the SWAT group dynamics as being what they liked most about the SWAT program overall. Themes relating to group dynamics included not feeling isolated or shamed, experiencing a sense of hope, and learning to give and to accept support. Other themes related to women's development of skills and to gaining knowledge about topics relating to sex work and addiction.

CONCLUSION

As Cusick and Hickman (2005) note, substance-misusing sex workers have many problems beyond their alcohol or drug dependency. Although the SWAT model represents a significant treatment innovation, the depth of the entrenchment between sex work and substance use and misuse, most notably for survival or street sex workers, suggests that further investigation and understanding are needed. Barriers to treatment for street-entrenched women are likely more complicated and challenging than they are for women in other parts of the sex industry (Golder & Logan, 2007). Shannon et. al. (2008, p. 9) argue that "certain risky sexual and drug use practices are rational coping strategies in the face of large scale social and structural violence." The street—and drug—entrenched women in Dalla's (2006) study who transitioned out of sex work typically had participated in long term (six or twelve months) residential drug and alcohol treatment programs, an option that is increasingly scarce.

Contrary to popular stereotypes, women who engage in sex work and misuse substances must be understood and treated not as a homogeneous group with similar needs and realities

but rather as a heterogeneous group of individuals with varied experiences who have valuable knowledge to contribute to their own recovery. Experiences of working in the sex industry and misusing substances are shaped in major ways by social divisions and exclusions, predominantly those of race, class, and gender (Monroe, 2005) that can be usefully attended to in treatment and detoxification programs. Niv and Hser (2007) point out that although clients who attend women-only treatment programs often have more severe problems than women who attend mixed-gender programs, they are more likely to complete treatment and have better outcomes at follow-up. As the SWAT pilot program demonstrates, substance-misusing sex workers will enter and complete treatment programs that address sex work and substance-misuse issues and which have at their foundation the knowledge and wisdom of experiential women.

Although successful, the SWAT program ran only as a pilot project, and suitable detoxification and treatment programs specific to sex workers continue to be otherwise virtually non-existent. Even when successful, such initiatives will do little to reduce engagement in sex work and vulnerability to addiction until many complicating factors are addressed by public policy initiatives. These include women's economic vulnerability; racism and colonialism and their effects on women of colour—and in the Canadian context particularly, their effects on Indigenous women; and other persistent structural inequalities related to gender, race, and class.

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