

Drug Use, Sex Work and the Risk Environment in Dublin



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Drug Use, Sex Work and the Risk Environment in Dublin

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Dr Teresa Whitaker (NACD)

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Foreword: Minister of State

I welcome this first Irish qualitative research on female and male drug using sex workers. The overall aim of research was to explore, and gain an understanding of, the local risk environment within which problem drug-using sex workers in Dublin live and work, and their responses to these risks.

The key findings of this report are that drug-using sex workers are exposed to multiple risks and harms in their living and working lives. The impacts on children and families are also highlighted. The multiple needs of drug-using sex workers include health, social and legal issues. Addressing their wider social and situational needs is as fundamental to reducing their overall risk of harm as is addressing their problem drug use.

I would like to thank the women and men who participated in the research and the research advisory group that facilitated their involvement. I also thank the National Advisory Committee on Drugs who commissioned the work and, in particular, Dr. Teresa Whitaker and Dr. Gemma Cox who carried out the research.

John Curran T.D.

Minister of State with responsibility for the National Drugs Strategy

Foreword: Chairperson, NACD

The NACD is very happy to present the findings from this first qualitative study of drug use and sex work in Dublin. This research fulfils a component of the NACD's remit to advise Government about 'at risk' groups (prostitutes) under Action 98 of the National Drugs Strategy (2001-2008). This report is the culmination of two and a half year's intense work by two researchers at the NACD namely Dr Teresa Whitaker (Lead Researcher) and Dr Gemma Cox, the NACD Research Officer and is the first internally commissioned research carried out by the NACD. On behalf of the Committee I would like to pay tribute to their professionalism and their sensitive approach to the topic and to the research participants. Hopefully the example they have shown in producing such an excellent piece of work will provide a template for similar "in-house" projects in future years.

The NACD believe that this highly detailed report will increase understanding of the serious issues facing those who struggle with the daily burden of drug dependency and who engage in sex work. At the outset it was decided to include both women and men sex workers in the research and this report highlights their commonalities (early drug use, lack of formal education, family conflict, chaotic home environment, physical or sexual abuse, bereavement, homelessness, victims of violence). The NACD is indebted to these men and women who spoke so honestly and openly about their experiences.

People live in situations not of their own making; therefore a focus on the risk environment highlights the physical, social, policy and economic influences that come to bear on this vulnerable group. Within these environments the women and men interviewed implemented a range of innovative strategies to reduce their risks but some of these strategies actually increased the risk of harm, for example some sex workers move off the street and have contact with customers through mobile phones, however this can increase their risk of harm because it makes it harder for services to reach them. The Report highlights the harsh realities of their backgrounds, and the current realities of their living and working conditions. By eliciting accounts from drug using sex workers and also from service providers and other professionals a clear picture emerges of the necessary and appropriate policy responses.

Arising from its consideration of the findings in this Report, the NACD has made a number of recommendations to Government. These recommendations are presented within the broad framework of the risk environment. In relation to the policy environment the key issues of harm reduction and the need for a continuum of harm reduction activities is highlighted as are the importance of interagency and

interdisciplinary working, the care of those with blood-borne viruses and the vulnerability of those leaving prison and residential facilities. Recommendations related to the social environment encompass outreach work and in particular the use of peer networks; given the fact that many sex workers are also parents, continued support of drug-using parents and children is needed. Within the physical environment the key recommendations include monitoring the local drugs and sex markets, further development of contingency management approaches within drug treatment, continued funding of specialist services, reducing the risk of violence through strategies designed with members of An Garda Síochána and addressing issues of homelessness. In relation to the economic environment employment has been shown to be an important component of rehabilitation, therefore it is recommended that programmes aimed at getting drug users into or back to work be continually funded.

On behalf of the NACD I would like to thank the Research Advisory Group comprising Emily Reaper (UISCE), Karen Murphy (Chrysalis), Caroline Gardiner (Progression Routes), Linda Latham/Carmel Hennessy/Joanne Talis (Women's Health Project), Pamela Whelan (HSE), Malika Aissousi/Jennifer Roche (Ruhama), Ciarán McKinney (Gay HIV Strategies), Mick Quinlan (Gay Men's Health Project), Mary O'Shea (NACD/Dublin AIDS Alliance), Jean Long (NACD/HRB), Barry O'Brien (NACD/An Garda Síochána), Paul Ryan (NUI), Mary O'Neill (HSE). Grateful thanks are also extended to Julie O'Shea who proof read the report and to Máirín Kenny, Sheena Duffy, Mary-Jane Trimble and Alan Gaffney who helped in the production of the document. We also acknowledge our indebtedness to the former Director of the NACD, Mairéad Lyons and to the present interim Director, Susan Scally for their painstaking work in bringing this report to completion.

Dr Des Corrigan

Chairperson, NACD

Acknowledgements

Drug use and sex work/prostitution are stigmatised and hidden in Irish society, therefore we are very grateful to the women and men who participated in this research and who gave of their opinions and experiences so honestly and candidly. We hope that this research may heighten awareness of some of the day-to-day issues affecting you and lead to an improvement in your living and working conditions.

This study would not have been possible without the help of key specialist agencies (in particular: The Women's Health Project, Ruhama, Chrysalis, Gay Men's Health Project, UISCE, Progression Routes, Dóchas) who helped to locate participants for this research.

We are also very grateful to the staff of the various services and other professionals who generously responded to our request for an interview and who provided private facilities for the interview.

Grateful thanks are expressed to the Research Advisory Group for their continued support and advice throughout the duration of the research:

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Jean Long (NACD/HRB)

Barry O'Brien (NACD/An Garda Síochána)

Paul Ryan (NUI)

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Gratitude is expressed to Sheena Duffy who transcribed the audio-taped interviews and appreciation is expressed to the Secretariat of the NACD who assisted in the production of this report. We are indebted to the former Director Mairéad Lyons and the present interim Director Susan Scally for their support and assistance in carrying out this research.

Glossary of Colloquial Terms

Benzos	Benzodiazepines: a class of psychoactive drugs. Benzodiazepines can be divided into two groups: Anxiolytics (anti-anxiety drugs such as Diazepam, Loreprazepam and Chlordiazepoxide) and Hypnotics (sleep-inducing agents such as Flurazepam, Nitrazepam and Triazolam).
Binge	To take a large amount of drugs in one session
Chasing	
/Chasing the Dragon	Heating heroin on aluminium foil and inhaling the heated vapours
Coke	Cocaine
Cold Turkey	Giving up a habit or an addictive substance all at once
Comedown	The physical effects when drug starts leaving body
Crack	A solid, smokable form of cocaine formed by dissolving powder cocaine (cocaine hydrochloride) in water to which an alkali (such as ammonia, baking soda (sodium bicarbonate) or sodium hydroxide) is added; the mixture is heated and then dried into hard smokable lumps or 'rocks'. The vapours are then smoked using a pipe or tooter.
Detox	Detoxify from drugs
Fix	To inject on self with a narcotic or take drugs – usually used with the indefinite article as in 'a fix'
Gaff	House/own home
Gear	Heroin
Gonner	'You're a gonner': you're going to die
Goof/Goofing off	Being in a state of sedation
Hit	Used in the sense of to give you drugs – 'they'll even get you a hit'
Hold you	Used in the context of 'At the time Phy would kind of hold you for two days. So it was better than the heroin'; in other words, the person won't suffer from withdrawal symptoms when taking methadone.
Holistics	Complementary therapies such as acupuncture, massage
IV-ing	Injecting drug intravenously
Jump-overs	Jumping over a counter in order to rob a shopkeeper
Junkie	Heroin addict
Mainlining	Injecting a drug directly into a major vein/ intravenously

Opiates	Opiates are derived from opium which is the strong milky latex extracted from the fruit of the opium poppy. Opium contains morphine and codeine which are strong painkillers.
Phy	Physeptone (Methadone)
Polydrug	Polydrug use refers to the use of at least two substances (e.g. heroin and cocaine) during the same time period.
Poppers	Street name for various alkyl nitrites, including isobutyl nitrite, butyl nitrite, and amyl nitrite; they are used as a stimulant producing a brief euphoric effect.
Punter	A person (usually male) who buys the services of a sex worker, also referred to as customer or client
Reg	Car registration number
Rent Boy	A young man who is paid for sex
Score	Acquire drugs
Skin-pop	Subcutaneous injecting
Speedball	Combining cocaine and heroin
Strung out	'Addicted' to a drug, usually heroin
Turn On	Usually used to describe an iv episode
Use/Using	Injecting drugs
Works	Injecting equipment

Acronyms

ACMD	(British) Advisory Council on the Misuse of Drugs
BBV	Blood-Borne Virus
B&B	Bed and Breakfast
CBT	Cognitive Behavioural Therapy
CE	Community Employment
CSO	Central Statistics Office
D/CRAGA	Department of Community Rural and Gaeltacht Affairs
DAIS	Drug and Alcohol Information System
DOH	Department of Health and Children
DTCB	Drug Treatment Centre Board
DTSR	Department of Tourism, Sports and Recreation
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GLEN	Gay, Lesbian, Equality Network
GUIDE	Genital Urinary and Infectious Diseases Clinic

HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSE	Health Service Executive
IDU	Injecting Drug User
LDTF	Local Drugs Task Force
NACD	National Advisory Committee on Drugs
NDS	National Drugs Strategy
OD	Drug overdose
RAG	Research Advisory Group
ROSIE	Research Outcome Study in Ireland
SPSS	Statistical package for the social sciences
STI	Sexually Transmitted Infection
SWAI	Sex Workers Alliance Ireland
SWIPING	Services for Women Involved in Prostitution Interagency Networking Group
TR	Temporary Release from prison
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	UN HIV/AIDS programme
UNGASS	UN General Assembly Special Session (26th, on HIV/AIDS)
WHO	World Health Organization

Statutes

The Criminal Law (Sexual Offences) Act, 1993, Dublin: Stationery Office

Medical Preparations (Control of Amphetamines) Regulations, 1970

The Misuse of Drugs Act 1977 (controlled Drugs), Dublin: Stationery Office

The Misuse of Drugs Regulations 1984, Dublin: Stationery Office

The Children Act 2001, Dublin: Stationery Office

Executive Summary

Introduction to the Research

The National Advisory Committee on Drugs (NACD) provides advice to the government in relation to the prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland based on its analyses of research findings and information. Action 98 of the National Drugs Strategy requires the NACD to carry out research on drug misuse among at-risk groups, including prostitutes/sex workers. In response, the NACD undertook this study to explore female and male problematic drug-using sex workers' lived experience of risk, and how the risk environment can mediate the individual's capacity to reduce the risk of harm. The concept of the risk environment was broadly defined as comprising risk factors that are external to the individual. Thus, the 'environment' encompasses not only the physical space within which drug-using sex workers live and work, but also the social, economic and policy environment.

The key findings of this report are that drug-using sex workers are exposed to multiple risks and harms in their living and working lives. While the men and women interviewed implemented a range of innovative strategies to reduce their risk of harm, there is an acceptability associated with certain risk behaviours in certain circumstances. The physical, economic and social environments within which drug-using sex workers find themselves impact on their construction of 'risk' and 'harm'. For example, the social organisation of risk means that what from the outside may be perceived as being risk behaviour can to members of the social network serve important social/group functions. In order to enable individuals to effectively reduce their risk of harm, policymakers and service providers need to focus and redirect interventions towards the risk environment, in particular the social situations and places in which harm is produced and reduced. As a client group, drug-using sex workers have multiple, interlocking needs that span health, social and legal issues. Therefore, addressing their wider social and situational needs such as poverty, housing, educational needs and employment prospects are as fundamental to reducing their risk of harm as addressing their drug use.

Research Objectives

The overall aim of the research was to gain an understanding of the local risk environment (i.e. the physical, social, economic and policy environment) within which problem drug-using sex workers in Dublin live and work and how they perceive and behave in response to risk.

In the qualitative interviews among drug-using sex workers the specific questions that the research sought to answer were:

- What aspects of the physical, social and economic environment produce risk in their everyday lived experiences and lifestyles associated with drug use?
- What aspects of the physical, social and economic environment produce risk in their working lives?
- What strategies do drug-using sex workers implement to reduce the risk of harm?
- What are the barriers to their attempts to reduce the risk of harm in their daily lives?

In the qualitative interviews among professionals, answers were sought to the following questions:

- What are their perceptions of drug-using sex workers as a client group?
- What changes have occurred recently in drugs and sex markets that increase risks?
- What are the obstacles to effective service provision for drug-using sex workers?
- How does the (micro and macro) policy environment influence the local risk environment within which drug-using sex workers live and work?

Research Methodology

In order to explore the lived experience of drug-using sex workers a qualitative methodology was chosen. The individual face-to-face in-depth interview was the primary research tool used to collect qualitative data from drug-using sex workers and professionals. To this end:

- In-depth interviews were carried out with 35 drug-using sex workers. In addition, biographical data were collected by means of a short questionnaire. The questionnaire also recorded information on participants' recent drug use and offending behaviour.
- In-depth interviews were carried out with 40 professionals across sectors (community, voluntary and statutory) from a range of disciplines who work either directly or indirectly with drug-using sex workers.

All interviews were recorded and fully transcribed. Inductive analysis of the qualitative data was facilitated by the use of QSR NVivo software, and quantitative data were analysed using the statistical package for the social sciences (SPSS).

Ethical permission was sought and granted by the Drug Treatment Centre Board.

In accordance with NACD policy on research, a Research Advisory Group (RAG), comprising representatives of the NACD and various relevant agencies and services, was established. The primary role of the RAG was to guide and manage the research project from inception to completion and to assist in locating and recruiting research participants.

Summary of Research Findings

Profile of Research Participants

Biographical data were collected from drug-using sex workers by means of a short questionnaire.

- Of the 35 drug-using sex workers interviewed, 31 were female. The remaining 4 participants were male; three of whom self-identified as being gay.
- The average age of participants was 32 years (median age 29 years) and most (68 per cent) were parents.
- One in four study participants was homeless at the time of interview; living in some form of emergency accommodation (e.g. hostel, Bed and Breakfast [B&B]).
- Even though most (88 per cent) of the men and women were in receipt of methadone maintenance treatment at the time of interview, levels of self-reported drug use were high. Approximately two-thirds of the participants reported recent heroin use (65 per cent), over a quarter reported recent cocaine use (29 per cent), and 15 per cent reported recent crack cocaine use. Analysis revealed that self-reported drug use was highest among those who were actively engaged in sex work at the time of interview.
- Levels of reported contact with health services were high (64 per cent); but so too were levels of self-reported Hepatitis C Virus (HCV) (78 per cent) and Human Immuno-deficiency Virus (HIV) (21 per cent) infection among the men and women interviewed.

Growing Up in a Risk Environment

- Most of the men and women grew up in inner-city working-class communities in Dublin in the 1970s and 1980s, which were characterised by high rates of intergenerational unemployment, low levels of educational attainment, social deprivation and economic marginalisation. It was within these marginalised communities that the circulation and economics of heroin were heavily centred.
- In addition, the majority of participants had adverse life experiences in their childhood and early adolescence, relating to one or more of the following areas: family conflict, chaotic home environment, parental and/or sibling substance use, child physical and/or sexual abuse, experience of being in care and/or youth homelessness, early school leaving, bereavement, and traumatic life event(s).
- To a large extent participants' formative years were characterised by vulnerabilities and exposures that made them susceptible to, and placed them 'at risk' of, a range of problems entering their late adolescent years.

Early initiation into drug use

- Most of the men and women had multiple opportunities to become knowledgeable about drugs, and they were exposed to a range of substances from an early age. The majority initiated drug use in their

early adolescence through peer or friendship networks, whereby the availability and use of drugs within their social circle facilitated initiation.

- Many experimented with a range of substances, starting with alcohol and cannabis, progressing on to amphetamines and ecstasy; some reported taking heroin to ease the ‘come down’ from ecstasy. However, a significant minority of the women interviewed had limited experience of drug use when they first took heroin, usually in their early teens.
- In most cases participants progressed from smoking or ‘snorting’ heroin on to injecting; many were largely unaware of becoming opiate dependent. However, participants’ drug use was not confined to heroin; the men and women had extensive drug-using repertoires, which continued once they were opiate dependent.

Entering sex work

- All the men and women interviewed were dependent heroin users prior to engaging in sex work; a significant minority were minors at the time.
- There were a variety of entry routes into sex work; the dominant route being through peer or friendship networks. This often happened when the person had financial problems and their friend/acquaintance paved the way for them to become involved in sex work. For a significant minority of participants this introduction happened while homeless and/or staying in emergency accommodation.
- For most of the participants the primary rationale for engaging in sex work was economic; to ‘make ends meet’ and/or ‘for the sake of me habit’. Sex work provided a source of income and hence financial independence. Moreover, it was often considered less risky than alternative sources of income, such as drug-dealing and shop-lifting.
- The interface between participants’ drug use and their sex work was complex. The men and women interviewed needed a continual source of funds to maintain their (often multiple) drug dependency. For most, sex work proved very lucrative in this regard. However, the increased income obtained from sex work invariably contributed to an escalation in drug use.

Living in a Risk Environment

Risk production

There are a range of behaviours associated with drug use and its accompanying lifestyle which place an individual at risk of harm. The likelihood and extent of these drug-related harms are mediated by the interaction of a range of individual, social, environmental and structural factors, which comprise the risk environment.

Drug use

- Injecting drug use, in particular, is associated with a range of adverse health consequences. Among the study participants (and professionals), injecting cocaine was considered particularly risky; it was associated with frantic, high-frequency injecting, binge use, extensive vascular and tissue damage and, for some, increased risk of sharing used injecting equipment and paraphernalia.
- It is not the injecting drug use itself that causes HIV and HCV infection, but the adoption of unsafe and unhygienic injecting (and sexual) practices. While all the men and women interviewed reported using needle exchanges to access sterile injecting equipment, most also admitted to knowingly and/or inadvertently engaging in unsafe injecting practices in the past.
- Most of the men and women interviewed had multiple dependencies and consequently used a range of substances, thus increasing the risk of fatal and non-fatal overdose, the risk of engaging in unsafe injecting practices, and the risk of involvement in crime in order to generate a sufficient income. The women in particular spoke about extensive benzodiazepine use. Alcohol use was also common among both women and men.

Homelessness

- Most of the men and women interviewed had experienced periods of prolonged homelessness, and the majority could be considered homeless at the time of interview (by virtue of their unstable accommodation). For many, their lifestyle hindered them getting appropriate accommodation and/or contributed to them being excluded from emergency accommodation. The precarious and impoverished existence brought on by homelessness places them at further risk of poverty, social isolation, and inadequate access to healthcare and other services. Moreover, homelessness increases the risk of engaging in unhygienic and risky injecting practices. Study participants when homeless were required to inject in public or semi-public places.

BBV infection

- Drug-using sex workers are at risk of blood-borne viral infections; the majority (n=26) of study participants reported being HCV positive, seven were HIV positive and five were HIV/HCV co-infected. Active drug users, with the complexity of needs of the men and women interviewed, are at risk of not receiving (and/or complying with) the appropriate treatment regimes for these blood-borne viral infections. Only one of the study participants reported receiving the combination interferon and ribavirin HCV treatment; three of the participants were receiving HIV triple therapy treatment.

Social networks

- All of the study participants were entrenched in drug-using social networks, which served a variety of positive functions in the lives of the men and women. However, these social networks were also a site

for risk management. Social networks produce risk by influencing patterns of risk behaviour through shared group and social norms. In addition, drug-using social networks often interfered with the individual's attempts to move towards being drug free.

Gendered risks

- The women interviewed had additional risks associated with their reproductive capacity and their roles as mothers: the risk of an unplanned pregnancy, the risk of complications during pregnancy and childbirth due to their lifestyle, the risk of miscarriage and infant mortality and, as primary carers of their children, the risk of parenting alone without the economic and emotional support of a partner.
- For many of the mothers the desire to provide for their children put them at risk of continued involvement in sex work due to the financially rewarding nature of the work. Moreover, the pressures and the financial demands of raising a family placed those who pursued a drug-free lifestyle at risk of relapsing or returning to chaotic drug use.
- The mothers also spoke of the risk of disclosure and the potential consequence to their relationship with their children, if their lifestyles (in particular their work) became apparent.

Risk Reduction

Drug use

- The majority of men and women interviewed implemented a range of strategies in an effort to reduce the risk of harm associated with their drug use. Some strategies were aimed at reducing the prohibitive cost associated with drug use, which in turn reduced individuals' financial need, and their level of involvement in illicit activities. This included changing the route of drug administration (e.g. changing from smoking to injecting because it was cheaper) and replacing one drug with a cheaper alternative (e.g. replacing heroin with non-prescribed methadone).
- Participants also introduced strategies aimed at reducing the risks associated with particular drug-using practices, most notably injecting drug use. Participants spoke of reverse transitioning from injecting to 'chasing' (i.e. smoking), only injecting certain drugs, injecting on their own rather than in a group, selective sharing practices (e.g. only with partner), and accessing needle exchanges.
- All participants in the course of their drug-using careers accessed drug treatment services in an effort to reduce their drug use and the associated harms. Coming off and going back on drugs was an integral part of the lives of the men and women interviewed. Motivations for becoming drug free varied, but a crisis point in life often triggered entry into treatment or renewed attempts to stop using.

Gendered risk reduction

- Most of the mothers tried to reduce their drug use during pregnancy and motherhood. However, motherhood produces many challenges for the drug-using women, who like many mothers were trying

to ensure the best care for their children. In an effort to reduce the risk of harm to their children, many of the women voluntarily put the children in either the informal care of a grandmother or other family member, or into formal care.

Imprisonment

- Prison provided an opportunity for the women in this study to reduce their risk of harm; it gave them an opportunity to access medical treatment, to reduce their drug use, to stabilise and/or reduce their methadone use, to detoxify from benzodiazepines, and to take part in educational courses. For many it provided a respite from the streets. No men were interviewed in prison.

Working in a Risk Environment

- Among drug-using sex workers, their work is an important variable in the management of drug use, in so far as it provides the much needed funds to support their continued drug use. However, there are certain aspects of the environment within which drug-using sex workers operate that produce risk to the individuals.

Risk production

Inexperience

- Sex work like drug use is a learnt behaviour. Consequently, among novice sex workers, their inexperience, lack of knowledge, ignorance of the potential harms, and fear put them at increased risk of harm. When starting out, participants spoke about not knowing where to go to get customers, how to attract customers' attention on the street, how much to charge, how long to spend with a customer.

The physical setting

- The micro-physical environment for drug-using sex workers is the street, apartments or customers' homes. On the street, commercial sexual interactions either take place in cars or in isolated/secluded lanes. These physical settings produce a range of risks.
- Street-based sex workers have an increased risk of violence. Most study participants had experience of street work and the vast majority had been physically and/or sexually assaulted by a customer or had witnessed violence. Street-based sex workers are also at risk of being mugged, of stranger assault and 'gay bashing'.
- Due to the stigmatised nature of sex work and their high visibility on the street, their reputations are constantly at stake and they are continuously at risk of exposure and detection by family/friends and by the Gardaí.

- Cars produce particular risks for sex workers; central locking means that individuals can be trapped and unable to remove themselves from a potentially dangerous situation. Many of the women reported being abducted in cars and physically/sexually assaulted.

Unprotected sex

- Unprotected sex puts sex workers at risk of contracting and transmitting a range of sexually transmitted infections (STIs); it also puts women at risk of an unplanned pregnancy. While the vast majority of study participants reported using condoms some, however, said they had unprotected sex with a customer for extra money. In addition a few respondents reported using condoms without any lubricant thereby increasing the risk of the condom tearing.

Drug use

- All the men and women were active drug users while they engaged in sex work and their drug use produced risks in their working lives. On the one hand, their drug use enabled them to work longer hours and to minimise the level of distress they experienced as a consequence of the work. However, working while 'stoned' affected their ability to negotiate with a customer and increased the risk of engaging in unprotected sex, of reducing their costs and of being unable to assess the potential dangers of a situation. Similarly, going out to work when 'sick' for drugs also renders sex workers vulnerable and desperate for money.

Stigma/Shame

- Sex workers often experience discrimination and stigmatisation; drug-using sex workers are doubly stigmatised. This stigma and shame increases the risks of drug-using sex workers not reporting violent crime to the Gardaí, and was often reinforced by some guard's prejudiced and judgemental attitudes. The stigma/shame also prevented some of the men and women from appearing in court because of their fear that it would be reported in the newspapers.

Risk reduction

- The men and women interviewed employed a range of strategies in order to manage and reduce the risk associated with the physical, social and economic environment within which they work.
- Generally, it was through social networks that most entered sex work and it was often these very networks that helped reduce the risk of harm to young uninformed noviciates. Experienced sex workers and sometimes customers gave advice and information on staying safe.

Moving off the street

- Some of the street-based sex workers, in order to reduce the risk of violence and disclosure, moved indoors to what they perceived as being a safer environment. These men and women usually gave their mobile number to regular customers. Moving indoors also meant that they did not have to put in long hours on the streets.

Staying safe on the street

- Others continued to work on the street but implemented a range of strategies to keep safe, such as working in pairs, taking car registration numbers, and reducing work hours. Some had regulars that they trusted. A few of the women said they carried a weapon.
- The men and women emphasised the importance of 'staying in control' while working. This included limiting the amount of drugs they took before work; retaining personal boundaries on what they were prepared to do sexually; having set prices for individual sexual acts; being discerning in their selection and interaction with customers and being prepared to walk away from suspicious clients.

Safe sex practices

- Participants used various strategies to reduce their risks of contracting and transmitting STIs and the risk of unplanned pregnancy. The participants spoke about always using condoms for protection, not only during sexual intercourse but also for orogenital and/or manual relief. Most were aware that they needed different types of condoms for different acts. Some used condoms as barriers to conception and some used condoms as barriers to intimacy. Most of the women availed of the relevant health services for STI screening and check-ups.

Gardaí

- Most of the men and women interviewed were of the opinion that the Gardaí played an important role in reducing the risks associated with street-based sex work. Many actively engaged the Gardaí in their protection and also complied with Garda requests to leave the street.

Exiting sex work

- The men and women interviewed moved in and out of sex work, often as a response to economic necessity and/or changing patterns of drug use. Others moved out of sex work in response to a positive or negative life event. Positive life events that facilitated exiting included pregnancy or the birth of a baby, a romantic encounter and the possibility of a different life, or accessing drug treatment. Negative life events included reaching the point of what is existentially unbearable such as the advent of a HIV positive diagnosis. Of the 35 participants interviewed only four, one man and three women, indicated that they had exited sex work for good.

Barriers to risk reduction

- The men and women identified a number of barriers to their attempts to reduce the risk of harm in their daily lives. These include difficulties navigating their way around the complexity and bureaucracy of the social care and drug treatment systems, inflexible access criteria within services, lengthy drug treatment waiting lists and limited service options.

The Professionals' Perspective

Clients with complex needs

- Drug-using sex workers were perceived by the professionals interviewed as being vulnerable people with multiple and often intractable problems. As a client group with complex needs (as opposed to a 'single need') they move more or less continuously through social, mental health and healthcare agencies, homeless hostels, drug and alcohol services and the prison system.
- The complex needs of this client group are extremely challenging to services, consequently, they frequently experience inappropriate and/or fragmented service responses, often due to the lack of suitable alternatives.

Interagency and interdisciplinary working

- All the professionals supported interagency and interdisciplinary working as a means of addressing the needs of drug-using sex workers. However, this did not always translate into practical strategies to address needs, as the degree of interagency cooperation required was often greater than usual and the spectrum of services broader.
- Identified obstacles to effective interagency and interdisciplinary working included differing professional roles, conflicting professional ideologies, knowledge, skills and competence deficits, and inconsistencies in working practices.

Changes in drug and sex markets

- Environmental conditions and different local risk environments shape the introduction of policies and responses as well as their implementation and impact. Changes in drug and sex markets have a direct impact on the ability of professionals to deliver effective services.
- The professionals were of the opinion that changes in the local drugs market, most notably the increased availability and use of cocaine, in particular cocaine injecting, has led to an increase in drug-using risk behaviour among this client group.
- Many of the professionals reported that sex work has become less visible in Dublin due to a number of factors, including technological advancement and the use of mobile phones and the internet by sex workers, and the regeneration and gentrification of parts of the city, disrupting long-established sex markets. Consequently, it is harder for outreach workers to locate and engage with this client group.

Drug policy

- In the past, problem drug using in Ireland was associated with ‘opiate users’ or more specifically ‘heroin users’. However, the current pattern of combined or sequential use of a range of drugs (including cocaine, crack, benzodiazepines and alcohol) by opiate-dependent individuals renders this notion of ‘heroin users’ as somewhat inaccurate. Harm reduction interventions, such as needle exchange programmes, methadone maintenance and outreach, while effective in reducing some of the associated harms, are hampered by lengthy waiting lists, inadequate detached outreach, staff embargoes, lack of out-of-hours services and limited access to detoxification and rehabilitation services.

Housing/Homeless policy

- Non-health related interventions such as housing and homeless policies form part of a harm reduction praxis. Moreover, the physical environment within which drug-using sex workers live influences their health vulnerability and their susceptibility to drug-related harms. The problems of exclusion and unmet housing needs of problem drug users have generated a range of innovative policy responses. Nonetheless, difficulties in accessing emergency accommodation, particularly out-of-hours, rigid policies of exclusion for drug use and clients’ non-compliance with hostel policies were highlighted. The inadequacy and inappropriate use of B&B accommodation and the private rented sector (which provides no ancillary support) was also identified as an issue for this client group. Transitional housing was considered beneficial but difficult to access and in short supply. Finally, two specific groups that were identified as being at risk of re-entry into homelessness were those leaving prison and those leaving in-patient drug treatment.

Conclusions and Recommendations

This is the first Irish study which uses a qualitative methodology to explore and understand the local risk environment (i.e. the physical, social, economic and policy environment) within which problem drug-using female and male sex workers live and work in Dublin and how they perceive and behave in response to risk. Despite the recognition of environmental determinants of health, the primary focus of harm reduction interventions for drug-using sex workers in Dublin centres on individual risk behaviour change. This emphasis on individualism (and behavioural interventions) overlooks the importance of the wider social situations and structures within which individuals find themselves and their impact on the construction of ‘risk’ and ‘harm’. Focusing on the risk environment encourages us to think about the social situation and places within which harm is produced and reduced. Using the broad framework of the risk environment as a guiding principle, the following key recommendations emerged from the research.

The Policy Environment

Despite some diversity in the interpretation of the term, *harm reduction* is expanding globally and has been adopted explicitly as the principle for national drug policy in a number of countries and is imbedded in international policies and commitments. Given the risks of blood-borne viral infections and the impact of the resulting morbidity and mortality on the individual and community, it is recommended that:

- **Harm reduction be explicitly stated as a guiding principle in the new National Drugs Strategy.** As the effectiveness of stand-alone interventions such as needle exchange and methadone maintenance are compromised in the absence of a continuum of harm reduction activities it is vital that the National Drug Strategy also:
 - a. **outlines the need for a continuum of harm reduction activities**
 - b. **provides an operational definition and strategy for harm reduction by providing a model package of harm reduction** interventions, minimum standards for services and optimal levels of service coverage.

The Social Environment

Drug taking, sex work and the associated risk behaviours are affected by the social environment, which includes the contextual forces, norms and social relationships within which individuals interact and function. The social organisation and context of risk behaviour highlight the importance of working with networks of drug users (and sex workers) in order to bring about changes to reduce the risk of harm in the immediate micro-social environment. To this end it is recommended that:

- **existing peer networks and peer-based learning strategies are continually funded**
- **secondary or peer-based outreach be developed, piloted and evaluated in areas of the city with known networks of drug users and drug-using sex workers;** the primary aim being to reduce vulnerability among sex worker entrants and to ensure that sex work does not introduce further vulnerabilities.

Reducing risks to drug-using male sex workers: Services need to address homophobia and heterosexism within service provision; increase awareness that heterosexual males are also involved in sex work; provide outreach to male sex workers in all settings in partnership with the Gay Men's Health Project, and the use of peer workers.

The findings of the research illustrate that in the daily lives of drug-using mothers, their relationship with their child(ren) is an important aspect of risk management. Many of the women found it difficult

to balance the demands of parenting with their drug-using lifestyles and work practices. To this end it is recommended that:

- **services working with problem drug users ensure that the well-being of the child is of paramount importance** by recognising the need to support clients' children, by providing services that are accessible and welcoming to drug users who have children, and by ensuring adequate provision for family and carer support services through including this in service specification
- **research be carried out with drug-using parents and their children to** assess the impact of parental drug use on children and to inform the development of strategies to ensure that mothers and fathers are successful in maintaining and/or re-establishing their role as parents during drug treatment.

The Physical Environment

The physical environment within which drug-using sex workers live and work can exert considerable influence over risk behaviour, the course of blood-borne viral transmission within this population and the effectiveness of harm reduction interventions.

Local drug market: This study highlighted the market shift in local drug availability in the inner city, in particular increased availability and intravenous use of cocaine (and to a lesser degree crack cocaine use) among drug-using sex workers, and its impact on increased risk behaviour. It is recommended that:

- **contingency management** (whereby individuals earn rewards for clean urine samples for drug/cocaine abstinences) – **a strategy proven to be effective in reducing cocaine use in methadone-maintained opiate and cocaine using outpatients – be implemented in all methadone-prescribing clinics**
- **a system of continual monitoring of local drug markets via the establishment of a drug trends monitoring system be established** to ensure that appropriate policy, care and prevention strategies are in place.

Local street sex market: The findings highlighted that the regeneration and gentrification of parts of inner-city Dublin and new technological advancements (such as the mobile phone and the internet) have led to the disruption of long-established street-based sex markets. As a result, sex workers are less visible on the streets, thus making it difficult for under-resourced outreach workers to identify and locate sex workers, learn about their practices, assess their needs and provide appropriate interventions to reduce their risk of harm. It is recommended that:

- **continued funding be provided to specialist services for (drug-using) sex workers**
- **adequate funding of drug and specialist (sex work) Outreach Services be provided to ensure their ability to carry out detached work** out of hours; these Outreach Services should target

existing and developing street sex markets and peer networks of drug users and sex workers rather than individuals

- **the Gardaí, working in partnership with local drug and specialist (sex worker) services in Dublin city, continue to develop strategies to reduce the risk of violence to street-based sex workers;** to that end it is important that Garda trainees receive training in order to increase their awareness of issues surrounding male and female drug use and sex work.

Homelessness is a key social factor that facilitates risk behaviour and health differences among drug users. However, it also influences the immediate physical environment in which drug users live and use drugs because homelessness is a physical environment that produces risk and limits the effectiveness of harm reduction interventions. The findings of the study reiterate the importance of structural interventions such as improved access to housing in creating an enabling environment. To this end it is recommended that:

- **on-site hostel needle exchanges are rolled out** in order to ensure that homeless drug users residing in emergency accommodation in Dublin have adequate access to sterile injecting equipment, paraphernalia, sin bins, condoms, etc.
- **funding and support be given to integrated primary care services for the homeless** to ensure adequate access to on-site primary healthcare for hostel residents and specialist support for hostel staff
- **flexible hostel accommodation be provided for homeless (drug-using sex workers) as part of a range of suitable accommodations from low-threshold facilities to accommodation to facilitate recovery and rehabilitation.**

The Economic Environment

Research has highlighted the uneven distribution of harm according to material, as well as social inequality (Bourgeois, et al. 1997). Economic dislocation can produce an environment extremely susceptible to the rapid spread of HIV and HCV. The economic environment can also hinder or prevent the development and implementation of appropriate harm reduction interventions, or limit the potential impact of such interventions. Employment has been shown to be an important component of rehabilitation and reintegration into sociality for (ex) drug users, and reduces the likelihood of relapse. It is recommended that:

- **programmes (such as specialist CE schemes for drug users) aimed at getting drug users into or back to work should be continually funded and evaluated** in order to provide robust evidence of effectiveness, identify models of good practice and prevent potential unintended negative consequences.

Chapter 1. Introduction

A painting of a pink rose with green leaves on a textured background. The rose is in the upper right corner, with several green leaves extending from it. The background is a mix of light green, yellow, and blue tones, with a visible brushstroke texture.

We didn't have Mommy and
Daddy there all the time,
we didn't have that luxury,
and when we were there
we were beaten up.

Chapter 1. Introduction

1.1 Rationale for the Study

Researching problem drug users and involvement in sex work is difficult because both groups represent hidden populations and both activities are illegal and highly stigmatised; consequently, finding representative samples is almost impossible (Bloor, et al. 1991); (Heckathorn 1997; Kanouse, et al. 1999; Potterat, et al. 1998). Nonetheless, the co-existence of problematic drug use and sex work is well documented. Various international studies have shown that a significant minority of problem drug users engage in sex work. For example, 14 per cent of injecting drug users in London were found to be involved in sex work and 22 per cent in Glasgow (Rhodes, et al. 1993). Similarly in Sydney, 14 per cent of injecting drug users reported having performed sex work for money in the preceding month (Roxburgh, et al. 2005). Likewise, studies have shown that many sex workers are problematic drug users (May, et al. 1999). For example, research among female sex workers in London found that 10 per cent of women working in a variety of locations were current or past injecting drug users (Ward, et al. 1993). Conversely, a study in Glasgow found that 72 per cent of sex workers were injecting drug users (McKeganey and Barnard 1996).

While sex workers are a diverse group with regard to their drug-taking behaviour, research consistently indicates that problematic drug use is substantially higher among street-based sex workers. A similar pattern is evident among male street sex workers who have been found to report higher levels of drug use than non street-based sex workers (Minichiello, et al. 2001). Estimates range from between 57 per cent to 90 per cent of female street sex workers engaging in injecting drug use, and between 46 per cent to 96 per cent being dependent on illicit drugs (Roxburgh, et al. 2008). For example, 93 per cent of a sample of street sex workers in Glasgow reported having ever injected a drug and 84 per cent of the women surveyed were current heroin users (Taylor, et al. 2008). Roxburgh et al. (2008) found that 94 per cent of their sample of female street sex workers in Sydney reported injecting drug use. There is also evidence suggesting that women move to street-based sex work from indoor markets due to problematic drug use (Hunter and May 2004).

Currently, there are no reliable estimates on the number of problem drug-using street sex workers in Dublin.¹ Findings from the ROSIE study (Research Outcomes Study in Ireland) (Comiskey and Cox, 2007) reveal that 9 per cent of opiate users starting a new treatment episode reported having ever solicited/

1 There is a much-cited estimated Garda figure for problematic drug using women involved in prostitution on the streets in Dublin in 1999 of 400 (Lawless et al. 2005). However there is no written record detailing how this estimate was derived. The Women's Health Project had contact with 98 drug using women involved in prostitution in 2008 (Personal communication with Linda Latham, WHP, April 2009).

sold sex and 4 per cent reported recent (last 90 days) involvement in sex work. Among the female study participants, self-reported involvement in sex work was substantially higher; 23 per cent of the women reported having ever sold sex and 14 per cent reported recent involvement in sex work. A survey of female street sex workers in Dublin found that, in line with the international literature, the vast majority (83 per cent) were injecting drug users (O'Neill and O'Connor 1999).

International studies that compared injecting drug users who are sex workers with injecting drug users who are not, have found that those who are involved in sex work initiate injecting drug use at a younger age (Roxburgh et al., 2005); report more frequent injecting (Gilchrist, et al. 2005) and sharing of injecting equipment (Gossop and Powis 1995); report more frequent cocaine use (Logan et al., 1998) and dependence on a greater number of drugs (Young, et al. 2000); and are more likely to report injecting related problems (Roxburgh et al., 2005).

In addition, the literature suggests that sex workers who are problem drug users (in particular injecting drug users) have higher rates of HIV (Darrow, et al. 1991) and HCV infection (Harcourt, et al. 2001), are more likely to be homeless (Paone, et al. 1999), have poorer safety outcomes of the sex encounter (Barnard 1993a; Barnard 1993b; Minichiello, et al. 2001), have high levels of depressive health symptoms (Alegria, et al. 1994; Kidd and Krai 2002; Paone, et al. 1999), are at greater risk of violence (Hester and Westmarland 2004; May, et al. 1999; Sanders 2004), and have more contact with the criminal justice system (Hester and Westmarland 2004; Logan, et al. 1998) than sex workers who are not problematic drug users. In short, problem drug users involved in sex work are more marginalised. Moreover, research from the UK suggests that dependent drug use may be a key factor for engaging in risk behaviour, rather than sex work *per se* (Gossop et al 1995), and drug use has been identified as an important predictor for poorer outcomes for sex workers (Maher 1997).

Interventions aimed at reducing the harms associated with problem drug use (and sex work) tend to focus on individual risk behaviour change and individually orientated models of change, often failing to recognise how risks and their perceptions are context laden (Bloor 1995; Rhodes 1995). Moreover, the success of these interventions is largely dependent on the relativity of risk and on variations in population behaviour in different social, cultural, economic, legal, policy and political environments. Although it is well documented that local risk environments can limit the impact of HIV prevention interventions (i.e. transition towards cocaine injecting and its influence on injecting risk behaviour) and that social conditions influence health and health-related behaviour, there remains an absence of adequate knowledge and understanding of the contextual and behaviour dynamic surrounding the experiences of problem drug-using sex workers in Ireland. There are conditions that affect risk factors, or the 'risk of risk'; the circumstances of people's lives that shape their exposure to risk factors, and/or make it difficult for

them to avoid such risk factors. Focusing on the social and physical risk environment of problem drug-using sex workers would enhance our understanding of people's needs within these circumstances. Risk behaviour is best thought of as an outcome of a variety of individual and social/environmental factors interacting together, rather than simply an outcome of an individual's choice and actions. International research highlights problem drug users working in prostitution as a highly marginalised group, vulnerable to a range of harms.

1.2 Background to the Study

The National Advisory Committee on Drugs (NACD) advises the government in relation to the prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland based on its analyses of research findings and information. Action 98 of the National Drugs Strategy (2001) requires the NACD:

To carry out studies on drug misuse amongst the at-risk groups identified e.g. Travellers, prostitutes, the homeless, early school leavers etc. including de-segregation of data on these groups. It is essential that the individuals and groups most affected by drug misuse and those involved in working to reduce, treat and prevent drug misuse have immediate access to relevant statistical information.

In response, the NACD undertook this exploratory study, the results of which provide an understanding of the local and micro-risk environment within which problem drug-using sex workers in Dublin live and work.

1.3 Definition of Terms

Problem/problematic drug user: The definition of problem drug use employed in this study is that used by the National Drugs Strategy (NDS 2001) which emphasises the harm to the individual taking the drug. To this end problematic drug use is regarded as drug use that causes 'social, psychological, physical or legal difficulties as a result of an excessive compulsion to continue taking drugs'.

Sex worker: When presenting the data in this study the term sex worker² is used because the men and women interviewed in this research usually described themselves as 'working'. It was considered important to respect study participants' right to self-identify. Moreover, the term sex work is also used by the World Health Organisation (WHO 2001; WHO 2005) and the United Nations (UN 2006; UNAIDS

2 Not all members of the Research Advisory Group agreed with the term 'sex worker', some preferred to use the term 'prostitute'.

2002). However, when discussing the published literature, the terms 'sex work' and/or 'prostitution' are used in line with the cited research.

In this study the term sex worker refers to a woman or man who exchanges or trades sexual acts for money over a sustained period of time. The authors recognise that sex workers may start and stop opportunistically, or engage in sex work in response to fluctuating circumstances or lifestyles (Cusick, et al. 2003). Consequently, individuals are considered to have exited sex work if they have not engaged in sex work over the preceding 90 days.

The risk environment: The theoretical framework used in this study is derived from Rhodes (2002) who describes a 'risk environment' as:

... the space – whether social or physical – in which a variety of factors interact to increase the chance of drug-related harm ... this model of risk environment comprises of two key areas: *types of environment* (physical, social, economic, policy) and *levels of environmental influences* (micro, macro)

Thus, the risk environment comprises risk factors that are external to the individual, such as policies, laws, economic conditions and wider cultural beliefs (Rhodes and Simic 2005). A broader understanding of the 'risk environment' is provided in Chapter Two.

1.4 Study Aims and Objectives

Aim

To gain an understanding of drug-using sex workers' lived experience of risk, in order to understand how the local risk environment (i.e. the physical, social, economic and policy environment) produces risks in their lived and working lives, and how drug-using sex workers implement strategies to manage and reduce the risk of harm.

Objectives

- To identify aspects of the physical, social, and economic environment that produce risk in drug-using sex workers every day lived experiences and lifestyles associated with drug use;
- To identify aspects of the physical, social, and economic environment that produce risk in drug-using sex workers' working lives;
- To identify strategies drug-using sex workers' implement to reduce the risk of harm;
- To identify barriers to drug-using sex workers' attempts to reduce the risk of harm in their daily lives;
- To identify how the (micro and macro) policy environment influences the risk environment within which drug-using sex workers live and work from the perspective of the professionals involved;

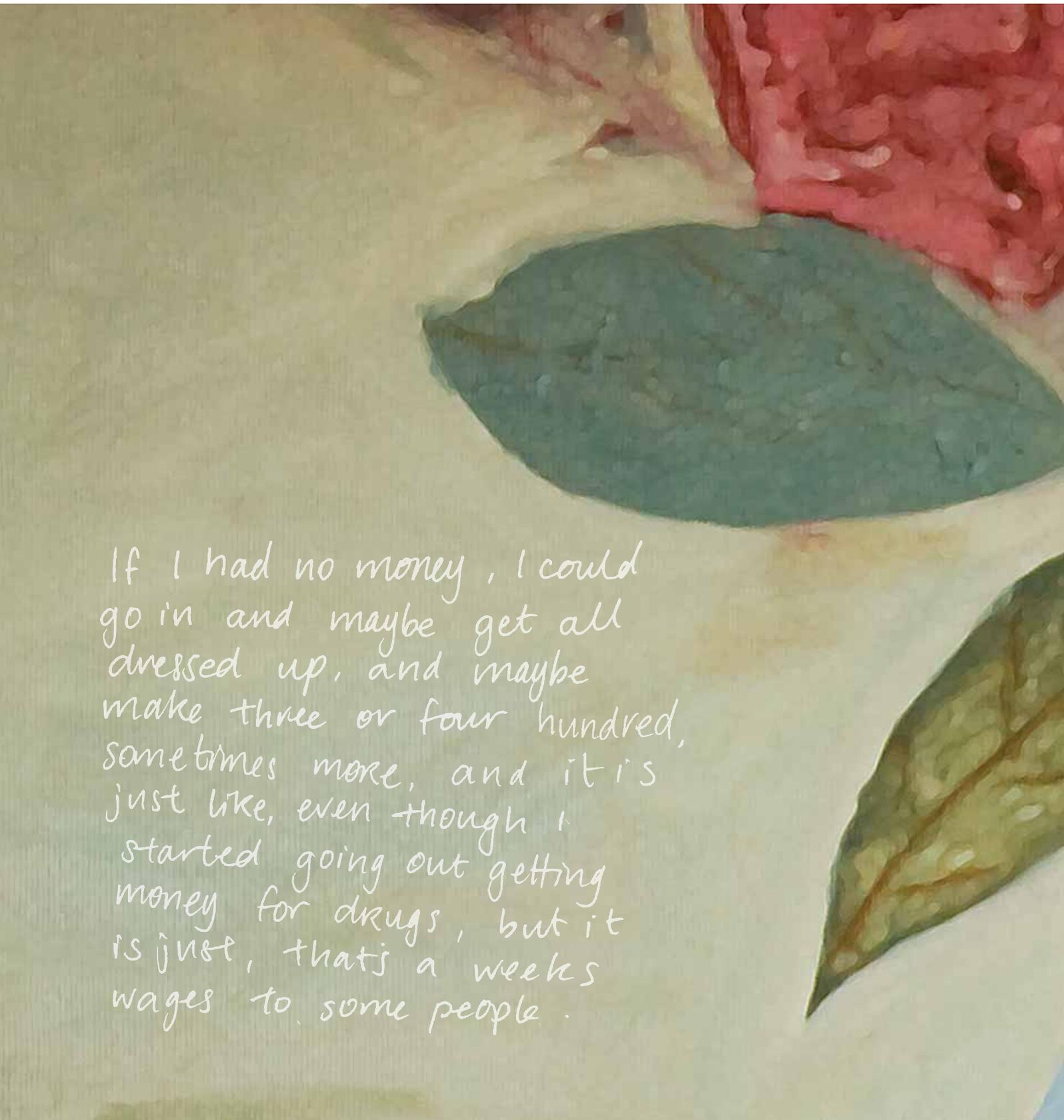
- To explore service providers' perceptions of drug-using sex workers as a client group;
- To explore service providers' perceptions of changes that have occurred recently in drugs and sex markets that increase risks, and;
- To provide recommendations aimed at creating an enabling environment.

1.5 Structure of the Report

This report endeavours to understand drug-using sex workers' lived experience of risk; the aspects of the physical, social, economic and policy environment that produce risk; how drug-using sex workers reduce the risk of harm; and to make recommendations on potential strategies and interventions to reduce the risk of harm by eliciting sex workers' opinions and the opinions of key professionals (from drug treatment services, homeless services, health services, criminal justice services, those who provide specialist services for sex workers and other relevant experts) in the field.

Chapter Two presents a brief review of current literature and places the study in context. **Chapter Three** outlines the methodology and methods that were employed to achieve the objectives of the study. A qualitative methodology was used which involved in-depth face-to-face interviews. The design and operation of the research instruments are discussed and a demographic profile of the women and men interviewed is presented. **Chapter Four** briefly describes the early lives of the men and women interviewed; it explores the range of risk factors present in their childhood and adolescent years; their initiation into drug use, transitions on to dependent use and routes into, and motivations for, involvement in sex work. **Chapter Five** explores how the risk environment influences the behaviour of drug-using sex workers in Dublin. The chapter is divided into two sections: the first explores what produces risk and how participants reduce the risk of harm in the context of their everyday lived environment and the lifestyle associated with their drug use; the second focuses on the working lives of participants and explores how the physical, social and economic environment within which the men and women work gives rise to and influences risk behaviour and how participants manage risk. **Chapter Six** explores how (micro and macro) policy influences the risk environment within which drug-using sex workers live and work from the perspective of professionals whose work directly or indirectly impacts on this client group. The report concludes with **Chapter Seven** where recommendations are presented that could assist in creating an 'enabling environment' for harm reduction.

Chapter 2. Harm Reduction and the Risk Environment



If I had no money, I could go in and maybe get all dressed up, and maybe make three or four hundred, sometimes more, and it's just like, even though I started going out getting money for drugs, but it is just, that's a weeks wages to some people.

Chapter 2. Harm Reduction and the Risk Environment

Introduction

Many of the harms associated with drug use and sex work stem from risk environments created by the social, economic and legal conditions within which the drug and sex trade occurs. Some of these harms can be reduced through effective and timely harm reduction policies and strategies. This chapter explores the concept of harm reduction and teases out the meanings of 'risk' and 'harm' and the relationship between harm reduction and public health policy. Thereafter, the theoretical framework within which this research is analysed – the risk environment – is discussed. This chapter goes on to explore the macro Irish social structure (social, environmental and legal environment) in which risk is produced and harm is reduced through examining the existing research, policy context, laws and macro-economic issues in relation to drug use, sex work and health issues in Ireland.

2.1 Harm Reduction

Harm reduction emerged as a policy response to the spread of HIV among injecting drug users (Strang and Stimson 1990). It provides a framework for identifying a range of strategies to target the consequences of drug use, rather than drug use *per se* (Roche, et al. 1997). Harm reduction emphasises short-term pragmatic goals over long-term idealistic goals. Consequently, it is neutral regarding the long-term goals of interventions, which is not to say that the eventual goal of a harm reduction approach may not include abstinence (Single, 1995). The harm reduction approach to drug use therefore attempts to identify, measure and reduce the adverse consequences of use – even though the user continues to take drugs – at the individual, community and societal level (Reily and O'Hare 2000). Conceiving of harm reduction in this way means that abstinence-orientated programmes and the use of criminal law to deter any drug use would not be considered 'harm reduction' measures (Single, 1995).

Thus, at a conceptual level harm reduction maintains a value-neutral and humanistic view of drug use and the user, focusing on the associated problems rather than on use *per se*. At a practical level the aim of harm reduction is to reduce the more immediate harmful consequences of drug use through pragmatic, realistic, non-judgemental and low-threshold services. At a policy level, harm reduction generated 'a patchwork quilt of middle-range policy measures' (Cheung 2000) that match a wide spectrum of patterns of drug use and problems and can be accommodated within the existing larger drug policy framework. It

is important to note that harm reduction is inextricably tied to local culture and politics (Cohen 2003); consequently, no two systems of harm reduction will be identical.

2.1.1 Risk and Harm

A precise definition of risk refers to the rate at which some event occurs in the population;³ thus, risk refers to the chances or ‘probability’ that a specific event will occur. A second very different and less precise definition of risk involves the notion of ‘uncertainty’, where the probability of an event occurring cannot be calculated, particularly in the short term. In common parlance, the distinction between the two meanings of risk is often blurred (Campbell, 2003).

Within a harm reduction framework, the term risk is used to describe the probability of drug-taking behaviour resulting in any of a number of consequences (Newcombe 1992). The term ‘harm’ is used if a particular consequence is viewed as negative, and the term ‘benefit’ if a consequence is viewed as positive. Some of the harms associated with drug use relate to the substance itself (i.e. the drug being used), others are associated with the technique of drug use (and the paraphernalia used), and some are associated with the context in which the drug is used (Strang, et al. 1999). The harm or consequences of drug use are usually conceptualised as being of three main types: health (physical and psychological), social and economic (occurring at an individual, community and/or societal level) (Reily and O’Hare, 2000).

It is important to note that risk does not refer to the magnitude of harm; in other words, the probability of harm and the magnitude of harm are not the same. Generally, the more serious the probable harm the less tolerance the public have for engaging with the risk (Campbell 2003). Harm can be described along a continuum; for example, the degree of liver damage, or the degree of family breakdown. Some drug-related harm is regarded as a single event of harm, such as the risk of HIV or HCV infection for injecting drug users. Other harm is cumulative; for example, the liver damage associated with cirrhosis. ‘Risk factors’ denote the elements that invite ‘risk behaviour’ and the outcome is a form of harm. Epidemiologists typically refer to the determinants of risk as ‘risk factors’.

2.1.2 Harm Reduction and Public Health Policy

Harm reduction falls into the conceptual framework of health promotion, with the minimisation of risks and harms forming one part of a broader continuum of strategies to promote health and avoid disease (Reily and O’Hare 2000; Rhodes 2002). Both approaches emphasise the importance of respecting individuals and empowering them to increase opportunities to maximise their health, whatever the circumstances. They emphasise the importance of understanding the broader determinants of health

3 That is, the numerator is the number of times a specific event, such as death, occurs and the denominator is the size of the population to which the event refers. The rates are often reported in terms of a common base such as 100,000 (Campbell, 2003).

and ensuring cost-effective approaches to the well-being of the entire population (Reily and O'Hare 2000). Moreover, harm reduction has been held up as a model of public health, in so far as jurisdictions that successfully controlled HIV transmission among injecting drug users have adopted interventions in keeping with effective public health (Ball 1998).

Key harm reduction interventions and policies that are in keeping with public health principles include syringe exchange and legal access to injecting equipment (Cox, et al. 2000; Des Jarlais, et al. 1998; Gibson, et al. 2001); low threshold treatment including methadone and other substitution programmes (Millson, et al. 2007), outreach interventions (Corr 2003; Coyle, et al. 1998; Single 1995), peer, social network and group interventions (Latkin, et al. 2003b) and public policies supportive of such interventions.

A number of countries have adopted harm reduction as both policy and practice. For example, the British Advisory Council on the Misuse of Drugs (ACMD), in response to the spread of HIV among injecting drug users, revised its policy on drug use to one of harm reduction by stating that '... the spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, services that aim to minimise HIV risk behaviour by all available means, should take precedence in development plans' (ACMD 1988). Conversely, it has been argued that the Irish approach to harm reduction has been somewhat ambiguous (Butler and Mayock 2005) and less explicit.

2.1.3 Harm Reduction and Sex Work

Although harm reduction is most commonly applied to reducing drug-related harm, the principles are increasingly being applied to sex work. The harms associated with sex work include the vulnerabilities that may lead to sex work, the harms that are introduced by engaging in sex work, and the mutually reinforcing harms such as problem drug use (Cusick, 2006). The nature and extent of sex work harm varies with the type of sex market. When sex markets have been directly compared the harms introduced by sex work are primarily concentrated in the street-based sex markets (Plumridge and Abel 2001) and where sex workers' pre-existing vulnerabilities can be exploited (Cusick, et al. 2003). As with drug use, the broader sex work risk environment is the crucial factor for controlling exposure and vulnerabilities to the harm that sex work may introduce.

Harm reduction interventions can and have been used to reduce sex work related harm, using techniques to inform, educate, communicate, reach out and motivate (WHO 1995; WHO 2005). Successful interventions include peer education, training in condom-negotiating skills, safety tips for street-based sex workers, the prevention-care synergy, occupational health and safety guidelines for brothels, self-help organisations, and community-based child protection networks (Rekart 2005) and 'ugly mug' schemes operated with local police and health agencies to warn sex workers about dangerous clients (Sanders

2005). Other successful harm reduction strategies include: education, empowerment, prevention, care, occupational health and safety, decriminalisation of sex workers, human rights-based approaches (Rekart 2005) and advocacy (WHO 2005). These pragmatic and practical interventions can improve and enhance the day-to-day lives of sex workers while they continue to work.

2.1.4 Limitations of Harm Reduction Interventions

In practice, the primary focus of most of the aforementioned (drug use and sex work) harm reduction interventions centres on individual behaviour change. The underlying assumption is that reductions in risk behaviour can be achieved by changing the knowledge, attitudes and beliefs of those who engage in, or are likely to engage in, risk behaviour and providing them with the means to reduce their risk (e.g. sterile injecting equipment, condoms). In theoretical terms, 'rational decision-making' and 'reasoned action' theories predominate, which Rhodes (2002) argues promote the conception of risk as a product of cognitive health beliefs and reasoned risk assessment. For example, interventions such as needle exchange and methadone maintenance offer one-to-one interventions that encourage individual behaviour change; they tend to work in the community rather than with the community (Stimson, et al. 1994).

While evaluations of these individually focused interventions, among both in-treatment and out-of-treatment drug injectors and sex workers, report reductions in risk behaviour, the focus on the individualisation of risk reduction and responsibility fails to adequately account for the situated pressures on risk decision-making (Bourgois et al., 1997) and how 'risk' and 'harm' are socially constructed discourses of risk and mortality (Lupton 1993). Risk behaviour is a product of the interplay between individuals, the actions of others and the social and physical environment; therefore, risk behaviour is the outcome of a variety of individual and social factors interacting together.

Individually focused interventions do not sufficiently take into account the influences of the physical, social, economic and policy environment – both at the micro-level and macro-level – on risk behaviour. While there are only a few behaviours capable of transmitting blood-borne viruses such as HIV and HCV there are a myriad of factors which determine whether and how these behaviours occur. Consequently, risk behaviour and risk reduction cannot be simply seen as the outcome of individuals' knowledge, beliefs and behaviours. Focusing on the social organisation of risk, and exploring the relationship between how social structures create risk in individuals' lives and how individuals act in response to risk behaviour recognises that effective risk reduction requires social change, rather than simply changing an individual's behaviour (Rhodes 1997b).

2.2 The Risk Environment

Rhodes (2002) argues that harm reduction interventions developed in the UK offered a ‘weak form of public health’ in so far as the rhetoric of public health implied a shift from individualistic models of behaviour change towards fostering social and environmental change but in practice the majority of harm reduction interventions focus on individual behaviour change. While individualistic interventions aim to encourage aggregate changes across atomised individuals, social interventions aim to encourage diffusion of change within intra-connected groups of individuals and therefore require knowledge of the social organisation of risk (Rhodes and Quirk 1998; Rogers 1983). There is now a well established body of research literature which indicates that individualistic models of intervention are limited in their scope for achieving and sustaining behaviour change. The individual and his/her cognitive set does not evolve in a vacuum but is shaped through interaction with others and by the setting in which action takes place.

In its broadest sense the ‘risk environment’ comprises all risk factors external to the individual. An orientation towards an understanding of the risk environment encourages a focus on the social situations, structures and places in which risk is produced rather than a reliance on a conception of risk as internal to individuals’ cognitive decision-making (Rhodes and Simic 2005). At its most basic level a model of the risk environment comprises two key dimensions: the type and level of environmental influences. Thus, within this framework ‘environment’ is not simply the physical space, and it is not natural or given, rather it is socially constructed in two senses – human actions shape the ‘risk environment’ and human conceptions filter the experience of it (Rhodes, et al. 2005).

An increased interest in exploring the ‘risk environment’ has led to calls for the creation of ‘enabling environments’ so that individual and community change can be brought about by structural prevention (Des Jarlais 2000). This approach advocates all forms of social interventions which can arguably be viewed as extra-individual – in other words interventions that change the context within which risks are produced and reproduced (Rhodes et al., 2005: 1036). Structural interventions are obviously distinct from individual-based interventions in that they seek to change or modify the environment. Des Jarlais (2000) explains:

The environment to be modified may be the social, legal, policy or cultural environment.

Structural interventions do not attempt to modify the knowledge, attitudes and motives of individual IDUs [*injecting drug users*], but rather structural interventions can ‘free’ individual IDUs to act upon already existing motives to practise risk reduction, or can ‘restrict’ individual IDUs from acting on existing motives to engage in HIV risk behaviour.

The ‘risk environment’ is a simple model or explanatory framework for researching multiple environmental factors that produce health and other types of risk. There are four types of environmental influences: physical, social, economic and policy in the context of three levels of environmental influence – micro, meso and macro (Rhodes and Simic 2005). The table below presents an illustrative depiction of the risk environment.

Figure 1: Simple model of risk environment

Environments	Micro-environment	Macro-environment
Physical	Sex work sites (Chapter 5)	Drugs and sex markets (Chapter 5)
Social	Peer and social norms (Chapter 4)	Stigmatisation and marginalisation of social groups
Economic	Income generation (Chapter 5)	Gender and social inequalities
Policy	Distribution of needles, condoms	Policies and laws

2.3 The Risk Environment in Dublin

2.3.1 Macro-environmental Structures in Dublin

The risk environment is a useful framework for conceptualising and understanding the environmental influences that affect the everyday lives of drug-using sex workers in Dublin. Obviously the boundaries and distinctions between the various environments are not rigid and tend to be blurred. The micro-risk environments (physical, social and economic) within which drug-using sex workers grew up, and in which they now live and work, are explicated in chapters four and five. The macro-social, economic and policy environments within which risk is produced are explored in the following sections.

a) *Social environment*

The social environment can produce stigmatisation and marginalisation of social groups such as drug users and prostitutes/sex workers. Stigma can be defined as an attribute that is deeply discrediting which leads an individual to occupy a tarnished and discredited identity and place in society (Goffman 1990 (First published 1968)). International research has shown how marginalised drug users not only experience high levels of discrimination and stigma, but how these multifaceted experiences are associated with poorer physical and mental health (Ahern, et al. 2007). Illicit drug users are stigmatised in Dublin society; research indicates that the position of ‘Drug Addicts’ has deteriorated very substantially in Dublin society during the period from 1972–1973 to 1988–1989; 34 per cent of respondents would deny citizenship to ‘Drug Addicts’. This has serious implications for the acceptance, support and rehabilitation

of this group. Other 'out' groups which are subjected to negative attitudes included Travellers, gays and those with HIV (Mac Gréil 1996). Those with a HIV-positive diagnosis are also stigmatised; 84 per cent of those who are living with HIV agree that people with HIV are viewed negatively by society, whereas 54 per cent of the general public agree with it – they rank it third to drug users and Travellers (Walsh 2006). One in five people would be worried about eating a meal that was prepared by someone with HIV and 37 per cent agree that if a family member were to contract the virus they would keep the HIV status a secret. In a Dublin hospital setting, drug users who were HIV positive also felt stigmatised by nurses (Surlis and Hyde 2001). Those with hepatitis C can also be stigmatised. A study of 87 persons awaiting interferon treatment for hepatitis C in a Dublin hospital felt stigmatised, socially isolated and had a fear of disclosure. There were high levels of stigma experienced by those whose disease was associated with injecting drug use (Golden, et al. 2006).

International research suggests that the stigma attached to sex work and the deviant social status conferred on drug users can result in many people remaining invisible to services (Ahern, et al. 2007; Day and Ward 1997). Drug users who receive treatment for their drug dependency often find it difficult to re-integrate into society. In three studies done in the UK, 76 per cent of drug users described themselves as either drug free and in control, yet their common experience was one of feeling stranded and socially isolated within a drug sub-culture, unable to break through the wall of social exclusion and afraid to be with the non-drug-using population (Buchanan 2004). Furthermore, the stigma attached to HIV is regarded as one of the major barriers to the development of effective prevention and care programmes (Reidpath and Chan 2005). Drug-using sex workers living and working in Ireland who may be HIV or hepatitis C positive or co-infected with HIV and hepatitis C suffer layer upon layer of stigma which can create social isolation that fosters discrimination which in turn can limit their access to legal, health and social services.

Drawing on Irish research the following two sections reveal that there are commonalities and differences in the intersections between gender, drug use, sex work and the social environment in Dublin.

Women sex workers

There have been a number of studies and reports on the issue of women in prostitution in Ireland; most of the research has been Dublin based (Lawless, et al. 2005; O'Connor 1994; O'Connor 1996; O'Connor 2004; O'Connor and Healy 2006; O'Neill and O'Connor 1999). This research showed an increase in drug use over time. Drugs and alcohol are sometimes used as a survival mechanism for working in prostitution. Some may enter prostitution to pay for a drug habit, others may use drugs to work (Lawless, et al. 2005). Research carried out with 84 women involved in prostitution in 1994 revealed that a substantial number used some kind of substance (alcohol – 43 per cent; cannabis – 17 per cent; ecstasy – 11 per cent; cocaine

– 8 per cent; heroin – 6 per cent; methadone – 5 per cent; and sedatives, tranquillisers or anti-depressants – 20 per cent). Most of the women were taking more than one drug; the three women who were on methadone maintenance were also taking heroin. Three were injecting drug users (O'Connor 1996). However, a later survey of 77 street-based prostitutes showed that 87 per cent of the women working in prostitution had a history of drug use and 83 per cent had injected drugs in the last month (O'Neill and O'Connor 1999). Of those surveyed, 38 per cent were receiving methadone maintenance, 10 per cent were using street methadone, 52 per cent cocaine, 21 per cent ecstasy, 66 per cent benzodiazepines, 27 per cent anti-depressants, and 43 per cent cannabis.

Mental health issues were reported by the women: 38 per cent had attempted suicide and 25 per cent suffered from depression and were being treated by a psychiatrist or General Practitioner (GP). In terms of protecting themselves from sexually transmitted infections, the majority reported condom use, nevertheless 12 per cent tested positive for a sexually transmitted infection (STI). In terms of blood-borne viruses, 35 per cent of the women were HCV positive and 11 per cent were HIV positive (O'Neill and O'Connor 1999). A study of 150 prostitutes in Dublin found that injecting drug users had higher seropositivity rates for HIV, hepatitis B or hepatitis C than prostitutes who were not injecting drug users (McDonnell, et al. 1998).

Men sex workers

There have been four studies of male prostitution in Dublin, all of which involved small sample sizes (ENMP 2001; INMP 2001; Kearins 2000; McCabe 2005; Quinlan and Wyse 1997). A study of 27 male sex workers found that the majority (90 per cent) took drugs (alcohol, hash and poppers) and most were polydrug users. Other drugs used were anti-depressants, cocaine, acid, speed, Valium, methadone, glue, heroin/naps and ecstasy. Over a third inject or have injected drugs in the past, of whom five had shared needles, while six stated that they had availed of a needle exchange service. The majority of those who inject or had injected drugs have also had treatment for drug use (Quinlan and Wyse 1997). Over half (14) of the men did not associate their use of drugs with prostitution, while the others (13) did. Men entered prostitution through a variety of routes, including homelessness and being on the streets, through friends who were doing it, and for the money. Service providers were also surveyed and the recommendations highlighted the needs of male sex workers (MSW) and the need for training and special services for male sex workers (Quinlan and Wyse 1997).

Research carried out with 12 male street prostitutes in Dublin revealed that all 12 were drug users (of whom seven used heroin) and had commenced drug use prior to engaging in prostitution (McCabe 2005). Findings concurred with those from other studies: in general male street prostitutes shared a common background of dysfunctional parenting; a childhood of emotional, physical, and sexual abuse; early school

leaving; some homelessness and dependence on heroin; and experience of depression, suicidal ideation and low self-esteem. The mean age at which they started taking drugs was 15 years; the mean age of first having been paid for sex was 21 years. Ten of the 12 male sex workers interviewed described themselves as heterosexual (McCabe 2005). This finding supports other research that men who sell sex may not identify themselves as homosexual and may have overlapping identities (WHO 2001), such as being gay or heterosexual, bisexual and transgendered (Sarma 2007). Homeless gay, bisexual and transgender men are a particularly vulnerable group for substance use and selling or exchanging sex (Cull, et al. 2006).

b) *Economic environment*

There are aspects of the macro-environment, such as economic conditions, social inequalities, and wider cultural beliefs, that interplay with micro-level environmental factors to produce poverty (Rhodes and Simic 2005). For many men and women sex work is an economic response to entrenched poverty, drug dependency and homelessness, and serves as a means of daily survival (Shannon, et al. 2008). Poverty, deprivation, disadvantage and gender and social inequalities continue to persist in Irish society; an EU survey on income and living conditions in Ireland revealed that almost one-fifth (19.4 per cent) of the population was at risk of poverty and that 7 per cent were 'consistently poor'. Persons at risk of poverty live in households where the income is less than 60 per cent of the median at an individual level. Members of lone parent households had the highest consistent poverty rate (31 per cent) in 2004. Poverty is also gendered: the 'at risk of poverty rate' for women was almost 21 per cent in 2004, compared to 18 per cent for men (CSO 2008).

Households with children had higher deprivation rates than those without children. The highest levels of deprivation were in lone parent households, where almost two-thirds of those at risk of poverty experienced enforced deprivation in respect of at least one of eight basic indicators. Almost 42 per cent of 'other households with children' with a risk of income poverty reported some level of deprivation; households with two adults and one to three children had a rate of over 37 per cent. The most common type of deprivation reported in 2004 among all households related to 'experiencing debt problems to meet ordinary living expenses' (8.7 per cent). It was particularly prevalent among lone parent households (36.6 per cent) (CSO 2008).

There are links between illicit drug use, socio-economic disadvantage, deprived urban areas, level of educational attainment, unemployment and social exclusion (O'Gorman 1996). Historically, socio-economic disadvantage, unemployment, poverty and social deprivation played a role in Dublin's opiate epidemic in the 1980s (Butler 2002) and these factors continue to play a role in the use of illicit drugs, for example, of cases commencing treatment for problematic drug use in Ireland in 2003, 61 per cent were unemployed compared to the national average of 4.6 per cent (Keane 2007).

There are tenuous links between extreme poverty and entry into prostitution. A study of 84 women who were engaging in prostitution in Ireland revealed that the main motivation (93 per cent) for becoming involved in prostitution was financial, specifically for 'money for bills' and to improve the material quality of life. Most (76 per cent) of the women had children, of whom fourteen had between four and seven children. Eleven women were grandmothers (O'Connor 1996). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has identified homelessness as both a social correlate and consequence of problematic drug use (Keane 2007). There are also links between homelessness, drug use and prostitution. Research carried out on drug-using women street prostitutes in Dublin revealed that almost half (35 out of 77) were homeless (O'Neill and O'Connor 1999); some male sex workers also entered sex work through homelessness (Quinlan and Wyse 1997). In a study of 20 active drug users who were homeless in Dublin, prostitution was the main source of income for eight per cent (n=4), and secondary source of income for four per cent (n=1) of the sample. In relation to sexual risk behaviour, 69 per cent reported being sexually active, of which 49 per cent reported never using a condom (Cox and Lawless 1999). Rhodes (2002) suggests that non-health oriented interventions such as housing policy may have harm reduction impact; social contexts such as homelessness influence health and vulnerability.

Estimating demand for sex work in Ireland

The exchange of a sexual service for money transforms it into a commodity in the market place where it will follow the abstract laws of supply and demand (Baseman, et al. 1999). It was stated in the previous chapter that there is neither an accurate figure for the number of sex workers in Dublin nor a reliable figure for the number of drug-using sex workers. However, there is a prevalence figure for men who seek the services of sex workers from a representative national survey (n=7,441) in Ireland (Layte, et al. 2006). It found that 6 per cent of Irish men between the ages of 18 and 64 have 'ever' paid for sex with a woman, and 3 per cent paid for sex in the last five years. The rate of 6 per cent (n=40) is the same as that reported in the National Survey of Sexual Attitudes and Lifestyles (UK,1990), while the figure of 3 per cent is higher than the 2 per cent reported in the same survey. The Irish figures are lower than those found in Australia (16 per cent). In Britain, 6.8 per cent of men had ever used the services of a prostitute and 1.8 per cent reported using the services of a prostitute in the last five years (Johnson et al 1994).

In Ireland, the oldest age group (54–64) of men are most likely to have paid a woman for sex at some time; however, younger men (aged 25–34) are most likely to have paid for sex 'over the last five years'. Men aged 18 to 24 are the second most likely group to have paid for sex over the same period (Layte, McGee et al., 2006:188). The results suggest that there may be an increasing trend toward payment for sex among younger age groups. Age-cohort patterns suggest an upward trend in men paying for sex.

Single men and those with higher professional occupations are most likely to have paid for sex both 'ever' and in the last five years. Men who have had a same-sex partner are 80 per cent more likely than other men to have paid a woman for sex. Men with a higher number of unpaid female sexual partners are more likely to have paid for sex. Less than half appear to be a regular customer of the same sex worker in that 44 per cent of men who have paid for sex did so with one paid partner, 50 per cent with between two and nine partners and 6 per cent with ten or more. Condom use is also high: 83 per cent of men who have paid for sex reported that they had always used a condom, 7 per cent used them inconsistently and 11 per cent never used them.

Findings from the All-Ireland Gay Men's Sex Surveys, 2003 and 2004 (n=781) found that 1 in 15 men (6.5 per cent) said that they had paid money for sex with a man in the last year, with slightly more men (7.6 per cent) in Dublin having done so. A minority (1.6 per cent) of respondents had both paid, and been paid for sex. Age was a factor: older men were most likely to have paid for sex (15.9 per cent) compared with 3.3 per cent of those less than 20 years. Being paid money for sex was reported by 4.3 per cent of respondents from Dublin. The most frequent method for finding sex workers was through gay websites (personal/profiles/chat) which was used by 27 out of 51 men. The second most frequent method was through escort/masseur websites, which was used by 23 men (Devine, et al. 2006).

c) *The policy environment*

Laws governing drug use, sex and consent

The macro-policy environment in Ireland enshrines laws governing drug use, soliciting, sex and consent. Illegal or controlled drugs are prohibited under a number of different Acts: the Medical Preparations (Control of Amphetamines) Regulations, 1970, prohibit amphetamine ('speed') type drugs without prescription. The Misuse of Drugs Acts, 1977 and 1984, are directed towards preventing the non-medical use of drugs; they prohibit the non-medical use of opiates such as heroin, sedatives and stimulants (Corrigan 2003). One of the most dangerous risks attached to illicit drug use is not related to the harmful health consequences but rather to its illegal status and the risk of arrest, incarceration and getting a criminal record (Buchanan 2004).

The Criminal Law (Sexual Offences) Act, 1993, sets out rules governing prostitution. Although selling sex is not illegal in Ireland, soliciting, living off the earnings of prostitution and organising prostitution are illegal (Lawless, et al. 2005). A person who commits or attempts to commit an act of buggery with a person under the age of 17 years is guilty of an offence. Children are protected from prostitution under the Children Act 2001; in relation to child sexual abuse, for the purposes of the criminal law, the age of consent to sexual intercourse is 17 years (Health and Children 1999).

Due to their high visibility, drug-using street sex workers are at increased risk of arrest. Soliciting or importuning can take place from a car or on the street. Section 8 of the Criminal Law (Sexual Offences) Act gives the Gardaí the power to direct those suspected of prostitution to leave the street or public place where they are loitering. An offence is only deemed to be committed when a person fails to comply with a Garda (O'Neill and O'Connor 1999). If the person moves to a different place they must be cautioned again. The Act does not make it clear what the time limit of the caution is; for example, if a prostitute leaves the street having been cautioned but returns to it later, it is questionable whether she/he has broken the law. Following enactment of the legislation, women involved in prostitution experienced increased surveillance from Gardaí; research reveals that 52 per cent of women prostitutes were charged with soliciting which resulted in 20 per cent of those women being imprisoned, 12 per cent fined and 18 per cent being held in custody (O'Neill and O'Connor 1999). The 2005 Garda Commissioner's Report shows that proceedings were commenced against 57 people for either soliciting or picking up prostitutes; there were 14 convictions, seven cases were withdrawn and the rest pending. There were 38 cases of loitering with the intention of prostitution, of which seven cases ended in conviction, three were withdrawn and the rest pending (Rogers 2007).

Those who uphold the right of consenting adults to engage in commercial sex work believe that the existence of legislation which criminalises those who buy and/or sell sex leads to: violence (Brookes-Gordon 2006); police harassment; increased HIV and STI risk; reduced access to services; psychological disease; drug use; poor self-esteem; loss of family and friends; work-related mortality; and restrictions on travel, employment, housing and parenting (Rekart 2005). The UN and WHO support decriminalisation of adult sex work if no victimisation is involved (UN Joint Programme on HIV/AIDS) (UNAIDS 2002; WHO 2005).

There are also calls for the recognition of human rights for drug users. The year 2008 marked the 60th anniversary of the Universal Declaration of Human Rights (UDHR) and the conclusion of the UNGASS (UN General Assembly 26th Special Session, on HIV/AIDS) ten-year action plan on drugs; these bodies called for the recognition of individuals' human rights within the context of the drug prohibitionist framework (Pike 2008).

Harm reduction interventions in Dublin for (drug-using) sex workers: preventing the spread of BBVs and STIs

The policy environment incorporates risk reduction interventions introduced at a community level. In response to the HIV threat in the early 1980s, which recognised that drug users who share contaminated needles could spread infection, harm reduction approaches were introduced, including methadone maintenance clinics, needle exchange programmes and outreach programmes (Butler 1991; Lawless

and Cox 2003; MQI 2003). A statutory service for women engaging in prostitution was set up in Dublin to prevent the spread of STIs and HIV transmission and also to provide support and assistance to a marginalised group of drug-using women. This specialist clinic provides a sexual and reproductive health clinic two days per week and provides STI screening, vaccination programmes, contraception, smear testing, free condoms and lubricants, crisis pregnancy information and referral to UK/Holland and a range of other gynaecological services for women in prostitution (personal communication with representative from the Women's Health Project). There is no dedicated service for sex working males but a statutory service was set up for gay men to improve sexual health among gay, bisexual and other men who have sex with men. It offers testing for blood-borne viruses (HIV testing, hepatitis A and B testing and vaccination), counselling, support, information, condoms, lubricants and screening for STIs. This organisation set up the Irish Network of Male Prostitution (personal communication with representative from the Gay Men's Health Project).

In terms of general services for men and women, there is a GUIDE (Genital Urinary and Infectious Diseases Clinic) in St James's Hospital in Dublin city centre, which provides free and confidential HIV and STI screening and specialises in the care of patients with STIs/STDs, HIV and other infectious diseases. It is open from Monday to Friday and operates a non-appointment walk-in clinic (personal communication with representative from the GUIDE Clinic, 2008). In addition, clients can seek services from General Practitioners or from physicians who specialise in genito-urinary medicine, but unless the clients seeking the service had a medical card they must pay for the service provided.

Methadone maintenance as a harm reduction intervention has been used in Dublin for the past 30 years (Keenan 2002). The Methadone Treatment Protocol was implemented nationally and treatment for opiate misuse is provided in the misuser's own local area whenever possible (Edgar, et al. 2003). There are over 77 methadone treatment clinics in the Dublin city area (Cox and Robinson 2008a). In addition, the Drug Treatment Centre Board is an independent statutory service which provides a tertiary service to meet the needs of the homeless population, those with dual diagnosis or specialist medical need. Clients can also receive treatment at satellite clinics where treatment is provided by a GP; methadone is prescribed at the clinic and then dispensed by a community pharmacist. Methadone is also available from Level 1 or Level 2 GPs (Edgar, et al. 2003). Methadone maintenance is also available in a specialist service for women sex workers seven nights a week at a specified location. There is no waiting list and it is available for all health board areas.⁴ This service also provides a low dose methadone programme from a bus seven evenings a week in the city centre.

4 Personal communication with representative from the Women's Health Project.

There is wide availability of needle exchange provision in Dublin city centre provided by statutory and voluntary services. Many of these needle exchange programmes are based in drug treatment centres or other fixed sites. A Dublin city centre voluntary religious organisation, Merchants Quay Ireland, provides, on average, 2,841 needle exchanges per month (Cox and Robinson 2008b). There are two homeless hostels that provide needle exchanges, and a voluntary organisation provides outreach and a back-packing needle exchange service. The statutory specialist service for women sex workers provides needle exchange on its premises and also through the provision of a mobile bus every weekday evening at 6 p.m. This service provided 4,006 works to drug-users in 2008 and provided 527 needle-exchange encounters on its specialised mobile service (Cox and Robinson 2008a). However, there are minimum services available out of hours.

Currently in Dublin, there are three organisations that target street working female sex workers through outreach. One is a statutory body that does outreach two evenings a week from 7 p.m. to 1 a.m. and distributes condoms and lubricants. The second is a voluntary body – a religious organisation that uses a van to provide outreach four nights a week from 9.30 p.m. to 12.30 a.m. and at weekends from 11.30 p.m. until 4.30 a.m. The van is designed to create a space for women who want to talk to project workers or avail of a hot drink. This organisation does not distribute harm reduction paraphernalia such as syringes or condoms but it helps drug-dependant women to access drug, homeless and other services (personal communication with representative from Ruhama). Outreach also takes place in health and drug clinics, prisons, courts and Garda stations. The third organisation is funded by a Local Drugs Task Force (LDTF) and offers a range of harm reduction services to drug-using women and women sex workers in the north inner city. It provides an outreach street service on Monday and on Thursday evenings (between 8 and 10.30 pm) and on Tuesday evenings (between 5 and 7 pm). It also does outreach in hostels, hospitals and residential accommodation, and provides and distributes condoms and lubricants (personal communication with representative from Chrysalis). Limited outreach for gay men is provided by one statutory service one evening per week in the waiting room of its clinical service and also in Outhouse (resource and community centre for the lesbian, gay, bisexual and transgendered communities in Dublin). Outreach services out-of-hours and at weekends are very limited.

The specialist services also advocate on behalf of female and male sex workers. A Negotiation Skills and Self-Defence course is provided by one organisation to give women skills in the workplace and to empower them to activate their sexual safety knowledge. This organisation also provides them with personal alarms and, with the input of women sex workers, has recently created a booklet about safety on the streets. In addition, the specialist organisations liaise with the Gardaí, and one organisation has commenced awareness training courses with Gardaí trainees. An interagency group was founded in 2002 called SWIPING (Services for Women Involved in Prostitution Interagency Networking Group) which consists

of representative from the various relevant agencies to improve interagency communication. The other is called SWAI (Sex Workers Alliance Ireland) which seeks to uphold the right of consenting adults to engage in sex work in an environment of harm reduction and human rights (personal communication with representatives from SWIPING and SWAI).

In addition, there are other non-governmental organisations in Dublin which target and offer support to those with a HIV positive diagnosis such as Dublin Aids Alliance, Cairde, Gay HIV Strategies and Open Heart House. There are also services which target lesbian, gay, bisexual and transgendered people such as BeLongTo, Johnny and Outhouse, GLEN (Gay, Lesbian, Equality Network) and Gay HIV Strategies.

Despite the existence of harm reduction interventions for three decades in Ireland there still exists a high incidence of blood-borne viruses, in particular HCV among injecting drug users (70 per cent). In 2004, there were 1,136 cases of HCV; in 2006, there was a 15 per cent decrease to 1,218 cases, but in 2007 there was an increase in the first two quarters (Cox and Robinson 2008a). Compared with hepatitis C, the incidence of HIV is relatively low. The prevalence of HIV infection among injecting drug users varies from 1 per cent to 17 per cent. There were 4,419 diagnosed HIV cases in Ireland by the end of 2006, of which an estimated 30 per cent were probably infected through injecting drug use (Cox and Robinson 2008a). Sexually transmitted infections have been increasing steadily since 1994; from 4,781 notified cases to 10,695 in 2004. Between 1994 and 2004, the number of cases of genital chlamydial infection notified in Ireland has increased from 133 to 2,803; ano-genital warts increased from 1,532 notified cases in 1994 to 4,174 cases in 2004. Gonorrhoea increased from 98 notified cases in 1994 to 270 in 2004; syphilis remains endemic in Ireland also (HPSC 2005).

The UNAIDS suggest that a strong and ultimately long-lasting response to STI/HIV for vulnerable groups to increase control over their health can only be achieved through a broad focus based on the concept of health promotion and endorsing the principles from the Ottawa Charter for Health Promotion. These five principles are: development of personal skills; re-orientation of health services; strengthening of community actions; building healthy public policy; creating supportive environments (UNAIDS 2002).

Summary

This chapter has explained the concept of harm reduction and how it relates to ameliorating the adverse and harmful health consequences of drug use and suggests that the harm reduction paradigm can also be applied to sex work to lessen the harms. Many of the harms associated with drug use and sex work stem from risk environments created by the social and legal conditions within which the drug and sex trade occurs (Tyndall, et al. 2003). However, harm reduction interventions are limited in that they

are focused on the individual and do not sufficiently take into account the influences of the physical, social, economic and policy environment – both at the micro-level and macro-level – on risk behaviour. Therefore this study takes a ‘risk environment’ approach and this model was then used to understand the health, economic, social and legal environment in Dublin where risk production and harm reduction take place for drug-using sex workers. There are many macro-environmental influences that continue to exert influence over drug-using sex workers in Ireland. Prostitutes, drug users and those with a positive HIV and hepatitis C diagnosis continue to be stigmatised. On a macro-economic level, social and gender inequalities persist and deprivation and homelessness continue, which puts some vulnerable individuals at risk and makes them susceptible to drug use and sex work. Previous research on Irish men and women who sell sex reveals that the majority of those interviewed took drugs and entered sex work for economic reasons; some entered prostitution through homelessness. On the economic demand side, there is a market demand for sex work in Ireland; it is estimated that 6 per cent of Irish men have ever paid for sex and 3 per cent have paid for it in the last five years. The current legal position creates risks for drug-using sex workers in that laws criminalise drug users and those who solicit for sex on the streets. To lessen the harmful health consequences of drug use harm reduction approaches were introduced during the last three decades in Ireland, including methadone maintenance, needle exchange and outreach programmes. These interventions have managed to reduce the prevalence of HIV but there is still a high incidence of hepatitis C among the injecting population.

Having described the macro-risk environment in Dublin, the next chapter will focus on the methodological approach and the research methods that were used in this study and will provide a profile of the research participants.

Chapter 3. Methodology

He'd give me money; it was more or less to keep my mouth shut. And the one thing that sticks in my mind, out of every single thing is him coming up to my fathers and my mothers home and giving me father and mother cigarettes, loads of sweets, loads of things for the grandchildren and this would go on and on and on.

Chapter 3. Methodology

Introduction

This chapter outlines the methodology and methods which were adopted to achieve the objectives of the research. The study used a combination of research methods and data sources to ensure a more rigorous, reliable and valid assessment. This chapter outlines the methods employed to collect data, including specially designed research instruments, access strategies, ethical and fieldwork issues and data analysis techniques. Findings and conclusions were established through cross-checking multiple sources of data, or data triangulation – the continual process of collecting and cross-checking information throughout the research process (Sarantakos 1993).

3.1 Research Methods

A literature search and review was undertaken and a qualitative methodological approach was selected as the most appropriate way to explore the local and micro-risk environment within which problem drug-using sex workers live and work (EMCDDA 2000; Marshall and Rossman 2006; UN 2004). To this end, the individual face-to-face in-depth interview was the primary research tool used to collect qualitative data from drug-using sex workers and professionals. In addition, biographical data were collected from drug-using sex workers by means of a short questionnaire. The questionnaire also recorded information on participants' current drug use and involvement in crime.

3.1.1 Research Advisory Group

In keeping with the NACD policy, a Research Advisory Group (RAG) was established consisting of representatives from relevant agencies (including those working with problem drug users and those working with sex workers) across sectors. The primary role of the RAG was to guide and manage the research project from inception to completion, to assist in locating respondents and in developing recommendations. The Research Officer and Lead Researcher from the NACD were responsible for conceptualising, developing, planning and implementing the research. The NACD Lead Researcher undertook all qualitative interviews with professionals and female study participants and an additional male fieldworker (with extensive experience of qualitative interviewing) was employed to carry out interviews with male drug-using sex workers.

3.1.2 Ethical Issues

Ethical approval was sought and obtained from the Drug Treatment Centre Board (DTCB) Research Ethics Committee in Trinity Court and the Prisoner-based Research Ethics Committee of the Irish Prison Service. Fieldwork commenced in August 2007 and finished in July 2008. The highly sensitive nature of this research posed numerous ethical challenges and concerns that required advanced planning not least that carrying out the research should not add to the exploitation of this group (Lee 1993; Shaver 2005). This research upheld the dignity, rights, safety and well-being of all research participants. It observed appropriate ethical standards and best practice guidelines. Research information sheets were provided to both participants and staff in agencies. The study was explained to research participants and informed consent was sought. Anonymity and confidentiality were guaranteed and data security was ensured in accordance with NACD guidelines. Respondents were recompensed for their expenses with €20 vouchers, as per NACD policy. Data were anonymised; all identifiers that could link the data with the participants were removed and data were stored in a secure place. Each (drug user) interview was numbered initially and then a new name was inserted and names were placed in alphabetical order; one sex worker asked that her working name be used in the report.

3.2 Research Design

As the research set out to explore the local risk environment, the location of the study was Dublin city centre, where known street sex markets exist.

3.2.1 Participation and Exclusion Criteria

In order to be eligible for inclusion in the study all participants had to self-identify as a problematic drug user – in so far as their drug use causes them social, psychological, physical or legal difficulties. Opiate and/or cocaine/crack users were accepted into the study, as were intravenous and non-intravenous drug users. Individuals who were in treatment for their drug use were also deemed eligible for study inclusion. In addition, study participants had to be currently engaged in sex work or have exited sex work after a sustained period of involvement.

Male and female problem drug users engaged in sex work were recruited to the study. Research from the UK suggests that male sex workers are much less likely to be problematic drug users than female sex workers (Cusick, et al. 2003; Gaffney 2002); consequently, the target sample comprised fewer males than females. The difficulty locating male sex workers may reflect their greater invisibility and/or the fact that male problem drug users are less likely to engage in sex work.

All study participants were over the age of 18 years. Although young people under 18 years are involved in street sex work, there are ethical issues involved in gaining parental consent, and the level of expertise required when working with this vulnerable age group was beyond the scope of this study.

All study participants had to be English speaking. Due to language barriers and difficulties in interpretation of meanings it was outside the scope of this research to include non-English speakers. Although anecdotal evidence (Lawless, et al. 2005) suggests that there are non-national, non-English speaking street sex workers in Dublin, during the course of fieldwork no non-English speaking drug-using street sex workers were encountered. This research focused on street-based drug-using sex workers in Dublin only; it is recognised that sex workers are not a homogenous group; some may work in brothels or for agencies. It is outside the scope of this research to make any comment on those who work in different aspects of the sex industry in Ireland.

3.2.2 Research Instruments

Three research instruments were designed, piloted and operationalised:

a) *Qualitative instrument: for target population*

A topic guide or interview schedule was used with male and female drug-using sex workers which focused on four key areas:

- Background information, early years, initiation into drug use and sex, and involvement in drug treatment
- The social and physical drug-use setting (e.g. where they use drugs, how they use, with whom); the perceived risks of their drug-use behaviour and their risk reduction strategies
- The social and physical work setting (e.g. where they sell sex); the perceived risks of their sexual and drug-use behaviour and their risk reduction strategies
- Perceived barriers to their attempts to reduce the risk of harm and their aspirations for the future.

b) *Quantitative instrument: for target population*

An abbreviated version of the research instrument used in the ROSIE Study (Comiskey and Cox 2007; Cox, et al. 2007b) was used in order to record biographical information and record current drug use frequency (last 90 days) and criminal activity. This provided the necessary background on the individual participants and also helped to ensure a more thoughtful and considered qualitative interview.

c) *Qualitative instrument: for professionals*

A topic guide or interview schedule was used to collect qualitative data from agency/ service providers and other key professionals in order to elicit their perspectives on:

- Drug-using sex workers as a client group
- Changes in local drug and sex markets and the impact on this client group
- How services respond to the needs of drug-using sex workers
- The structural obstacles to effective service delivery
- How policy responses influence the local risk environment.

3.2.3 Sampling and Recruitment Procedures

Sampling procedures in qualitative methodology corresponds to the underlying philosophy of interpretativism (Hughes 1993). Non-probability, purposive, or snowball sampling was used. Snowball or chain referral sampling – a term used to denote the practice of securing additional study participants via the introductions and recommendations of participants previously interviewed (Robson, 1993) – was also utilised. RAG members were also asked to assist with recruitment, and to act as locators by promoting the study and encouraging eligible individuals to participate. Thus, ‘targeted sampling’ (Watters and Biernacki, 1989) was utilised when appropriate, in instances where, for example, the research team was made aware that a particular individual or individuals were eligible for participation in the study. Dedicated mobile phones were provided to the fieldworkers which meant that they were available ‘on call’ to speak with service providers and/or potential study participants, to arrange interviews, etc.

The study was carried out in Dublin city centre, where known street-based sex-markets exist. To promote the study and assist with recruitment, posters and postcards explaining the research were circulated to all drug services in Dublin, to specialist services for sex workers and those engaging in prostitution and to hostel/homeless service providers. To encourage male participation, an advert was placed in a gay magazine (GCN, November 2007, No. 215, www.gcn.ie) and information about the research was placed on an internet site (www.gaydar.ie). Information about the research was also included in the magazine *Hyper* (Health Service Executive [(HSE 2008) which targets drug users.

Accessing eligible study participants proved difficult and time consuming and many hours were spent locating and recruiting men and women to the study; the final number recruited was 35. Despite intense efforts to find problem drug-using male sex workers, the final number achieved was only four. When their interviews were analysed it was discovered that they shared the same predictors of entry into sex work, risk behaviours and harms as the women.

3.2.4 Fieldwork and Data Collection

Most of the interviews were conducted in a specialist agency which provides harm reduction services to women drug-using sex workers. Introductions were made through outreach workers who approached

the women to see if they were interested in participating in the research. Other locators (including RAG members) contacted potential interviewees and gave them the contact details of the Lead Researcher and these interviews were held in quiet city centre venues, two interviews were held in respondents' cars (near drug services), two interviews were conducted in participants' accommodation (apartment/house), two in the NACD offices and four in hostels. Seven interviews were held in prison or in accommodation provided by criminal justice intervention.

Prior to the interview, the research was explained and informed consent was obtained from all participants. Interviews lasted approximately an hour. The quality of most of the interviews was good. In total, 31 women and four men told their stories. In sum, individual in-depth face-to-face interviews were conducted with the following research participants:

Group A: (n=35) Individuals recruited into this sub-sample were problematic drug users who were involved in sex work or had recently exited sex work after a prolonged period of involvement.

Group B: (n=40) In-depth interviews were held with 40 professionals across sectors (community, voluntary or statutory) from a range of disciplines who work either directly or indirectly with drug-using sex workers. These included:

- Drug service providers (e.g. outreach workers, managers, key workers, social workers)
- Specialist (sex worker) service providers (e.g. outreach workers, managers)
- Homeless service providers (e.g. key worker, managers)
- Healthcare professionals (e.g. doctors, nurses, counsellors)
- Criminal justice personnel (Gardaí, probation officer, prison officer)
- Other experts in the field e.g. those involved in doing research for academic purposes.

The recruitment process aimed to include roughly equal numbers of staff from each area of service provision and included those at the coal face as well as those in managerial positions. Interviews were conducted in private rooms provided by the agency or service.

3.2.5 Analysis and Interpretation

All interviews were audio tape-recorded and subsequently transcribed. The data were analysed in a cyclical continuous process that went through data reduction, data organisation and interpretation (Sarantakos 1993). The research team became immersed and familiar with the data by listening to the pre-recorded interviews and reading interview transcripts. The analysis started with summarising each set of inputs, ideas and views provided by the respondents. Similar categories of responses were first identified and thereafter variations in the responses utilizing the constant comparative method (Silverman 2006). Classification schemes emerging from the identification of these patterns permitted the research team

to conceptualise and theorise the data. The software package QSR NVivo assisted data management (Silverman 2006).

The data from the quantitative instrument were analysed using the statistical package for the social sciences (SPSS). Quantitative data were subjected to univariate analysis which provided simple descriptions of the characteristics of the sample and distributions of scores; bivariate analysis was used to examine two variables (De Vaus 1996). The general principle adopted regarding the data collected was that of adequacy rather than scientific perfection. Reliability and validity were achieved through cross-checking and triangulating the data collected using multiple methods and techniques (Silverman 2006).

3.2.6 Limitation of Data

The data are limited in a number of ways. Firstly, all participants had been involved in both drug use and sex work for a long period of time and consequently they had learnt and implemented a range of strategies to reduce their risk of harm. Consequently, no new entrants to sex work were interviewed who would not yet have learnt harm reduction strategies and who may be at greater risk of harm. Secondly, research participants may not be representative of all drug-using sex workers in Dublin, as the majority were recruited through services. Despite this, the findings concur with international research and this study provides rich descriptions and insights into the backgrounds and daily lives of this group.

3.3 Profile of Sample

All study participants completed a short quantitative research instrument. The women and men interviewed were white indigenous Irish people; the vast majority were from Dublin, and all, but one, were living in Dublin at the time of interview. Of the 35 drug-using sex workers interviewed, 31 were female. The remaining four participants were males, three of whom self-identified as being gay. The average age of study participants was 32 years (median 29 years) and the majority were parents (68 per cent) of children under 18 years. Over half the sample (57 per cent) was actively involved in sex work at the time of interview; the remaining 47 per cent had not sold sex in the preceding 90 days. This is not to say that they would not do so in the future.

Table 1: Demographic characteristics

Profile elements	Representation in sample
Gender	31 Females, 4 Males
Sexual orientation	Heterosexual: 29 females, 1 male (86% of total sample) Homosexual: 3 males (8% of total sample) Bisexual: 2 females (6% of total sample)
Parent	23 females, 1 male (69% of total)
Age	Range 21–49 years; median = 29
Age of first drug use	Range 7–39 years; median = 13
Age entered sex work	Range 13–34; median = 19
Sex work	Currently in sex work: 18 women, 2 men (57% of total sample) Not currently in sex work: 13 women, 2 men (43% of total sample)

3.3.1 Housing Status

More than one-third of the study participants (37 per cent) were living in the private rented sector. Four of the women were in prison at the time of interview, either serving a sentence or on remand. An additional four women had recently been released from prison and were living in transitional accommodation (specifically for women released from prison) at the time of interview. Over a quarter of the sample was living in emergency accommodation, most in city centre hostels.

Table 2: Accommodation

Type of accommodation	Percentage (n)
Rented	37.1% (13)
Emergency (Hostel/ B&B)	25.7% (9)
Prison	11.4% (4)
Transitional housing	11.8% (4)
In parental home	5.9% (2)
With friends	5.9% (2)

3.3.2 Substance Use

Participants were asked about their recent use of a range of substances; that is, use in the 90 days prior to interview. Given the fact that the vast majority of participants were on prescribed methadone (88 per cent), self-reported drug use was high. For example, the table below shows that approximately two-thirds of the sample reported recent heroin use (65 per cent), over a quarter reported cocaine use (29 per cent), and 15 per cent reported crack cocaine use. All participants smoked cigarettes; in addition, Table 3 suggests that participants who were actively involved in sex work at the time of interview were more likely to report the use of all substances.

Table 3: Substance use and engagement in sex work in the last 90 days

Substance used last 90 days	% Engagement in sex work		Total
	Current (n=20)	Not current (n=15)	Sample
Cigarettes	100%	100%	100%
Alcohol	55.0%	35.7%	47.1%
Prescribed methadone	95.9%	78.6%	88.2%
Heroin	75.0%	50.0%	64.7%
Prescribed benzodiazepines	63.2%	57.1%	60.6%
Non-prescribed benzodiazepines	55.0%	35.7%	47.1%
Cannabis (Hash)	42.1%	28.6%	36.4%
Cocaine	40.0%	14.3%	29.4%
Non-prescribed methadone	35.0%	21.4%	29.4%
Other prescribed medicine	26.3%	28.6%	27.3%
Ecstasy	21.1%	7.1%	15.2%
Crack	15.0%	14.3%	14.7%
Amphetamine (speed)	5.3%	0.0%	3.0%

All respondents had a history of injecting drug use, and over half of the sample (53 per cent) reported injecting drug use in the 90 days preceding interview. Moreover, one-fifth of the sample (20 per cent, n=7) were high frequency injectors, in so far as they reported daily injecting in the preceding 90 days, most injecting more than 4 times per day (n=5). Half of these high frequency injectors (n=4) were daily injecting cocaine users.

3.3.3 Blood-borne Viruses

Participants reported a high level of contact with healthcare services; 64.7 per cent reported having had a health check in the 90 days prior to interview. The vast majority of respondents also reported having been

tested for HIV (97.1 per cent) and one in five (20.6 per cent, n=7) self-identified as HIV positive. Over three-quarters of the study participants (78.1 per cent) self identified as being HCV positive; 26.7 per cent said that they had received information about the virus, 36.7 per cent reported having received an onward referral; however, only 13.3 per cent (n=4) reported having ever received treatment for HCV. Less than half the sample (43.8 per cent) reported having received the hepatitis B vaccine, and 17.2 per cent had received it in the last three months; 19.4 per cent had received confirmation that the vaccine had worked. In relation to STIs, 78.8 per cent (n=26) had been tested for other STIs in the previous 90 days, of whom three had tested positive and had received treatment.

Table 4: Self-reported blood-borne viruses and infections

Type	Percentage(n)
HCV Positive	78.8% (26)
HIV Positive	20.6% (7)
STIs	8.6% (3)

3.3.4 Involvement in Crime

Participants were asked about their criminal involvement in the 90 days prior to interview. Over a quarter of the sample reported shoplifting (28 per cent) and 19 per cent reported handling stolen goods. Approximately 13 per cent reported theft from a person, and theft from a property. In addition, roughly one in five (19.5 per cent) reported having been the victim of a crime.

Table 5: Offending behaviour in the 90 days prior to interview

Offence type	Percentage (n)
Shoplifting	28.1% (9)
Handling stolen goods	18.8% (6)
Theft from a person	12.9% (4)
Theft from a property	12.5% (4)
Selling drugs	9.4% (3)
Fraud/forgery	6.3% (2)
Other crimes	6.3% (2)
Theft from a vehicle	3.1% (1)
Theft of a vehicle	3.1% (1)

Participants were also asked whether they had any outstanding legal issues at the time of interview. One quarter of the sample reported being on probation or community service at the time of interview; an

additional 13 per cent were in prison on remand or serving a sentence. A similar proportion (13 per cent) was on bail awaiting a hearing or sentencing, and 19 per cent had outstanding warrants. Finally, more than a quarter of the participants had outstanding fines.

Table 6: Current legal status

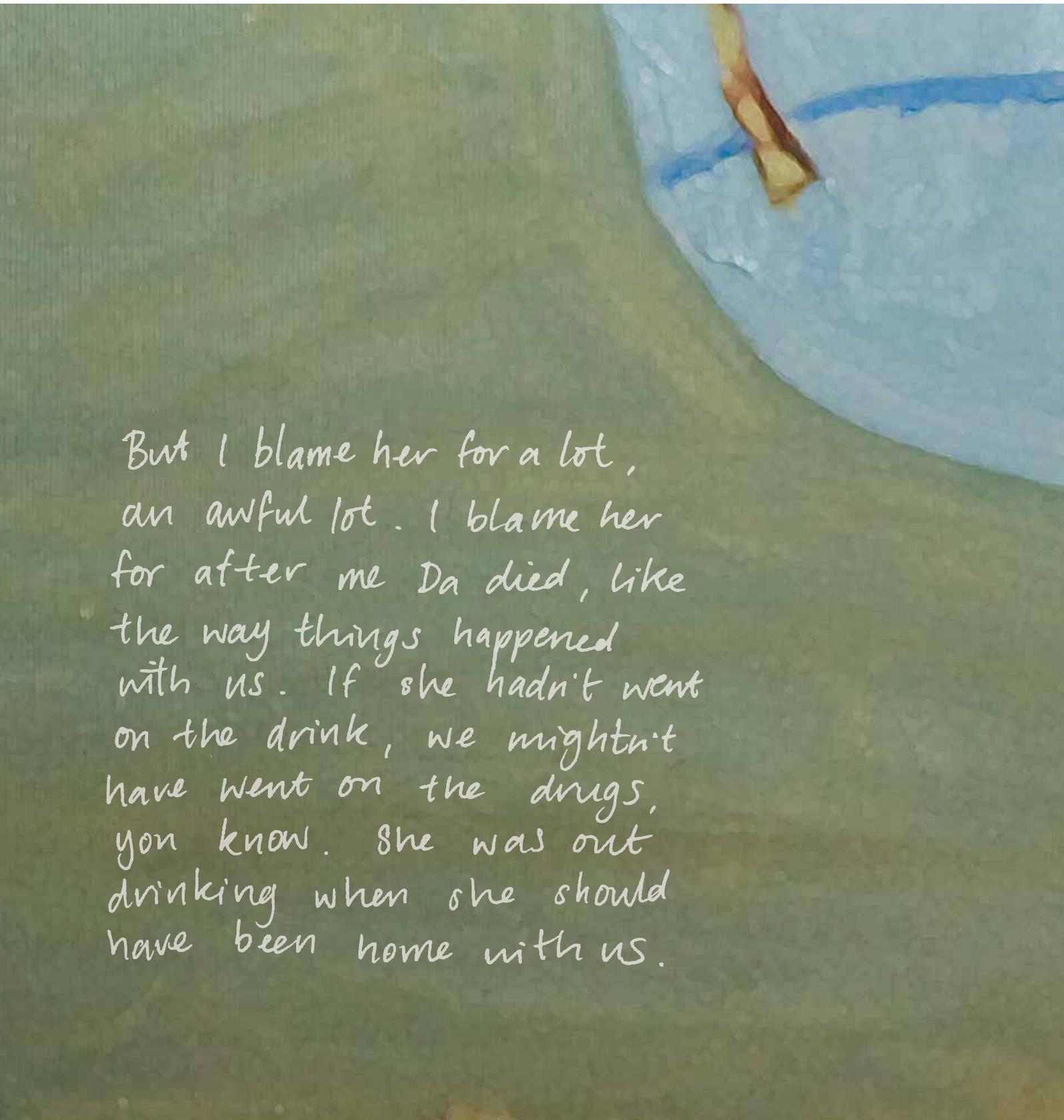
Status	Number	Percentage of total (n=)
Outstanding fines	9	28.1%
Probation or community service	8	25.0%
Outstanding warrants	6	18.8%
In prison (sentenced/on remand)	4	13.0%
Temporary release/parole	3	9.4%
On bail (awaiting sentencing)	2	6.3%
On bail (awaiting trial or hearing)	2	6.3%

Summary

This chapter described the methodology and methods that were used to elicit the required information. The dominant methodology was qualitative; three research instruments (two qualitative and one quantitative) were developed and utilised. Qualitative interviews were conducted with 35 problematic drug-using sex workers and 40 professionals in order to explore the risk environment of problematic drug-using sex workers in Dublin. In addition, the drug-using sex workers completed a short quantitative questionnaire. The results of the quantitative instrument, which reports on the demographic profile, current illicit drug use and health harms associated with drug use, were presented. Although the vast majority of participants were receiving methadone treatment (88 per cent), self-reported drug use was high. Approximately two-thirds of the sample reported recent heroin use (65 per cent), over a quarter reported cocaine use (29 per cent), and 15 per cent reported crack cocaine use. All participants had a history of injecting drug use, and the majority (78 per cent) reported being HCV positive. Despite this, just over a third had received an onward referral for treatment. Less than half the sample (44 per cent) reported having legal problems at the time of interview.

Having described the biographical and demographic characteristics of drug-using sex workers the next chapter explores the micro-risk environment in which research participants grew up and their pathways from drug use to prostitution.

Chapter 4. Becoming a Drug-Using Sex Worker



But I blame her for a lot,
an awful lot. I blame her
for after me Da died, like
the way things happened
with us. If she hadn't went
on the drink, we mightn't
have went on the drugs,
you know. She was out
drinking when she should
have been home with us.

Chapter 4. Becoming a Drug-Using Sex Worker

Introduction

A risk factor is ‘an individual attribute, individual characteristic, situational condition, or environmental context that increases the probability of drug use or abuse or a transition in level of involvement in drugs’ (Clayton 1992).⁵ The literature identifies a range of risk factors in childhood and adolescence associated with the development of a drug problem, including risk factors present in the child or young person, risk factors present in the family, and risk factors in the wider community (Lloyd 1998). The most extensive evidence relates to family factors (e.g. parental discipline, family cohesion and parental monitoring); with consistent evidence supporting a link between adolescent drug use and peer drug use, and drug availability (Frisher, et al. 2007). Risk factors have different predictive values throughout adolescence; some factors may occur at birth, while others occur at varying times throughout adolescence; some may persist for long periods of time while others are transitory. Moreover, individual risk factors are interconnected in so far as risk factors for problematic drug use may also simultaneously be predictors of other interrelated social problems such as youth homelessness (Mayock and O’Sullivan 2007) and involvement in sex work (Cusick, et al. 2003).

This chapter briefly examines the early lives of the men and woman interviewed and explores the range of risk factors present in their childhood and adolescent years. Detailed analysis of participants’ early initiation into drug use and transition on to dependent intravenous use is then presented. This is followed by an analysis of dominant routes into, and motivations for, involvement in sex work by study participants. Finally, the interface between drug use and sex work is briefly discussed.

4.1 Growing Up in a Risk Environment

Most of the men and women interviewed were exposed to multiple risk factors and predictors associated with problematic drug use at a very young age. This section explores some of the key themes to emerge from the data; analysed and presented within the framework of a ‘risk environment’ (Rhodes 2002).

As previously discussed, the distinction between the physical and the social environment is somewhat artificial as the boundaries are often blurred; however, it provides a useful framework for researching multiple environmental factors that produce health risks. Moreover, it shifts the focus of attention away

⁵ Conversely, a protective factor is ‘an individual attribute, individual characteristic, situational condition, or environmental context that inhibits, reduces, or buffers the probability of drug use or abuse or a transition in level of involvement in drugs’ (Clayton, 1992).

from the individuals and their behaviours to the social situations, processes and structures in which individuals participate.

4.1.1 The Physical and Economic Environment

Over the past two decades, research in Ireland has consistently demonstrated a link between heroin use and various indicators of poverty and social exclusion, including unemployment, poor housing, one-parent families and lower educational attainment (Coveny, et al. 1999; O'Higgins 1998). Moreover, several studies have reported that drug availability (in particular, access to, or perceived access to drugs or being offered drugs) is associated with drug use (Mayock 2000; Parker, et al. 1998; Parker, et al. 2002).

As children, most of the men and women interviewed grew up in inner-city and suburban working-class Dublin communities during the 1970s and 1980s. These communities were characterised by high rates of intergenerational unemployment, low levels of educational attainment, social deprivation, and economic marginalization. The sharp economic decline of the 1970s went hand in hand with deteriorating housing stock and the disruption and relocation of many people from inner-city communities to the new suburbs (Murphy-Lawless 2002). Moreover, the rise in the numbers of jobs available in the inner-city communities since the 1990s and the advent of the Celtic Tiger did not significantly reduce unemployment for long-term residents in these areas because many of the new jobs were part of the expansion of skilled employment in specific sectors, e.g. the financial sector and technology (Murphy-Lawless 2002). Unemployment in the inner city increased by 23 per cent between 1986 and 1996; this area also had more than twice the national average of youth unemployment in 1996 (Gamma 1998).

Heroin was introduced into these working-class Dublin communities in significant quantities in the early 1980s (Dean, et al. 1983) when they were already undergoing a process of change imposed by the decline in traditional industries in the area. Bourgois (1997) argues that drug abuse is both 'symptom' and 'symbol' of the entrenched and complex dynamic of marginalization and alienation (Bourgois 1997). The developing 'opiate epidemic' in these Dublin communities, in the midst of ongoing economic disintegration, had a devastating effect on the lives of people living there. Moreover, the heroin trade came to have a major influence on the local economy. The affected communities came to benefit from the informal economy of the criminal activities of drug users (as user-dealers and as buyer-sellers of stolen goods), which inevitably fostered conditions for continued heroin use in the absence of effective State interventions to revive the local economy (Parker, et al. 1988; Taylor 1993). Thus, the majority of participants grew up in marginalised communities where the circulation and economics of heroin were heavily centred.

4.1.2 The Social Environment

The social environment influences health and vulnerability in general as well as drug-related harms in particular. Family, peer and friendship networks are key micro-social environments that influence childhood and adolescence. The family is the primary socialisation unit for children (Kumpfer and Alvarado 1998). However, over the course of their development children become less dependent on the family and more dependent on their peer or friendship networks for emotional and social support. That said, research suggests that parents play an important role in determining their child's peer group; children tend to choose peers who come from families with values similar to those of their own families. Consequently, the influence of parents on children's values, attitudes and beliefs is enduring. This section explores the family and home environments within which participants grew up, and the role of peer and friendship networks in early initiation into drug use.

4.1.3 Family and Home Environment

Many of the men and women interviewed came from very large families with limited financial resources. Although in participants' accounts of growing up they often spoke nostalgically about their childhood most of the respondents experienced significant family disruption in their formative years.

A significant minority of the men and women interviewed endured personal bereavement and family illness during their childhood and early adolescence. Of the 35 respondents, almost half had experienced the death of a close family member in their formative years, including a parent, a sibling and/or a grandparent. Several individuals experienced multiple interfamilial deaths in relatively short succession. For example, Zoë was 12 and living with a foster family when her mother and father died within a year of each other; two years later her brother committed suicide while in prison. These bereavements had devastating consequences on the lives of the young people involved. In extreme cases, the death of a guardian – whether a parent or grandparent – was exacerbated by the loss of a 'home', resulting in the young person being placed in care or ending up with precarious, transient living arrangements. For all of the men and women who experienced the premature death of a parent, it had a profound and prolonged impact on their lives. Many of these participants, when interviewed as adults, were still struggling to come to terms with their losses.

Some of the participants reported parental substance use. Research suggests a significant association between parental substance use and adolescent drug use (Hoffman and Cerbone 2002; Merikangas and Avenevoli 2000), whereby parental substance use is at the centre of a web of problems that often include diminished financial resources, family disruption, neglect, unpredictability and violence (Bancroft 2004).

Consequently, children of substance misusers are considered at risk of emotional and physical neglect, and of developing emotional and social problems later in life (Cuijpers, et al. 1999).

Losing a parent through ‘enforced separation’ or death is a more common experience for the children of problem drug users than for other children (ACMD 2003). In the most extreme instances, parental substance use resulted in death, prolonged illness and imprisonment. For example, Áine’s mother died of a drug overdose, after 18 years of living with HIV. On the other hand, Zoë, a mother of two young children, interviewed in a women’s prison, was herself born in a prison to a drug-using mother. For others, parental substance use had a negative impact on the home environment often causing friction, neglect and the physical (and emotional) absence of the parent(s). Some of the women and men interviewed retrospectively ‘blamed’ their parents’ substance use on their subsequent drug use problems.⁶ For example, Carol, when speaking about her mother, said:

But I blame her for a lot, an awful lot ... I blame her for ... after me Da died, like the way things happened with us. If she hadn't went on the drink we mightn't have went on drugs, you know. She was out drinking when she should have been at home with us. (Carol)

Many of the respondents recounted direct experiences of physical abuse when growing up. For most, this happened within the context of the family home. As in other research, violence was more often associated with alcohol misuse (rather than drug misuse), invariably by a father or male sibling (Bancroft et al., 2004). Participants spoke about frequent violent outbursts and family disruptions. Rachael recounted how her father would ‘come in from the pub and upend the dinner table’ or ‘he’d rudely spit into our dinners or push one of our heads down into the hot dinner’. Others spoke about being subjected to verbal abuse and humiliations, and witnessing violence being inflicted on their mothers or siblings.

Some of the men and women interviewed disclosed incidences of sexual abuse in their childhood or early adolescence. The women were more likely to report interfamilial sexual abuse by a male relative, whether a father, brother or an uncle. In some cases the abuse persisted over many years. For Rachael, one of the consequences of seven years of sexual (and physical) abuse by her father was to travel to England at the age of 13 for an abortion. In addition, three women reported being sexually abused (by priests) while in school and in foster care. Bríd recalls, ‘I was raped first by my brother; I was taken away to Goldenbridge and raped by the priests there.’ Two of the (four) men interviewed said that they were ‘raped’ by older men while in their early adolescence. Colm gave a disturbing account of persistent and prolonged abuse from the age of 12 by an older male neighbour, known to his family. He concluded:

He'd give me money; it was more or less to keep my mouth shut. And the one thing that sticks in my mind, out of every single thing is him coming up to my father's and my mother's home and giving me father and mother cigarettes, loads of sweets, loads of things for the grandchildren and this would go on and on and on. Little did they know he was abusing me all this time. Like, that was like a payment to them ... (Colm)

In addition, one of the men, Barry, reported a prolonged period of sexual abuse from the age of seven to fourteen by his father.

There is some evidence to support an association between childhood sexual abuse among both men and women and involvement in sex work (Faugier and Cranfield 1994; Foster 1991). Some authors hypothesise a direct causal link, whereby abuse produces loss of self-worth, indifference to treatment and whereby abuse is seen as rehearsal for sex work (McMullen 1987). Others argue that any causal link is indirect, with intervening factors, such as running away from home, living in local authority care or involvement in risky activities (such as adolescent drug use and crime) having an associated role (Seng 1989; West and de Villiers 1992).

For a variety of reasons several participants had their home and family life disrupted by having to spend time in care during their teenage years, in orphanages, residential care homes or with foster families. For some, this involved a succession of moves from one foster and/or residential care home to another, indicating periods of prolonged instability during their formative years. For example, Yolanda was put into care at the age of 11 and after living with a series of foster families, she eventually ending up in a 'children's hostel'. This lack of a continuous carer during childhood and early adolescence had a profound impact on the lives of the young people involved. The overall picture provided by respondents was that only a minority had long-term unconditional supportive parental relationships. For Molly (the mother of four children in foster care), who grew up in institutional care, the lack of a supportive parental relationship had a profound effect on her view of parenting; she considered parental care a 'luxury': 'We didn't have Mammy and Daddy there all the time, we didn't have that luxury, and when we were there we were beaten up.'

Others who reported no history of formal foster or residential care nonetheless found themselves homeless in their adolescent years. From some, like Eileen, this was a gradual process starting with staying out for a night or two at a time to avoid 'fights' at home, and eventually, in Eileen's case, 'being stopped from going home' by her father. Others, like Angela, 'ran away' from home. Conversely, for Alan a persistent precarious home environment ultimately resulted in him being homeless at 15. He explains:

I never really had a permanent, like stable situation, but the most permanent one that I could possibly remember is – [named flat complex], my grandmother lived around there and I slept with her a lot of the time until she died there in May 1999 and ever since I've been floating about. (Alan)

A large body of research shows that experiences of living in care, running away and homelessness are strongly correlated with young people's entry into sex work (Boyle 1994; Kirby 1995; O'Neill 1997; Shaw and Butler 1998; Stiffman, et al. 1988; Yates, et al. 1991). According to Cusick et al. (2003) the particular aspects of vulnerability, which these aforementioned experiences share, are poverty, separation from parental care and exposure to life on the street and the opportunities for learning alternative means of survival. In addition, the factors that lead to a young person being placed in care or becoming homeless may contribute to their vulnerability to problem drug use and involvement in sex work (Cusick, et al. 2003).

4.1.4 Peer Networks and Early Initiation into Drug Use

Several studies report a significant association between adolescent drug use and friends' use of licit and illicit substances (Beckett, et al. 2004; Li, et al. 2002; Von Sydow, et al. 2002) and being offered drugs by friends (Von Sydow, et al. 2002). Mayock (2000) and others have observed that initiation into drug use is strongly dependent on availability and social context. Most of the women and men interviewed were exposed to drug and alcohol use at a very young age. For some, this happened within the context of the family home, either through parental or sibling drug use. Research suggests that children of drug-using parents are often exposed to drugs by being present when their parents are buying, selling and using drugs (Thompson et al., 1996). That said, no participant reported experimenting with or using drugs in the presence of a parent.

As in other research (Mayock 2000; Parker, et al. 1988), the vast majority of interviewees were initiated into drug use through peers or friendship networks, whereby the availability and use of drugs within their social circles facilitated initiation. Participants rejected the notion of peer pressure; for example, Angela described how at 13 she and her friends 'decided that we would all try' heroin. Florence, in explaining her initiation into drug use, said, '... the crowd I got in with was doing it, and I wanted it, no more, no less, I wanted it, do you know what I mean?'

In many instances participants were first introduced to drugs within the context of an older peer social network and/or older siblings. Similar to other research, both male and female friends were instrumental in introducing the women interviewed to drug use (Taylor 1993). However, many of the women had older boyfriends; as Noreen, who first started smoking cannabis and drinking alcohol at 11, explained, 'We started going out with older fellows. Well, actually that was always the way it was; the younger girls went out with the older fellows.'

Drug trying usually occurred in a familiar everyday setting within the context of a peer social gathering, highlighting the social dimension of drug use. For many, engaging in illegal drug use was a positive activity,

one that delivered pleasure and satisfied curiosity. Consequently, for most, the possibility of addiction and dependency was a long way removed from the young person's thoughts when they first used drugs.

There were three exceptions to early initiation into drug use. Florence and Donna were slightly older (18 years of age) than other respondents when they first tried drugs and Bríd said she first took drugs at 39 years of age following the death of her child.

School is often considered a haven from risk. Although participants were not asked in detail about their experience of school, the majority of men and women interviewed reported leaving school at a young age without any formal educational qualifications. Some respondents reported being unable to cope with the demands of school because of their home circumstances and escalating drug use. When asked when he left school, Alan said:

I think 15, going on 16. It was just when the Junior Cert was over. And even then I was never in; you know that kind of a way? I couldn't, you know what I mean? You were, like, homeless, and you're going from house to house. You need drugs just to function; you know that kind of a way? So I wasn't doing anything. (Alan)

Others were expelled from school. Only Carmel managed to complete her Leaving Certificate despite the fact that she 'had gear every morning before a test'. Laura, on the other hand, was the only participant who reported a sustained period of education/training upon leaving school. Thus, most of the participants were not afforded the protective factor of the school environment in their adolescent years.

4.2 Drug Transitions – Risk of Dependency

As outlined above, drug use was already an accepted feature of the physical and social environment of respondents in their early adolescence and most respondents initiated substance use at a young age. However, drug trying in early adolescence does not necessarily lead to more serious forms of use. The evidence for the impact of early drug use on later problematic use is complex and often appears to be contradictory (Frisher, et al. 2007). This section will briefly explore the transition from drug trying to more persistent patterns of drug use and dependency.

Mayock (2000) highlighted that there are many routes of passage from one stage to the next in the career of a drug user. That said, Parker et al. (1988) suggest that the curiosity to use heroin is often aroused by the previous use of other drugs. Equally, the opportunity to use heroin is an important factor in initiation (Stephens and McBride 1976). Accounts of how heroin users first came to engage with drugs reveal that it's an uneven process highly dependent on what drugs are available on the street market at what time, and on the highly local conditions of social context and friendship networks (Coveny, et al. 1999).

Many respondents experimented widely with a range of drugs; starting with alcohol and cannabis, and progressing to tablets, amphetamines ('speed') and ecstasy, the use of which was usually associated with raves, parties and social events. The opportunity to use heroin often presented itself at the post-rave parties, within their social network. Within this context the transition to heroin was usually to ease the 'come-down' from ecstasy. As Alan explained:

... Raves would be on and then I started taking ecstasy tablets and I used to take bucket loads of ecstasy tablets, you're talking about, at the start two tablets per night and then I would take five, ten, fifteen ... And the comedown was very, very severe and cannabis no longer dealt with the comedowns until one day someone whipped out some tinfoil and it was heroin at the time. And sure I was in such a come-down like you know, probably the lack of serotonin probably affected my judgement in some manner or form that I had to ... So the first time I tried heroin I would have been about 13 and a come-down eh, at a rave ... (Alan)

In these situations heroin was usually smoked or 'chased'. The increase in the practice of heroin smoking in Dublin after 1994 when it became the most common route of use among new attendees to treatment is well documented (Gervin, et al. 2001; Smyth, et al. 2000).

However, a significant minority of the female respondents (nine) had relatively limited, if any, experience with drugs when they first used heroin, generally in their early adolescence. This usually happened in the context of older peer networks. Although many of these participants spoke about getting 'violently sick', most persisted in their use; Irene explained that after (unknowingly) smoking heroin for the first time she 'got the taste for it'. Conversely, Áine, who first smoked heroin at 12 said, 'I didn't like it when I was 12, so I stopped' then re-commenced heroin use a few years later. As naïve and inexperienced drug users, some of these participants were unaware that they were taking heroin. For example, Irene and Finola said they unwittingly took heroin for the first time; both women were 14 years of age at the time and were told (by older peers) that they were smoking hash-oil. As Finola explains:

... at 14 I was doing gear. Now saying that when I started on gear, for three and a half months I didn't know, and this probably sounds ridiculous but I was only 14, but I didn't know it was heroin. That is the God and honest truth. I did it with two boys ... they told me it was hash oil and I had seen hash oil. It looked exactly like what they were showing me and giving me so I had no reason to doubt them. And it was three and a half months before I found out what it was ... (Finola)

Not all people who try heroin become dependent problematic users, as highlighted by the growing body of literature on controlled heroin use (Shewan and Dalgarno 2005; Warburton, et al. 2005). Among those who do, Pearson (Pearson 1987a) concluded in his ethnography of heroin users in England that heroin 'creeps' into the lives of individuals by 'stealth, slowly and imperceptibly'. As use becomes problematic, people begin to lead a 'self-destructive daily life' (Bourgois 1997).

In most cases, participants progressed from smoking or 'snorting' heroin to injecting drug use. For some of the study participants moving into injecting use and becoming daily users denoted the start of problematic drug use. Alan describes the transition from smoking to injecting heroin as 'crossing the line'. However, four participants (one male and three females) reported that the first time they used heroin they injected the drug. All these female participants were very young at the time (between 11 and 15 years of age) and all continued to inject the drug. Colm was slightly older when he first used heroin; he injected it into his muscle or 'skin popped' the drug at 16 years of age.

Many of the participants were largely unaware of becoming dependent on heroin. Angela explained how she started 'snorting heroin once a week, and then it went to just weekends and then it started bit by bit by bit. And then I was strung out'. Similarly, Laura recalled:

I was working as a chef at the time, and I was getting paid enough to buy a bag every day, and that went from one to two a day and when I wanted to stop then it was too late, because I was working for about two years when I was on it. Yeah, so I was taking heroin for two years every day and for the second year was taking two bags every day. I was strung out without even realising it. (Laura)

Two of the women said they first became dependent on methadone and subsequently progressed on to heroin use. Barbara unknowingly became dependent on methadone at 15 years of age. She said she was getting it 'for nothing' from a female acquaintance every day until she began to experience withdrawal symptoms ('I was actually sick because I had none'). It was, Barbara said, 'her way of getting me in'. She then continued to buy methadone from the same woman for a few months and then progressed on to heroin.

However, as in other studies of opiate users, the vast majority of participants' drug use was not confined to heroin. The men and women had extensive drug-using repertoires, which continued once dependent on heroin. The most frequently mentioned drugs apart from heroin were cocaine and benzodiazepines. Most of the participants who reported using cocaine said that at some point in their drug-using career their cocaine use had become regular and problematic. In addition, a significant minority of study participants reported crack cocaine use.

Given participants' early initiation into drug use, and progression into dependency and problematic use, predictably, all respondents had extensive treatment experiences. As outlined in Chapter Three, the majority of participants were on a methadone maintenance programme at the time of interview. Most had previously been on methadone programmes and had accessed a range of other treatment options, including detoxification facilities and residential treatment programmes since becoming drug dependent. The majority of participants spoke of periods of being 'drug free'; for many of the women these periods coincided with having a child and/or imprisonment.

4.3 Entering Sex Work

There is a large body of literature concerned with sex work career entry. A range of situational factors have been identified as underlying motivations to sell sex, including poverty and financial exclusion (Davies and Feldman 1997); lone-parenting (Scrambler and Scrambler 1997); childhood neglect or abuse (Dunlap, et al. 2003); family dysfunction (Nadon et al., 1998); running away, youth homelessness, living in care (Cusick, et al. 2003; Kirby 1995; Nadon, et al. 1998); and drug dependency (Cusick and Hickman 2005; Dalla 2002). Brannigan and Van Brunschot (1997) argue that the focus should not be on any single factor, rather on a cluster of wider social and situational factors that negatively impact on relevant social 'bonds and boundaries' (Brannigan and Van Brunschot 1997).

Research among male and female drug-using sex workers shows that dependent problematic drug use usually precedes or coincides (Potterat, et al. 1998) with entry into sex work (Bloor, et al. 1991; McKeganey 2006). All the men and women interviewed were dependent heroin users prior to first engaging in sex work; a significant minority were minors at the time. This section explores the main routes into, and motivations for, participants' involvement in sex work.

4.3.1 Routes into Sex Work

The data revealed a variety of routes of entry into sex work. Similar to findings from other studies (Jesson 1993; O'Neill, et al. 1995), for the majority of study participants the dominant route into sex work was through a peer or friendship network. This often happened when an individual had financial problems and their friend/acquaintance paved the way for them to become involved in sex work. Thus, the introduction to sex work by friends was usually a point of opportunity to getting started in the business. For example, Colm was 16 when he first realised the economic potential of sex work after a chance meeting with a friend in the city centre. He explained:

I remember one time walking past Burgh Quay and I seen a friend of mine standing there ... And I was talking to him. I said 'What has you here? He says, 'I've been playing in the amusements', he said, 'stalling around to see if I can get a few bob, you know.' I said: 'How are you going to? Are you begging or something?' He said: 'No, see the toilets over there, the men come over, you know what I mean, when you see one of them going in, follow them in, they give you £20 odd, a tenner or £20.' (Colm)

Some of the women started by accompanying or 'tagging along' with their friends who were sex workers; for example, Mary said she was 'going down watching my friend's back, taking regs'. Others, like Úna, were accompanying friends but were unaware at first of what was going on: 'I didn't know where she was going, I didn't really know anything about prostitution at the time and she was going off doing it.' Conversely, Darragh (who self-identified as heterosexual) first became aware of male sex workers in the Phoenix Park

through a highly publicised case in the media. Two of the women were introduced to sex work by family members; Olive's aunt was a 'working girl' and Carol said 'me sister, she done it first'.

For a significant minority of the men and women this introduction to sex work happened while they were homeless and staying in emergency accommodation. Research has continuously found that experiences of living in care, running away and homelessness are strongly correlated with young people entering sex work (Cusick and Hickman 2005; Cusick, et al. 2003). In this context, individuals were again usually introduced to the possibility of sex work through their peer networks. Noreen explained that at 21 and living in a hostel 'the girls there introduced me to it [sex work]. I can't say they put much pressure on me; they didn't.'

For a few of the men and women getting involved in street-based sex work was like a natural progression for them. Both Carmel and Zoë said that they had previously exchanged sex for drugs or money so the transition to street-based work was like the next step. For example, when Carmel was asked about how she first got involved in sex work she said:

My mates say that I always done it, 'cause, well I don't think that I always done it, but they say that I always done it. It's just that I wasn't on the beat, do you know what I mean? It was, I would be with fellas around the place ... 'cause I used to always have young fellas around me ... 'cause they used to know I'd have sex with them for the gear ... but I never thought of them as punters, I just thought of them as being mates, that were sorting me out for having sex with them, do you know what I mean? (Carmel)

On the other hand, two women, Karen and Finola, had moved from indoor agency sex work to street-based work. Both women were introduced to agency-based sex work through a friend. Karen made the decision to move from indoor work to street-based work because she was having problems with her bosses and was unhappy with the lack of control she had over the selection of customers and where she was required to travel to. Finola moved from indoor work when the agency she was working for closed down. Conversely, Barry progressed from casual anonymous sex to sex for money when he was 14 years of age. He recounted, 'I met a fella on Burgh Quay and I'm after having sex with him ... he handed me money then and I said this is great, I can go and get more drink now ...'

There is evidence that coercion and abuse (of a physical, sexual and verbal nature) are commonly present in the process of becoming involved in sex work, particularly in relation to street-based sex work (Harding and Hamilton 2008). For a significant minority of the women, their accounts of entry into sex work involved varying degrees of male coercion. A few of the women said their male sexual partner coerced them. For example, Florence, who was in an abusive relationship with a drug-using partner at the time of entry into sex work, said:

... he [her partner] made it so that it was like my idea the first time, and then after that he bullied me into doing it. And he'd sit and watch and be very abusive, and he'd hit me if I didn't, if anyone got ahead of me, you know, got a punter before I did, he'd go around the corner, I'd have to explain why, what happened, why didn't I force, do you know what I mean? ... it was the most degrading time of my whole life, the most horrible time in my life, was that year, he'd literally hit me, but he would always hit me where it wouldn't show. (Florence)

Molly who knew a 'few girls that were doing it' said her partner 'pressured' her into sex work. On the other hand, Rachael was intimidated (by a third party) into sex work to pay off her partner's drug debt. Finally, Helen, who started injecting heroin at 11 years of age, spoke about being forced into sex work at a very young age by a 'pimp':

... I was put out on the game, when I was 14, by a pimp [name] he put me out when I was 14. I was only a child, it is not easy money, but it is quick money, and I liked that when I was strung out very bad at the time, so when he got locked up for what he done to me, like, I ended up going out on my own because I was starting to get to keep the money, so I was making good money as well. (Helen)

4.3.2 Rationale for Engaging in Sex Work

There is an economic aspect to drug dependency. The high cost associated with illegal drug use means that many dependent problematic drug users have to resort to various forms of illicit activity to generate a sufficient income to support their level of drug use. The men and women interviewed had poor employment prospects; most had low levels of formal educational attainment and a lack of employable job skills, compounded by their opiate dependency and for some a criminal history. Consequently, the majority had few legitimate economic opportunities. Walters (1985) argues that drug users need to be 'flexible and versatile' and ready to take advantage of any opportunity which arises (Walters 1985). As outlined above, for many of the men and women, the introduction to the possibility of engaging in sex work provided such an opportunity.

For most of the participants, the primary rationale for engaging in sex work was economic: to 'make ends meet'; 'for the sake of me habit'; 'I was becoming a bit desperate [for money]'. Alan who was homeless at 15 explained:

... if you are under 18, you can't get any supplementary welfare allowance at all. It was voluntary, quote, unquote, voluntary me leaving the house, you know that kind of a way, which was untrue. The house situation was unbearable at the time ... I couldn't get any money off the Government whatsoever. I was homeless. I couldn't get any cash. No cash whatsoever. (Alan)

For many, like Alan, a crisis incident, such as becoming homeless, created an immediate economic need. Similarly, for some of the women, this economic need followed a separation from a partner – either

through the end of the relationship, bereavement or imprisonment. For example, three of the women entered prostitution when their partners were imprisoned. Gemma explained that when her partner was sent to prison 'he left me nothing to live on ... I couldn't manage.' Similarly, Carol said that after her partner was sent to prison for seven years, 'I had an addiction and at the time I had no clinic and I had to feed me habit and I had to look after me daughter so that was my only escape.'

Drug dealing offers a lucrative source of income and provides status (Pearson 1987a). A significant minority of the participants interviewed reported having dealt drugs. However, for many of the women in particular, the risks associated with alternative sources of income, such as drug dealing and shoplifting, particularly when opiate dependent and homeless in a relatively small city, increased over time. Úna, who found herself homeless at 18 after being released from Oberstown, explained:

... I started getting strung out on drugs, and I was going shoplifting and it was getting to the stage then that I got known too well in the shops like you know, for it. I couldn't get into the shops [to do] any more shoplifting, so I wasn't making any money out of shoplifting any more. So I ended up going out on the streets one night and the money that I made that night sort of made me go back the next night. And then when I went back the next night, the more nights I was going back the more money I was making. And I ended up just going on the game basically. (Úna)

For these women there was a calculated risk assessment involved in deciding to engage in sex work. Noreen, who often shoplifted and had tried selling drugs but got caught, said, 'It became that I couldn't shoplift because I was caught every time I did. So that was the next step, prostitution.' Finally, a few of the interviewees were of the opinion that the only person being harmed by their engagement in sex work was themselves. As Úna explains:

... the way I used to look at it was, the only person I'm harming is myself. I'm not going out taking a purse, because if somebody was working for a week they'd be getting money for feeding their kids or whatever. I'm not going out doing that. I'm not breaking into someone's house, because they're out working, and come back, and things are gone from their house. The way I looked at it was, I know it's not one of the greatest things a woman can do, and I know it's shameful as well, but the way I looked at it was, 'I'm harming myself', I'm not harming anybody else, you know what I mean? (Úna)

4.4 Interfaces Between Drug Use and Sex Work

The interface between problematic drug use and sex work is complex. Ethnographic accounts of heroin users consistently report the extent to which an individual's life is structured around activities which prioritise drugs (Bourgois 1997; Pearson 1987b; Preble and Casey 1969). Daily drug users, in particular, have to 'work' to keep their habit going. Their lives are dominated by the issue of raising funds to pay for

their drugs, sourcing drugs and consuming them. Once drug users become dependent they often need additional money to fund their habit. As indicated, the starting point for most participants entering into sex work was out of economic necessity. Once participants got accustomed to sex work (as Molly explained 'after a few months it came easy, second nature') and realised that there was money to be made, sex work offered them a sense of financial independence. Karen, like many, was acutely aware that she could earn more in one night than what most women could earn in a week:

If I had no money, I could go in and maybe get all dressed up, and maybe make three or four hundred, sometimes more, and it is just like, even though I started going out getting money for drugs, but it is just, that's a week's wages to some people. (Karen)

However, respondents frequently reported that the more money they earned the more money they had available to spend on drugs. Consequently, for the majority of participants, their increased income from sex work led to an increase in drug use. Úna explains the effects of increased income on her cocaine use and getting caught in the cycle of drug use and sex work:

And the more money I was making the more coke that I was buying and then I'd go up and work on the streets, make my money, I'd go off, score coke, get the coke into me. I wouldn't have any money left. I'd go straight back up to the street, make more money, back down and get coke, back up to the street and I'd be doing that from say, I'd start going out about 10 o'clock at night and I'd be working until then about 6 o'clock in the morning ... and that would be going on all night like for the whole week like through the nights, you know ... But the more coke I was taking, the more I was going out on the game. The more I was going out on the game, the more drugs I was taking. (Úna)

For the women in a relationship with a drug-using partner, the money they earned funded their own drug use and that of their partners. Consequently, women who did not report being pressured or coerced into sex work by their partners nonetheless said that their partners benefited from their involvement in sex work. As Olive said, 'Imagine my husband used to sit at home and let me [engage in sex work], and wait for me to come back home with me money.'

While most of the participants were involved in sex work primarily to source money to survive and fund their drug use, many of the men and women interviewed said that taking drugs enabled them to do the work. Áine said, 'Honest, I wouldn't have the guts unless I be stoned.' That said, a number of women believed that the money earned from sex work did not affect their drug use. For example, Irene, who lived with her partner and engaged in sex work as a career, said:

I don't think the drugs has anything to do with the work that I do to be honest; going back years ago I had to work to support me habit before I met him [partner]; now, I could stop work tomorrow and still live the life that

I live today, and still continue the habit I have today, still have me car, me apartment, and still go on me foreign holidays and I could still do all of that because he has his own business and I don't want for anything, so in that sense I don't need to work to have that kind of lifestyle, do you know what I mean, or a drug habit. (Irene)

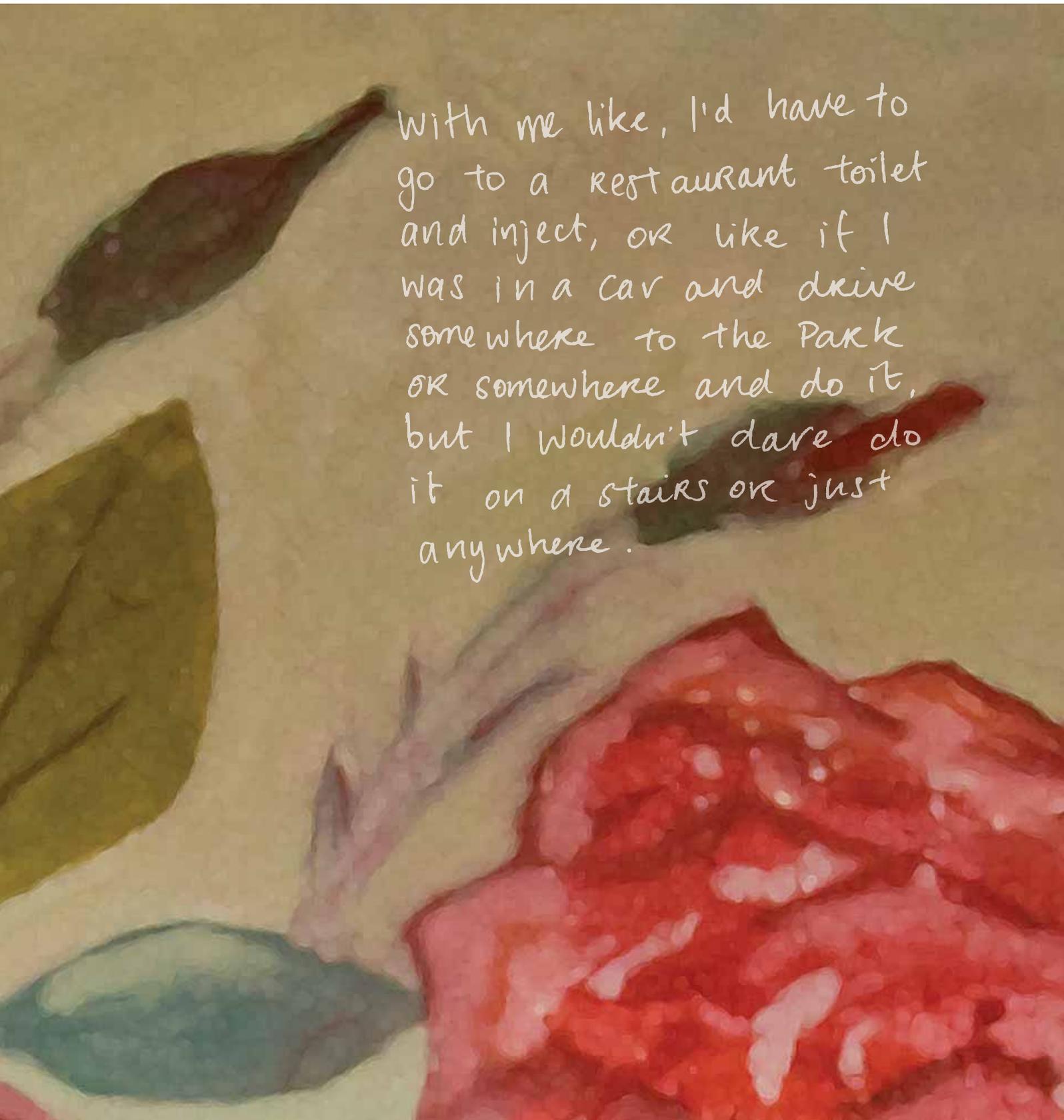
Conclusion

For the most part, participants grew up in inner-city working-class communities where the heroin market was well established. These communities were associated with social and economic marginalisation and high levels of unemployment. In addition, the majority of respondents had adverse life experiences in their childhood and early adolescence relating to one or more of the following areas: family conflict, chaotic home environment, parental and/or sibling substance use, child physical and/or sexual abuse, experience of being in care, youth homelessness, and traumatic life event(s). To a large extent, participants' formative years were characterised by vulnerabilities and exposures that made them susceptible to, and placed them 'at risk' for, a range of problems entering their late adolescent years.

Study participants had multiple opportunities to become knowledgeable about drugs, and were exposed to a range of substances from an early age; drugs were an essential feature of their social scenes. The majority initiated drug use at a young age, usually in the company of their (older) peers. It is argued that damaged childhood experiences and problems are perpetuated and increased by illicit drug use (Klee and Reid 1998). There was no single pattern to participants' drug-using careers, in terms of how they started and how they progressed.

The dominant route into sex work among participants in this study was via peer and social networks, which provided the point of entry. Knowing someone with sex worker experience appears to be all that was required for an introduction into sex work. All were dependent opiate users at the time; consequently, economic necessity was their primary rationale. For many, engaging in sex work followed an incident such as becoming homeless or losing a partner, which led to an immediate financial crisis. Most considered it their only viable option at the time. Involvement in sex work proved to be financially rewarding enough for all study participants to be able to purchase drugs on a regular basis. Moreover, it was often accompanied by an escalation in drug use, due to the increased availability of money.

Chapter 5. Living and Working in a Risk Environment

A watercolor illustration of a hand holding a syringe. The hand is rendered in shades of pink and red, with visible brushstrokes. The syringe is dark brown and is held in a way that suggests it is being used. The background is a mix of muted colors, including green, blue, and yellow, with soft, blended edges. The overall style is artistic and somewhat somber.

With me like, I'd have to go to a restaurant toilet and inject, or like if I was in a car and drive somewhere to the Park or somewhere and do it, but I wouldn't dare do it on a stairs or just anywhere.

Chapter 5. Living and Working in a Risk Environment

Introduction

It has increasingly been acknowledged that among the most important determinants influencing the transmission of blood-borne viruses (such as HIV and HCV) is the environment in which risk is produced (Barnett and Whiteside 1999; Friedman and Reid 2002; Rhodes, et al. 2005). For example, research shows that the transmission of HIV and HCV associated with injecting drug use does not progress within networks of drug users or communities in a uniform or random way, but is subject to the relativity of risk and to variations in population behaviour in different social, cultural, economic and policy environments (Rhodes, et al. 1999; Singer 2001; Wood, et al. 2002).

Sex work, drug use and associated risk behaviours are subject to environmental influences. Consequently, reducing the risk associated with drug-using sex workers requires not only targeted interventions designed to foster changes in individuals' behaviour, but also interventions that aim to create local environments conducive to, and supportive of, individual and community-level behaviour changes (Rhodes, et al. 2005). To this end, it is essential to gain an understanding of drug-using sex workers 'lived experience' of risk.

This chapter explores how the risk environment influences the behaviour of drug-using sex workers in Dublin. The qualitative data gathered from drug-using sex workers were analysed to explore the physical and social contexts within which drug-using sex workers live and work in an effort to understand the interplay of factors which give rise to individually situated risk perceptions, risk behaviours and risk reduction strategies.

Among drug-using sex workers, their work is an important variable in the management of drug use, in so far as it provides the much needed funds to support their continuing drug use. However, it is also a site of risk management in its own terms. Consequently, this chapter is divided into two main sections: the first section explores participants' lived environment and the lifestyles that have evolved around their use of illicit drugs. The features of participants' lived world that produce risk are highlighted and the strategies individuals implement to manage and reduce risk are identified. The second section explores participants' working environment and identifies the aspects of sex workers' physical, social and economic environment that produce work-related risks and the strategies individuals adopt to reduce their risk of harm.

Living in a Risk Environment

This section provides an in-depth account of how drug-using sex workers perceive risk in the context of their everyday lived environment and the lifestyle associated with their drug use. The qualitative data are analysed in order to explore how social (and interpersonal) situations, physical environments and structures in which drug-using sex workers find themselves influence risk behaviour, and how risk behaviour is managed and reduced.

5.1 Risk Production

Drug use and its associated lifestyle produce risks. However, it is important to take into account the broader context in which drug use occurs from the perspective of the drug user. This section explores the lived environment as a determinant of risk.

5.1.1 Drug Use

The previous chapter exemplified how study participants used a repertoire of drugs in the course of their drug-using careers. That said all were opiate dependent and had injected drugs at some point in their lifetime; half were injecting drug users at the time of interview. There are a range of behaviours associated with drug use, in particular, injecting drug use, which place an individual at risk of harm. Drug-related harm can be defined as a negative consequence of drug use to the individual, the local community or society at large (Newcombe 1992). At an individual level, injecting drug use is associated with injecting-related health problems, blood-borne viral infections, drug overdose and involvement in crime. The likelihood and extent of these drug-related harms are mediated by the interaction of a range of individual, social, environmental and structural factors, which comprise the risk environment. The key risks produced by participants' drug use, and the physical and social environment within which these risks occur are presented in this section.

a) Cocaine use

The increase in the availability and use of cocaine in Ireland has led to an increase in use among the general population (NACD 2008a) and among the opiate-using population (NACD 2007; NACD 2008b). A few of the study participants reported using cocaine while out socialising – 'going out for a gargle, having a buzz with a few mates'; most cocaine users, however, reported problematic patterns of use, either injecting cocaine and/or smoking crack. International research indicates that (injecting) cocaine and/or crack use is not uncommon among injecting heroin users and among individuals maintained on methadone (Bux, et al. 1995; Camacho, et al. 1996; Condelli, et al. 1991; Foltin and Fishman 1998; Grelle and Wugaalter 1995). International research suggests that sex workers initiated sex work before they first

used crack (Jones, et al. 1998). While all participants first injected heroin, many subsequently injected cocaine; the men and women who progressed on to injecting cocaine powder and/or crack did so either on its own or in combination with heroin (speedball). They all considered it a particularly risky activity. Frequent cocaine injection is associated with frantic, risky injecting practices in part because the short-acting cocaine is injected more often than heroin, leading to high frequency injecting and 'binge use' of the drug. Participants explained:

Coke is the type of drug when, like, when you take heroin it does you for a few hours, but when you take coke, like when you buy coke, you only get a few minutes buzz out of it, and it's like when you put it into you, you just get a little rush. And it's that rush that makes people want and want and want and it does be too nice and I don't know! I think it's just the feeling you get off it ... and I just keep going back to it and back to it. (Úna)

I want to get more [crack cocaine], I want to get more, all you want to do is get more. (Evelyn)

I was after spending ten grand on coke in a couple of weeks ... it's not a drug you can pick up and put down, well not for me, it's not. I can't just pick up coke and say I'll just take a €50 bag, because it's more, more, more. You just want more of it all the time. (Vera)

... I think it's ten times as bad as heroin. If you had €2,000 a night you'd spend it on it. But you just want more, more, more. At least if it's heroin, like, you'll fall asleep for a little bit, or you'll just be chilled out. But with coke you just want more, more, more. (Karen)

b) Route of administration (adverse health consequences)

Injecting as a route of administration is associated with a range of adverse health consequences that are often neglected clinical problems (Takhasi, et al. 2003). These include vascular and tissue injury (such as bruising and scarring) and reduced vein access; thrombosis and other circulatory disorders; soft tissue infections such as abscesses and ulcers; and systemic and toxin-producing infections such as septicaemia, endocarditis, wound botulism and tetanus (Cherubin and Sapira 1993; Del Giudice 2004). The serious sequelae of these problems include amputation, organ failure, paralysis and death (Cherubin and Sapira, 1993). Because injecting drug users tend not to seek timely medical care for their injecting-related health problems, emergency treatment is often required.

The majority of study participants reported abscesses; the women in particular were conscious of the scarring left on their bodies after years of injecting drug use. Áine believes that the scars identified her as a drug user:

... I think I'm prone to abscesses and scars. I've marks all over me. You know I've still got them. Marks from abscesses that I did have, you know that way, you see the abscesses left big marks, you know that way. Like

what needles does, is it? ... It's embarrassing, like you know. It's only when you get older you say: 'What the fuck did I do that for?' There are people looking at you and I never shoplift and I wouldn't shoplift but I get followed everywhere. It's just that look, you have that look. (Áine)

Participants who were injecting cocaine in particular reported an extensive range of injecting related problems. Cocaine's local anaesthetic effects leave the injection site numbed, increasing the risk of vascular and tissue damage (Rhodes, et al. 2006b). In addition, the combined injecting of heroin and cocaine is associated with abscesses and cellulites (Murphy, et al. 2001; Spijkerman, et al. 1996).

... well, I have a few abscesses ... I had an abscess there and I went in to get it lanced in Beaumont, they said, 'There is actually an artery underneath there, and they said, you have to stay in 'cause I had to get an X-ray because they said 'if we lance that now, you could lose your hand' ... I have a big hole there and a big hole there from going into each side of my groin. (Karen)

... I nearly lost my leg. I was injecting cocaine into it. And the cocaine didn't go into the vein; it went into the muscle, which then caused an infection which is just pus. And the pus just kept eating away at the flesh because of where it was, it wasn't near the bone, it was near the meat ... (Noreen)

I had an aneurism in my leg. I lost the use of my left foot because of it ... because of the aneurism, I have a dropped foot; I can't lift my foot ... I got a blood clot, pneumonia and an abscess on my lungs. That was all at the one time, I nearly died then as well ... (Laura)

I ... got gangrene in that arm, yeah. Yeah, I nearly lost that arm; I had to get an operation there on that twice. I was supposed to get plastic surgery on it but I never went back in. Yeah, I have got infections for the drugs, gangrene and that, yeah ... (Úna)

One of the consequences of vein damage for study participants was being unable to find an injecting site. Participants spoke about having to inject into their groin or their neck in order to get a 'hit'. Arterial injection and the use of veins in the groin and neck are particularly risky practices; long-term use of these sites can lead to vascular complications and circulatory problems such as deep vein thrombosis, ulcers, as well as arterial infections (Mackenzie, et al. 2000; Roszler, et al. 1988; Woodburn and Murie 1996). Iseult explained:

My hands have no veins, well they have but you can't see them, like you know the way yours are visible ... I tried it once in my groin and I wouldn't be able to do that again. That even frightened me, I was really bad, but the powder [cocaine], you really feel the effect in your groin, it goes straight to your head. (Iseult)

... I went into my groin and all with the coke, and I fucking hit an artery, I hit a tendon, and pushed everything back, I won't be doing that again ... (Helen)

In order to avoid their injecting drug use being detected, some participants chose to inject in their neck. Carmel explained:

... I inject in my neck because you can't really notice and then me foot, but your feet get very sore. But it's like in my gaffe, they think that I'm off it, so I have to inject, sort of away from the obvious so, you know what I mean like, so I don't get scars ... so I try and go for anywhere but my arms. (Carmel)

Research indicates that injection recipients (i.e. those injected by others) are more likely to engage in other injecting related risk behaviours (Kral, et al. 2002). A few of the women interviewed were unable to inject themselves and had to get assistance. Karen explained:

I have gone into my neck a few times, but I haven't, I had to get someone to go into it, I couldn't do it, but that is one place that I'd probably still be able to get a vein. But I couldn't go into my neck, I know I said I couldn't go into my groin, but I did, compared to your neck your groin is easy. (Karen)

I was on a clinic when I got more, I was up to 90 mls, but I was using heroin, I really didn't give a damn that time; that was only about a year and a half ago. And then about nine months ago I got a bad case of pneumonia, double pneumonia, and both my lungs had collapsed, and they were flooded full of fluids, I nearly died basically and I was up in James's, the same hospital I have been in four times for pneumonia, so, mmm, I said to him, 'Ah, I have to stop, I have to' and then I got another visitor, a girl who I know, she actually brought me up something. Would you believe that? I went into the things in my neck, the mainlines. So, you know, it's friends as well. (Molly)

Although heroin is commonly taken by injection, it may also be taken by inhalation of heated vapours. Users heat the powder on aluminium foil and inhale the smoke. This practice is known as 'chasing the dragon'. Smoking or chasing is often considered a less risky route of administration of heroin. However, heroin overdose deaths are not restricted to the injection of the drugs, but injection may constitute a greater overdose risk factor (Darke and Ross 2002; Warner-Smith, et al. 2001). In addition, there is some evidence to indicate that smoking heroin off aluminium foil is associated with heroin-induced toxic leukoencephalopathy,⁷ which can result in death. Trish explains some of the other complications associated with smoking heroin:

I get an awful lot of chest infections 'cause you see, at the beginning I was burning the tinfoil and I was smoking the aluminium as well. My chest and I'm asthmatic as well, so that didn't help. (Trish)

7 Toxic leukoencephalopathy is believed to be caused when a toxin within the heroin, whether added to the heroin or produced when the heroin is heated, leads to injury of the white matter in the brain. The first identified cluster of toxic leukoencephalopathy cases was identified in Amsterdam in 1982.

c) **Poor injecting hygiene and practices**

It is not injecting drug use itself that causes HIV or HCV infection, but engaging in unsafe injecting (and sexual) practices which permit the spread of the viruses (ACMD 2009; Smyth, et al. 2005); in particular, borrowing used syringes, backloading⁸ and sharing 'cookers' and filters. In addition, poor injecting hygiene and injecting practices introduce and/or exacerbate vascular and tissue damage and infection. These include: reusing needles/syringes, inadequate washing of hands or cleaning of injecting site; using mixing agents, filters and cookers contaminated by contact with unwashed hands, saliva, and other surfaces; multiple injection attempts before locating a suitable vein; incorrect injecting angle; poor injecting site rotation; and arterial injection and use of high-risk injection sites such as the groin and neck (Darke, et al. 2001).

While all of the men and women interviewed reported using needle exchanges to access sterile injecting equipment, most admitted to engaging in unsafe injecting practices in the past. As many of the participants commenced injecting drug use at a young age, some did so prior to awareness of the association between injecting drug use and HIV transmission and the identification of HCV. Thus, many were unaware of the risks at the time and unable to access sterile injecting equipment, because there were limited harm reduction interventions in Dublin. For example, Colm, who is HCV positive, explained:

... I remember at one time, 11 of us, 11 people washing out a cup of water, just one cup of water, not 11 different cups of water. One cup of water and we'd all wash it out after and we'd all inject, you know what I mean, and I was third last ... same needle, same plunger, same barrel, 11 of us. So you can imagine. And we didn't even hear of AIDS. The only thing you were afraid of in them days was hepatitis, you know, the jaundice, the yellow jaundice. If you got yellow jaundice you'd know everyone would be looking at you and saying: 'He's on drugs, she's on drugs.' Because that was the only thing that people knew by, being on drugs. And you really got it because there was only one syringe you know ... (Colm)

However, others spoke about more recent occasions where they put themselves at risk by sharing injecting equipment. Eileen explained:

... I have shared works and that's how I got the hepatitis. And then one day last year I was with a girl and she has the HIV. We were actually out one night and we got cocaine off somebody. And I actually brought her home back to the hostel. And we went to IV cocaine, and she was after putting her needle, her works into me and she only realised, or so she said, she only realised that she put the wrong needle in, that it was hers. And it was after being used already because she had HIV. So my head was wrecked, for the whole three months I had to wait for the antibodies and all to come back. (Eileen)

In addition, the men and women interviewed reported occasions when they inadvertently used someone else's injecting equipment.

8 Preparing an injection in one syringe and subsequently transferring half the contents to a different syringe.

... I was dying sick that day and we were just basically rushing to get the drugs into us like, 'cause I was dying sick. And he ended up anyway taking my works and giving me his works. And I didn't know. I didn't cop it until I had my turn on and then until he was having his turn on and I copped that the works that he had was my works and I looked and I had his works and I nearly died. I went mad over it like ... I came in here then (prison) and I found out then a few weeks later that I was HIV positive. (Úna)

... the time I got the hepatitis C, 'cause when I was on the coke, I, it's like, with gear you have a conscience, but with coke you don't and this young fella, now, I wasn't going out with him, we were just friends, but I couldn't get meself, so I needed him to get me, and that's how, I got hepatitis from him. I knew he had hepatitis and I still used, we just threw the works on the table and whichever ... (Florence)

d) Polydrug use

Polydrug use is either the concurrent or simultaneous use of drugs (Earlywine and Newcomb 1997). It can occur in a range of patterns and for a variety of reasons, and may or may not involve the use of substances the user is dependent on. Polydrug use is common among dependent opiate users, moreover, it is argued that 'the pure heroin user is extremely rare and to characterise a drug user as a "heroin" user misses the context in which drugs are used' (Darke and Hall 1995). Polydrug use has emerged from the national and international research as a major contributor to 'heroin' overdoses, with the majority of these overdoses involving the simultaneous consumption of non-opiates (Coffin, et al. 1998; Strang, et al. 1999). Consequently, the main risk associated with polydrug use is overdose; in particular, fatal overdose which is even more closely linked to polydrug use than non-fatal overdose (Farrell, et al. 1996). All the study participants who spoke about previous overdoses reported the use of more than one substance.

For example:

You know I was just having a 'turn-on' and taking a few tablets and then next of all, two and a half months later I woke up in hospital. (Olive)

I injected [heroin] about five times and the fifth time I mixed it was coke and heroin and I overdosed on it ... (Gemma)

The majority of study participants were polydrug users and consumed a range of substances. The co-use of benzodiazepines by opiate users has long been recognised (Browne, et al. 1998; Rooney, et al. 1999) and is associated with increased risk of sharing injecting equipment, of HIV and HCV infection (Darke 1994; Darke, et al. 1992; Klee, et al. 1990), of depression and episodes of deliberate self-harm (Darke 1994; Rooney, et al. 1999) and of death (Ward and Barry 2001). The use of benzodiazepines was widespread among study participants:

I have to have my benzos and I have to have my heroin. And with me I'm not happy until my head is in between my knees ... I would take the benzos first and wait until they work then I'd have me turn on. You know what I

mean. I'd inject me heroin. And 'cause when I take the benzos first and then you'd take the heroin after it, you'd get a better goof, you know like, but like if you take it the other way, you wouldn't really. (Áine)

I'm on benzos all the time, I need them every morning I wake up, I wouldn't be able to talk to you now if I hadn't one inside me like. Do you know what I mean? ... I'm cutting down ... now I'd say I take between €50 and €100 worth [a day]. (Carmel)

If it was Valium, if it was Roche 10mgs, I'd probably take about 30 [a day], but it was the 5 mgs I'd take double that. And if it wasn't Roche tablets, if it was Dalmane, I'd take a box of Dalmane, which is 15 in each card. But, if I could afford more, I would take more. (Áine)

I take 30 a day. I give €50, they're €2 each, but he always throws in extra for you. If I give him €50 he gives me €60 worth and he always throws me a batch every so often. (Síle)

As previously discussed, the majority of study participants reported using cocaine. The co-use of cocaine by heroin users increases the risk of unsafe sexual and injecting practices (Condelli, et al. 1991), and among methadone maintained individuals there are added difficulties in clinically managing cocaine use.

Alcohol is one of the most commonly misused substances among individuals on methadone maintenance (De Leon 1989; Hillebrand, et al. 2001). Heavy drinking is also common among individuals entering drug treatment, and drinking outcomes at 1-year follow-up are poor (Cox, et al. 2006; Gossop, et al. 2000b). Heavy and frequent drinking among problem drug users is associated with increased health risks, including the risk of overdose (Best, et al. 1999; Darke and Zador 1996; Gossop, et al. 1996), of medical complication during methadone treatment and of premature discharge from treatment (Gossop, et al. 2003c). In addition, even low levels of alcohol use among individuals with HCV infection increase the risk of serious liver disease (Pessione, et al. 1998) by accelerating the rate of hepatic fibrosis and reducing the time to cirrhosis (Cooper and Mills 2006; Freeman, et al. 2001).

Approximately half of the men and women interviewed reported no alcohol use. Trish had stopped drinking: 'I was an alcoholic, but I detoxed off the drink, it's two years now since I took a drink.' The remaining participants reported alcohol use; for some this was in moderation: 'I wouldn't even drink every weekend'; for others it was only on special occasions: 'at funerals or a wedding or a party or something like that'. However, a significant minority of the participants reported daily heavy drinking:

I would actually go asleep, wake up and get drunk, and if I could make it out of bed, I'd have, well, I'd always made it out of bed in the morning, but every time I woke up, I was drunk and topped up and got drunk again, I was totally out of me head all the time, but I always got, had like a few benzos for the next morning, a half bottle of wine, or a naggin of vodka, just to get to be able to wash and shave. (Barry)

I drink a lot now you know ... a day you would be talking easily about, easily six to seven cans a day. Most of the times when I have to go up to the Park like I have to [drink] ... if I wasn't [drinking] I'd go down there snapping and probably do damage. (Darragh)

It used to be three bottles of WKD [a day], but I'm trying to snap out of it though. Three large, it went up to four large bottles of WKD, it is like a blue alco pop, vodka ... yeah, but now I am trying to stop. (Carmel)

I'd drink a naggin of vodka, a half bottle of vodka ... everyday. (Olive)

I'd easily drink a bottle of wine and six or eight cans of lager a day. (Rachael)

In addition, most of the participants also reported smoking cigarettes daily, 'from when I open my eyes to when I go to sleep'; and a significant minority also reported daily cannabis use.

e) *The injecting environment*

Public or semi-public injecting environments (e.g. on the street, in stairwells, derelict buildings, public toilets) increase the risks of individuals engaging in unhygienic injecting practices. Injecting while anxious and/or in a hurry due to fear of being detected or being disturbed means that injecting drug users are more likely to omit cleaning their injecting sites, to share injecting equipment and to inject rapidly and miss their intended vein (Broadhead, et al. 2002; Klee and Morris 1995), thus increasing the risk of vascular damage and bacterial infection (Murphy, et al. 2001). Homeless drug users in particular are often required to inject in (semi-) public environments (Lawless and Corr 2005). For example:

... sometimes I have to take them [drugs] in the toilets of – [drug service]. You're not meant to, you're not allowed to, but people do it, you know what I mean, but I'd use, most of the time I'd use in public toilets. I'd do it on my own ... most of the people that I know are on the streets and you're not going to be going with a group of people somewhere to have a turn on. So you go into the discretion of a toilet where no one sees what you are doing. (Laura)

... With me like, I'd have to go to a restaurant toilet or sometimes and do it [inject], or like if I was in a car and drive somewhere to the Park or somewhere and do it, but I wouldn't dare do it on a stairs or just anywhere. (Úna)

f) *The cost of drug dependency*

Maintaining drug dependency is expensive. The cost of participants' drug use varied depending on the severity of their dependency and the range of substances consumed; for example, Vera spends between €50 and €100 a day on heroin and is grateful that she is not dependent on any other drugs:

... Thank God, I'm only on the heroin and literally, I mean it, the heroin is bad enough but when you look at some of them, you think to yourself: 'They're strung out on the coke, the heroin, the drink, the methadone.' You know. No, I am happy the way I am. (Vera)

Laura, who is not in treatment, uses six to eight bags of heroin a day at a cost of €15 per bag. Thus, in order to maintain this level of use Laura needed to acquire between €90 and €120 per day. The men and women interviewed all reported that the cost of maintaining a cocaine 'habit' was enormously expensive. For example, Yolanda reported spending approximately €1,200 a day on cocaine.

The high cost associated with illegal substances means that drug users are at risk of engaging in various forms of prohibitive activities including drug dealing, sex work and acquisitive crime in order to generate a sufficient income to support their preferred levels of drug use (DeBeck, et al. 2007), thereby putting themselves at risk of receiving a criminal conviction and imprisonment, which in turn increase the risk of HCV infection (Allwright, et al. 2000; Long, et al. 2001).

5.1.2 Homelessness

Homelessness is a complex concept embracing states of rooflessness, houselessness, living in insecure accommodation, or living in inadequate accommodation (Edgar, et al. 2003).⁹ There are many risk factors for becoming homeless, including physical and sexual abuse, alcohol and/or drug misuse, mental health problems, contact with the criminal justice systems, debt, and lack of social support networks (Wright and Tompkins 2005). However, in addition homelessness is a social/physical environment that produces risks.

Most of the men and women interviewed experienced periods of homelessness and a substantial minority could be considered homeless at the time of interview. Moreover, the majority of participants had long-standing problems accessing suitable housing and consequently experienced numerous periods of homelessness, often moving from one inappropriate setting to another. For example, Rachael was staying in a hostel at the time of interview, having previously lived in a car with her boyfriend. Laura described herself as 'living all over the place'; the night prior to her interview she was in a hostel. For many of the participants their drug use further hindered them getting accommodation, or resulted in them being excluded or evicted from accommodation; for example, at the time of interview Alan said that he was going from 'couch to couch'; he further explained:

... I was kicked out of transitional housing there in February 2007 [names housing unit] and that was for drug use. It's strictly no drugs policy, so I got kicked out of there. (Alan)

Similarly, both Yolanda and Zoë were 'thrown out' of hostels for drug use and ended up sleeping rough. Síle, who describes herself as being 'at large' from prison, was barred from a number of hostels, and at the

9 'Roofless' includes rough sleepers. 'Houseless' included those living in emergency and temporary accommodation such as night shelters, hostels and refuges and those in long-term institutions such as psychiatric hospitals, prisons, detentions centres, community or foster homes with nowhere to go upon release. 'Living in insecure accommodation' described people who are staying with friends or relatives on a temporary or involuntary basis, tenants under notice to quit and squatters. 'Living in inadequate accommodations' includes overcrowded or substandard accommodation (Wright and Tompkins, 2005).

time of interview was renting a room for €75 a night from a man who keeps demanding higher and higher rent from her. She said:

I actually used to get thrown out of them [hostels], for fighting and people just annoying me, doing things, robbing things and I got barred from them, so I slept rough. (Sile)

Some, like Carol, have been 'blacklisted off the corporation' housing list for anti-social behaviour. She explained how she got her current accommodation:

... I was in my auntie's for nearly a year. So I had the form to get my name back on to the housing list to get the rent allowance for this place. And I had to fight really hard; I had to get on to the TDs [Teachta Dála i.e. members of the Dáil, or lower house of parliament] and everybody like, get letters saying I was clean and I would give urines if they wanted urines, do the whole lot. (Carol)

Homelessness is a key social factor that facilitates risk behaviours and health differences among drug users (Galea and Vlahov 2002). Homelessness increases the risk of syringe sharing (Frischer, et al. 2007) and engaging in unhygienic injecting practices (Lawless and Corr 2005), sexual risk behaviour and of the risk of HIV (Corneil, et al. 2006) and HCV infection (Sheriff 2003). Moreover, the precarious and impoverished existence brought on by homelessness puts individuals at further risk of poverty and social isolation and inadequate access to healthcare and other services (Metraux, et al. 2004). In addition, homelessness increases the risk of engaging in sex work (Adia et al., 2001). The previous chapter showed how a significant minority of the women were introduced to sex work through peers living in hostels. In addition, some of the women directly attributed being homeless and having nowhere to go to them getting started in sex work; for example, Úna said:

I was homeless, I had nowhere to go. I wouldn't go to the hostels because of the crowds in them hostels. I just didn't feel comfortable in the hostels so I was walking around the streets all night. And then it got to the stage that I was sick of walking around the streets. I was fucking cold and then so I'd go up on the game, I'd go up and make money on the streets. I'd go off and I'd be paying for B&Bs every night so I think that was what made me go up and that ... I had no home, no job, I had no nothing like, I had no family to turn to ... (Úna)

5.1.3 Release from Prison

A significant minority of the women (and one of the men) interviewed had experience of imprisonment. Irish research shows that homelessness is a key issue for women both entering and exiting prison (Comiskey, et al. 2006). Úna explained what happened when she was given temporary release from prison with nowhere to go:

I asked the Governor if I could stay for one more night so I could get a hostel to go to the next morning ... they say you either want TR or you don't want it and I said, 'Well, I said, I'm not refusing TR, I want TR. But I'm

just asking, I have nowhere to go tonight, I have nowhere to sleep tonight. Would you not let me stay until the morning so I could get a place and all?' 'I'm giving you five minutes to get out.' So he gave me five minutes to get out. I got out of the prison that day, I was raped that night. I had nowhere to go and I had to stand out on the streets and I didn't know whether to walk this way or walk that way. I didn't know what way to walk because I had nowhere to go. I ended up just walking this way and that way and I ended up walking the streets. And I ended up getting raped and all that night, so I don't know. I think in here [prison] they shouldn't let girls out until they know that they are safe and that they have somewhere to go. (Úna)

Additional risk factors associated with being released from prison include the increased risk of death, particularly during the first two weeks (Binswanger, et al. 2007; Seaman, et al. 1998), increased risk of relapse into drug use (Pollini, et al. 2006), of non-fatal overdose (Kerr, et al. 2007), of suicide (Pratt, et al. 2006) and of re-offending. Moreover, the transition from prison to community requires re-establishing family roles and the difficulties that released offenders encountered are invariably related to the availability of support networks. Barbara, who was released from prison three days prior to being interviewed after serving a 22-month sentence, explained:

I'm finding it tough really, really tough at the moment. I know I was in for only 22 months but it's like I want to go back for the security and the peace. Not so much the peace but just the security of officers around you that cared about you. I'm still sort of vulnerable in that department. I'm dependent on them. (Barbara)

5.1.4 Living with Blood-borne Viruses (BBVs)

Injecting drug users are at risk of blood-borne viral infections, in particular HIV and HCV infection. Approximately seven in ten injecting drug users in treatment in Ireland test positive for the antibodies to HCV (Long 2006; Long, et al. 2001). Given the high incidence of HCV infection, the complications of chronic HCV infection will impact on the morbidity and mortality of this population. The health consequences of HCV are serious and potentially fatal. Initial infection produces symptoms that are mild or nonexistent. Unlike other forms of hepatitis, HCV rarely resolves completely, chronic infection occurs in 80 to 85 per cent of cases and cirrhosis may develop in as many as 20 per cent of those with chronic infection. The vast majority of men and women interviewed reported testing positive for HCV infection (only one participant had never been tested); however, a few were unsure of their current hepatitis C status.

I got hepatitis but, since last year. I got my tests and me body has filtered it, that's what the doctor said ... I didn't think that could happened. (Donna)

I don't think it's affecting me, I don't think I have it anymore, I don't get any symptoms. See, I don't drink, so my liver won't be as bad as someone that drinks, so you know what I mean. (Gemma)

I keep forgetting the one I have, I imagine it was C, the more common one. (Evelyn)

For one of the women in particular, receiving a positive diagnosis had a significant emotional impact.

I am hepatitis C positive. I was in bits I was (starts crying). I was so upset ... when I told people that I had it, I was upset about it. And they'd say why are you upset? I have it, and she has it and we all have it. I said 'Yeah, you all have it but now I have it, that's why I'm upset. I have it, that's the point.' They just couldn't understand why I was getting upset about. We all have it but I didn't want it. (Hilda)

Only one of the women and none of the men interviewed were undergoing treatment for HCV. Although treatment is available, there are multiple obstacles that reduce the likelihood of past, and in particular current, injecting drug users receiving combination interferon and Ribavirin HCV treatment (Cooper and Mills 2006). Mistrust of the medical community may influence drug users' willingness to be assessed and initiate HCV treatment. Many of the study participants were critical of healthcare professionals and the information they received.

Nobody tells you anything. You have hep C and that's the end of it. There's no one telling you what hepatitis is, or anything like and to get to the doctor, now you ring the doctor and you have to wait three months to see the doctor. When you go into the doctor you're only in there and you could have a list of questions and they only want you in and out real quick because of the way it runs; so many behind you. It's ridiculous. (Barry)

... see with hep C, I have had to ask my doctor, anytime I wanted to get my liver checked, they gave me nothing, you are just told you have hepatitis, that's it, do what you want ... (Karen)

There are a range of factors that influence HCV treatment consideration. Psychiatric health is an important variable because interferon-based HCV treatment is well known to increase the frequency and severity of depression (Bonaccorso, et al. 2001) and other psychiatric illnesses (Dieperink, et al. 2000). Homelessness also provides an obstacle to receiving treatment due to the lack of safe storage facilities for HCV therapies among people with unstable housing or those who are homeless (Cooper and Mills 2006). There is also a reluctance to treat active drug users for HCV due to issues related to adherence to treatment regime, tolerance and effectiveness, psychological health and risk of re-infection. Some of the participants were aware that they were unlikely to receive treatment while actively using drugs. For example, Áine said:

I knew I was positive for hep C since about 1996 ... my first ever test I got done I got counselling and that, so any time you ever went to them again, I always said 'Look here I got it done', I know what it's about like! I know you can get Interferon and all but I know you have to be off heroin and that like about a year or so ... (Áine)

Others were reluctant to undergo HCV treatment due to what they believed were the associated side effects of the therapy.

I have hepatitis C ... they did ask me, but I said I didn't want counselling or anything. I've read leaflets about it but I don't think I would get the treatment. My friends got treatment and their hair fell out and everything so I don't want that. (Zoë)

As a result of common risk factors for exposure, HCV and HIV are often found concurrently. The pace of HCV-induced hepatic fibrosis is accelerated in those with HIV co-infection and the likelihood of successfully clearing HCV infection is diminished in those with HIV co-infection (Cooper and Mills 2006). Moreover, a 20-year follow up study of pregnant women entering opiate treatment in Dublin identified HIV-related illness as the most common cause of death (Whitty and O'Connor 2007). Five of the study participants who were living with HIV were also HCV positive; two additional study participants were unsure of their HIV status.

One time they told me I had it (HIV) and one time they told me I hadn't got it, so I don't know! (Colm)

... I don't like answering questions about it because I'm not sure if I have it (HIV) or not ... One place told me I had it and another place told me I hadn't. (Mary)

Some of the study participants have been living with HIV for many years. Olive, who was diagnosed in 1997, explained how the health professionals broke the news to her.

I have HIV ... they didn't tell me any ifs or buts about it, or nothing, just you have to go and see Dr – It's a disgrace the way they go about it. It really is a disgrace, like my doctor didn't even say to me, I don't know anything about it, I only know I have HIV and that's it ... I had the test, but what happened with me, I was after taking an overdose and I was brought into hospital and kept in hospital, I was in intensive care, I came out of intensive care and the doctor came round to me, a few doctors came around, and told me I had HIV, that was it. (Olive)

Participants also spoke about the stigma of living with HIV, 'Some of my brothers and all was afraid to drink out of a cup after me.' Angela, who is HIV positive said, 'To me HIV is a manky disease.'

Only three of the women were receiving HIV treatment – triple therapy; all commenced treatment while in prison. Úna, who was serving a prison sentence at the time of interview, explained:

They have me on treatment for HIV. She [doctor] said that she feels now my hepatitis ... is getting bad ... But she thinks I'm on enough treatment at the moment ... the treatment I'm on now has been making me very sick. So, because I don't know if I'm getting out or not for Christmas ... she said 'see how it goes in here' and if I do get out I'll go up to the hospital myself. Basically I think she wants ... to see if I keep my appointment in the hospital from the outside. She knows that I'm keeping my appointment from the inside because she thinks: 'She's locked up and the officers are going to bring her to the hospital' ... When I'm on the outside I think she's afraid I won't turn up because I'm out there. But I will turn up because I need to. And if I don't turn up, that means that my treatment will get stopped. My triple therapy and all would get stopped. (Úna)

5.1.5 Social Networks

The previous chapter indicated that it is through social networks that access to, and information essential to, obtaining drugs becomes available to study participants. However social networks are more than simply instruments that enable individuals in their pursuit of drugs; social networks and relationships serve other functions in the lives of the men and women interviewed. Extensive drug-using social networks are vital to drug users given the uncertainty surrounding their relationships – acquaintances can be imprisoned, become abstinent from drugs, move into rehabilitation centres or die. These relationships not only develop within the community in which drug users live but are also fostered within establishments such as prisons and treatment services. Consequently, it is argued that in this way the very agencies set up to control and help drug users are also agents for the continuation of drug use (Taylor 1993). However, social networks also influence patterns of risk behaviour (Rhodes, et al. 2005) in so far as drug-using risk behaviour is shaped by shared social and group norms (Broadhead, et al. 1998; Friedman, et al. 1999) as well as the structure of social and injecting networks (Friedman and Aral 2001; Latkin, et al. 2003a).

All the study participants were entrenched in drug-using networks, and many self-identified as ‘junkies’. While these networks were vital for a drug user’s survival, as previous outlined, participants’ injecting related risk behaviour usually occurred within their social networks. In addition, the men and women interviewed frequently reported that once they attempted to move towards being drug free, their social networks often interfered with this, and contributed to relapsing. Having once been drug users – no matter how motivated individuals were to give up their lifestyle – many felt uncomfortable shunning their previous peer group.

... when I came out [of detox] my living conditions weren't great. There was about 12 or 13 homeless people coming in and out of this cottage where I was staying with my kids and my partner before he passed away. And they were all injecting and asking me to get them the turn ons and to burn heroin and whatever. And it used to kill me to do it for them but I done it. That lasted only for about 11 weeks ... and I just got pissed off and ended up going back on it. (Mary)

I try and tell myself that I'm off it [heroin] now, do you know what I mean? So I'm convincing myself that I'm off it. But yet if they [friends] came up for it, to my gaff, I might end up doing it [injecting], so I don't know. (Carmel)

Also, the majority of women interviewed had drug-using sexual partners; only three of the women had sexual partners who were not drug users. Having an injecting drug-using partner may increase the risk for female drug users getting involved in sex work. As outlined in the previous chapter, although few women specifically said they were coerced into sex work by a partner, many of these men benefited from the

money the women earned through sex work. Some of the women were aware of the inequalities within these relationships and resented their male partner living off their earnings. For example, Olive explained:

I was out working to make money for me and me husband, like while I was pregnant ... I started going out for all the money, the money was great, when I went out working on the street ... the money was too handy, and me husband knew that. Like he used to sit back and let me go out and do it, and I was pregnant and doing it.
(Olive)

In addition, research shows that injecting drug users are more likely to share syringes in sexual relationships than in other social relationships such as friendships and acquaintanceships (Hunter, et al. 1995; Rhodes and Quirk 1998), and are at greater risk of HCV infection.

5.1.6 Gendered Risks

Most female drug-using sex workers are of child-bearing age; consequently, they run the risk of unplanned pregnancies, complications during pregnancy and childbirth due to their lifestyle, and having to financially and emotionally parent alone. Research shows that drug-using women, like women in the general population, are more likely to have primary childcare responsibilities (Cox, et al. 2008a). The majority of women interviewed were mothers. This section explores some of the gendered risks to emerge from the data.

a) **Pregnancy**

There is a large body of literature on the risks to the foetus from continued drug use during pregnancy, including low birth weight, congenital defects, early gestation, neonatal withdrawal symptoms (Bunford 1997; Fischer 2000; Lester, et al. 2004; Wang 1999). Among women who are HIV and/or HCV positive there is the additional risk and fear of passing the infection on to the unborn child.

Especially now, I'm worried about the baby, that is what's going through my head. 'Is the baby going to get this [HCV]?' She is still getting tested for it; she has to go for a test now in a few months to see if she has got it.
(Hilda)

Most of the women interviewed were aware of the risks associated with continued drug use and attempted to stop using when pregnant for fear of the harm it might cause their baby. For a few of the women, however, the knowledge that they were pregnant came too late for them to change their behaviour. They were unaware of their unplanned pregnancy until near delivery time, as one of the effects of opiate use can be amenorrhoea (Sonnex 1987);¹⁰ consequently, the absence of menstruation is not taken as an indication of possible pregnancy. Molly explained:

On my last baby now, I didn't even know I was pregnant, because using the heroin so much I wasn't getting my monthlies, so I couldn't tell, and one day I got this pain, it was during the night ... and I thought I was just sick, you know, and then I said to -, that's my partner, I said give us some money and I'll go and get something you know ... So I went, got stuff, came back, injected it and I still had this pain in my stomach, so I went down to Baggot Street that night, about 7 o'clock, and at 8 o'clock it was getting worse, and ... one of the girls there was trying to tell me 'I think you are pregnant, you are having a baby' I said 'What?' 'cause I wasn't even showing, I was that skinny, I was about 6 stone ... so she just pulled a taxi, dragged me into it, brought me up to the Coombe, ten minutes later she was born. (Molly)

Conversely, Angela was very young when she became pregnant, and despite her best efforts she was unable to remain drug free.

I was only 16 when I went to Cuan Dara. I stayed the whole six weeks ... well I left a day early, and I didn't take any drugs, anything until, you see I made an agreement that I wouldn't take any drugs until I had the baby. So I was clean and didn't take any more drugs. I went into the hospital ... and they told me they were taking me in the following day. So I came out roaring crying ... I went home terrified of labour, so after staying off drugs all that length of time I went and bought gear that day. I knew I had to go to hospital and have twins which I didn't know about. I had twins, I didn't know about it, two baby girls. One come out legs first ... she died a year later ... the doctor told me that because the pregnancy was so early, it was nine weeks early, and I was praying that it wouldn't be to do with the drugs. (Angela)

In common with many other mothers, drug-using mothers are anxious and fearful for the health of their babies. Many of the women interviewed who had children, spoke about their sense of guilt surrounding the harm that they may have caused to their children due to their lifestyle. The women coped with these feelings of guilt in different ways; for some it contributed to an escalation in their drug use.

I felt awful after I had her, she was going through a little bit of withdrawals, not enough that she had to go up into the unit but ... I was in tears, by the third day, we were still in the hospital and I was just sitting on the bed in tears, because she just wouldn't sleep, she couldn't sleep! I just felt so bad and the nurse came into me and said 'Are you feeling bad? And I said 'Yes'. She said: 'Will you have another baby while you are on the Phy?' She was being a bit bitchy. I said 'No'. (Hilda)

I left her in the hospital, my partner came up, I left her in the incubator, she had to be there to get her weight back up, they were actually weaning her off the heroin, and I couldn't bear to look at her. They actually had it in the veins in her head, so I left with the help of him, and I was back on down on the street the next day. (Molly)

The rate of miscarriage among drug-dependent women is far higher than in the general population (Lester, et al. 2004; Llopis, et al. 2002). There was a high rate of miscarriage among the women interviewed and

some were also struggling to come to terms with the tragic death of a young child, in some cases after a prolonged illness.

I have three kids but I had a stillborn baby in March 05, and then I had twins in 03 that were born dead so like I had six children. (Barbra)

... when – [baby] died I seem to have dropped back a lot from where I was trying to get when he was with me. Because as well as me daughter, he was the best thing that ever happened. But I still feel he is with me all the time. I'm finding it very, very hard to accept that he is gone. Because I had him for three weeks and I had him for five months inside me. – died of a cot death in – Hostel. 'Cause when I came out of hospital I had nowhere to live. (Rachael)

... she (the baby) had so many problems with her ... they had to give her a lot of X-rays and she was in and out of hospital in the year that she did last. I'd say I really only ever had her home for about three months ... When my young one died I couldn't handle life at all, I didn't want to. Yet I tried, I never admitted to trying and killing myself, and I still won't, but when I look back, I wouldn't hang myself but yet, I did overdose; but I think that it was just a spare second, I was just thinking everything was gone. (Angela)

b) Parenting without support

Many of the women experienced prolonged periods of parenting alone without the support of family or partners, some of whom were in prison, deceased, or simply not involved in their lives. A few of the women, like Finola, decided themselves that single parenthood was more acceptable than living with their partners.

My [ex-partner and father of children] is a heroin addict, heroin dealer, complete scum bag, in and out of prison, I made a huge mistake. I was only with him for a number of months. I left a relationship where I was engaged and everything to be with him ... I ended up going into his pockets one night and taking his keys so that when he left the next day he couldn't get back in. It's terrible, isn't it? I knew he wouldn't check until he was coming home that night. (Finola)

Lone parenting increases the risk of poverty (CSO 2008) and the women frequently spoke about the financial stresses and strains of taking care of their children. Like other mothers, the women interviewed wanted to make sure that their children had the best start in life.

It's ridiculous, it's ridiculous the money they give you, do you know what I mean? They give me the same money that they give a single person, with twenty pounds to look after him. Twenty euro to look after him, to look after a child – that is a bag of nappies. The odd time, the Vincent de Paul drop out to me and give me some vouchers. I have to say that is a great help. (Iseult)

I get €257 a week on social welfare. But the crèche is €500 ... €500 a week, €250 per child. It's a private crèche so the social welfare won't help with it. They [twins] are getting a better start there than they would in a social welfare crèche. I did have them in a social welfare crèche when they were four months old but they couldn't be tainted by the environment then. It sounds terrible snobby but they couldn't be tainted by their environment at that point, they were too young. But now they could, you know what I mean? And there is no way, I want them to have the best start ever and there is no way would they have it in town or any of the townie kind of suburbs. It is just better that they go where they go, and it's worth paying the money. (Finola)

Financial stresses were not only experienced by women rearing young children, as Noreen explained:

I get paid on a Wednesday [social welfare] and I would need some things that my benefits won't cover. My son is in prison, he's 21 and he smokes cigarettes, and just lemonade, chocolate biscuits, anything that you might like, anything that we take for granted, other than food, they get fed but other than that, that's it. Everything else has to be bought; soap has to be bought, shower gel, shampoo. So, at first that's what brought me back out [working on the street] because I was panicking that, because I smoke cigarettes and cigarettes is €45 a week. I hadn't got enough to leave him in enough ... So that's what brought me back out. (Noreen)

As in other studies (Bletzer 2005; Taylor 1993), many of the drug-using mothers interviewed were torn between their desire to be good mothers and the demands of going out to source money for their children and their drug dependence. Sex work and sourcing drugs are time-consuming activities and, without support, many of the women found it difficult to balance the demands of motherhood and those of their drug-using careers.

I worked every single night for a month ... you see – [sister] was working [on the street] as well at the time and – [daughter's] father was locked up, so it was just me, – [sister] and my daughter. And because we used to try and hide everything from her, – [sister] would probably go out first and then come home and I'd go out after her. Then I would come home and she would go back out or whatever; whichever way it was. That's the way we used to do it ... There was no really set time for me going out working. (Carol)

I was down there at 6 o'clock this morning, I got a phone call to go and do business from one guy, you're on the go all the time with coke! I'll go home now. I have to go home now, back home to the kids for nine. I'll get into bed with the little fellow and I'll probably come back about 11 or 12 for an hour or two ... (Donna)

Thus, for many of the women, the desire to provide for their children put them at risk of continued involvement in sex work due to the financially lucrative nature of the work.

I just don't want them [children] to ever have to endure anything; I want them to have the best of everything. So I would go to the end of the earth to do anything I had to do to give them, they go away, my kids go away three times a year, either I go with them or – [husband] brings them away. They go foreign three times a year ... I would go the ends of the earth just to give them that because I never had anything like that. I want them

to have it and yet I've to go to fucking do what I have to do, I'll do it so that they will remember. And what if they ever found out! ... They'd say: 'Mam, you didn't have to do that just to let us go on holidays you know.' I remember my mother going without dinner and all so that we would have more. (Gráinne)

However, the mental, physical and financial demands of motherhood often contributed to a relapse or a return to chaotic drug use.

When I got pregnant on me daughter, I went into Cuan Dara, and I came down to 18 mls on my Phy, and I stayed on that all the way through my pregnancy. When I had my young one, when she was two, I relapsed and went back up. (Pauline)

It [drug use] didn't actually escalate really until I had me daughter. She was two when I really, really got bad, when I really went into addiction. (Carol)

Finally, many of the women spoke about living with the fear that their children would find out about their lifestyle and worried about the negative impact that would have on their future relationship with their children; consequently, the women did their best to conceal their drug use and sex work from their children.

Someone else could say things to them or I could be in town with them some day and this toothless strung-out person comes up and says: 'What's the story?' 'Mammy how do you know that ugly terrible-looking person?' What do you say? ... as children ... grow older they start to understand. That is the bit that will do damage and I have seen other kids lose respect for their parents when they found out that their parents were on drink or drugs or part of the industry or whatever and I never want that for myself. (Finola)

Kids have said it to my kids: 'Your ma is a junkie' do you know what I mean? First they will ask me that and then they will say; 'Well, blah, blah, blah says that you are a junkie. Are you a junkie mammy?' It is horrible to explain and you don't want to explain to them 'what is a junkie'. I just say: 'No, I'm not. Go tell blah, blah, blah that. Tell them to run around and tell his ma!' (Hilda)

5.2 Risk Reduction

The men and women interviewed employ a range of strategies to reduce the risks associated with the physical, social and economic environment within which they live. This section explores risk reduction in the context of the everyday drug-using lifestyles of participants and how they attempt to reduce the variety of risks that complicate daily risk management.

5.2.1 Changing Drug-use Patterns

The majority of men and women interviewed implemented a range of strategies in an effort to reduce the risks associated with their drug use. These strategies can be broadly categorised into those aimed at reducing the cost associated with drug use, and those aimed at reducing the risks associated with particular drug-using practices.

a) *Strategies to reduce the financial cost associated with drugs*

As previously discussed, the cost of drugs is prohibitive. In the course of their drug-using careers participants implemented a range of strategies to reduce the cost associated with their drug use, which in turn reduced their financial need, and their level of involvement in illicit activities. For some, this involved changing the route of administration; for example, moving from smoking heroin into injecting. Eileen explained:

I was smoking but the tin foil wasn't holding me. I have to smoke so much, but when I'm actually IV-ing I could only use one bag and it would hold me. But when I was smoking it I'd probably have to use three or four bags. So at least I'm saving money by injecting. (Eileen)

Some of the men and women spoke about substituting one drug for another cheaper drug. In most cases, participants mentioned substituting non-prescribed methadone for heroin.

... I actually started buying methadone for myself because a bag of heroin would cost €20 and you could get maybe 100 mls of methadone for €20. And a 100 mls of methadone would probably last you two to three days. One bag of heroin would last probably only half an hour. (Helen)

You see – [friend] would be dying sick one minute, and you'd know she wasn't after doing heroin or anything like that. And the next minute she'd be grand. And you'd say what are you after taking? And she'd say: 'I'm after getting Phy off blah, blah, blah.' And that's how I knew how to buy Phy then. At the time Phy would kind of hold you for two days. So it was better than the heroin. (Carol)

While the cost of cocaine/crack motivated some participants to curb their use of drugs, some of the crack users spoke about preparing the drug themselves in an effort to reduce the cost.

... crack cocaine on the streets now is very expensive to buy, but you can actually buy the cocaine yourself and you can actually wash it up yourself, or else there's people actually selling it in rock, but it costs more expensive to buy it than to do it yourself. (Evelyn)

It has already been mentioned that all of the men and women interviewed were active members of established social networks of drug users. Thus, participants knew where to go to acquire their drugs.

Some of the women interviewed spoke about travelling to known dealers to acquire drugs at a reduced cost, or buying in bulk.

You can get heroin around – Street and things like that. They do sell bags up there but the bags do be real small and it's ridiculous the amount of money that you pay for it. And then other places – they sell it in three or four bags of what they sell in – Street; they charge you £30 or £40. On a day-to-day basis I might get one of those bags. So ... a normal typical bag that you would buy in – Street would probably be three or four times smaller than those bags. So that would last me say today and tomorrow as well. (Eileen)

Well I'd buy a half of an eight. Now, that's two grams. That costs €100 ... and you'd get 18 to 20 bags out of it ... if I was to buy 18-20 bags it costs me a lot more money. (Áine)

I buy in bulk, a 100 (euro) bag and put it into 12 street bags. (Gemma)

b) Changing drug-using practices

It was previously stated that all study participants had injected drugs. However, in the course of their drug-using careers many ceased injecting for prolonged periods of time. The difficulties in finding and hitting a vein and the risk of losing a hit can encourage 'reverse transition' from injecting to chasing (Rhodes, 1997). Some of the men and women interviewed reported reverting to smoking in order to reduce the risk of harm. Mary explained:

I smoke. I used to inject but I stopped injecting because I injected what I thought was cocaine and it was rat poison and washing-up detergent. I was dead and they brought me back alive, I was in hospital for nearly ten months, so that made me stop injecting because I got a second chance at life. (Mary)

Others continued to inject, but would only inject certain drugs either because of what they had heard about the potential consequences of injecting a particular substance or due to their own negative personal experiences.

Oh yeah, I inject gear, yeah. I don't inject coke. I never have actually injected coke that's why 'cause I was told that it was worsen than gear when I was starting. Well, if I was working on the streets for gear, what the fuck will I be doing like if I start injecting coke. 'Cause everyone was saying you'll be doing worse things than what you're doing now. I couldn't understand what could be any worse than being on the streets. So I just wouldn't go near it. (Carmel)

Since I'm out of Mountjoy I haven't touched cocaine, 'cause of last year, I don't want it to take me back to where it led me last year. (Vera)

Some participants, in an attempt to reduce the likelihood of engaging in injecting-related risk behaviour, said they preferred to use drugs on their own, rather than in a group.

At one stage I used to smoke it [heroin] with whoever would be smoking or injecting, I didn't mind. But now, no, I'd rather do it in my own comfort, in my own space, in my own time, either at home or wherever. I'd rather, I wouldn't like to be with a group of people the way I used to, because now I'm more alert to what is going on and the dangers and the risks, you know. The least little thing that can happen, you can pick up fucking hepatitis or HIV or whatever. What I mean is, if you are sitting around with people that are injecting you can get HIV, if you fix with them. (Noreen)

I'd rather smoke [heroin] alone because I don't like the whole circle, do you know what I mean? ... I find it dirty or something. I can't describe it ... so I'd rather do things on my own and have me smoke. (Trish)

While the majority of men and women reported having shared used-injecting equipment early in their drug-using careers, all participants were aware of the risks associated with such behaviour. At the time of interview all respondents reported using needles exchanges to access sterile injecting equipment.

Merchants Quay gives me needles and when I'm finished with it I bring it back to Merchants Quay ... I have my own spoon and everything, we have our own separate stuff, because he's got hepatitis C ... They showed me how to inject safely and everything like. (Deirdre)

I'd never share needles, I was always that careful, because to be honest there is no necessity for a person to share needles in this country. First and foremost, there is no necessity. And even if you go up to a homeless person on the street and say: 'Here, listen, have you got any needles?' If they like you, they'd say: 'Yeah'. If they didn't like you they'd say: 'Yeah, but it will cost you.' There's no necessity for that (sharing needles), you know. (Alan)

I never share I always have them with me, always, always. I actually get all the different colours and I use blue or grey. I bump into people and if they haven't got any, I have them here. (Laura)

Some, such as Colm, were acutely aware of the benefits of these harm reduction services, as they were not available in Dublin when he initiated injecting drug use and contracted HCV.

I tell you, the needle exchanges have really, really been fantastic because they have changed everything. I'm telling you a lot of people would be infected with HIV or hep C only for them. Whoever got that brought in, may God bless them, I'm telling you. Because I'm hepatitis C, 'cause I was unlucky because I was using well before they allowed that ... so I didn't know what to do. (Colm)

Others, like Alan, were aware not only of the benefits these harm reduction services provide to reducing personal risks but also to reducing risk to the wider community.

I go to Merchants Quay and get clean needles. We have puncture bins. We call them sin bins. I always carry one of them around with me to make sure that, you know, I'd hate the idea of any syringe being left around or the thoughts of a child pricking themselves on a syringe, you know that kind of way. (Alan)

A significant minority of participants reported that they engaged in the selective sharing of injecting equipment; this was usually with their sexual partner.

The very odd time we'd share barrels, I'd give him [partner] a barrel, or I'd take a barrel, but I'd clean it and take it out and take the rubber bit off, and put the rubber bit of one of mine on, and we'd clean it out with boiling water, and bleach, and leave it sitting, do it, clean it and that would be while he'd be gone out to get the gear. (Florence)

I'm a very fussy, a fussy junkie, people say, but I am. I'd only share with my sister and – [daughter's] father at the time. Anybody else, no I wouldn't. (Carol)

Participants who continued injecting and who accessed needle exchanges implemented a range of strategies in order to reduce the damage to their veins through injecting drug use. For example, Alan explained:

I try to alternate [injecting sites] as much as possible, because citric acid burns away your veins, you know that. It makes your veins transparent. My favourite place would be my arm, but usually with my arm, when the veins are disappearing, I go from my wrist all the way up, because you're working back slowly from the veins. And then you go on the left hand and work all the way back ... I'd only use half a packet of citric acid and I'd use a filter ... I'm not destroying my veins and I don't have to start using blue spikes and going into the groin and things like that, so it's very important to me, I use diabetic syringes at all times, I know they clog on occasions but ... (Alan)

c) Accessing treatment and stopping drug use

In an effort to reduce their drug use and the associated harms, all the study participants, in the course of their drug-using careers, accessed treatment services. As illustrated in Chapter 3, the majority were on a methadone programme at the time of interview and among those who weren't, most had previously been on a methadone programme. A significant minority of the women had accessed the low-threshold methadone bus, which targets drug-using sex workers in particular. There were mixed views on methadone treatment; however, the majority considered it beneficial.

At the moment I'm in Dr Stevens. There's a bus down there, but I'm not on the bus, I'm on the clinic itself ... the staff are very good. There is a key worker there and ... she helps an awful lot; she knows what it's about, you know. (Áine)

I'm on methadone, yeah, I couldn't believe it. A friend of mine was on the bus and she was telling me that she went in one day; I think it was about 2 o'clock in the day and they started her that night. I thought that was great, there's a chance of getting me habit down. I think it worked. It got me habit down it did. (Trish)

I'm on methadone the last three years ... I'm at 120 mls, but at the start I was at, I think I was at 70 to 80 for a while, and then ... he [doctor] put me up saying that will do you good. I was making an agreement saying: 'Yes, I'll get off it [heroin], I'll get off it', and I tried like, you can only try so much. Sometimes you just say: 'Fuck it! Do you know what I mean?' (Carmel)

Some participants, however, did not find methadone as effective in reducing their drug use as they had hoped. For example, Síle was critical of the dosage provided on the methadone bus, and decided to stop taking methadone.

I was on the bus, on 50 mls. The highest they can give you is 50 mls on the night bus, the 'girls' bus. I was on 40 for a good while but they put me on 50 because my habit was still bad ... and I was still strung out to bits. So I was strung out on tablets, I had three habits. So I didn't want three habits, the methadone wasn't holding me so there was no point. Do you understand me? It wasn't holding me so there was no point in being on tablets and methadone ... I was still dying sick so I stayed on the gear and the tablets instead. If the doctor had given me 70 or 80 mls I would have been fine. The extra 20 mls would have meant an awful lot to me, do you know what I mean? (Síle)

Carol, however, had a very different view on methadone dosage than Síle, she explained:

It takes 40 mls to hold a horse but I was on 120. When you are in that condition, it's greed with drugs as well. No matter what drugs there is, like if someone says to you: 'There's 40 mls that will hold you', you'll be grand till tomorrow or the day after. But if someone says 'There's 120 mls, that'll hold you until tomorrow' you are going to take the 120. It is greed. Once you keep asking them. (Carol)

Others, like Trish, were reluctant to (re)commence a methadone maintenance programme, and some participants expressed concern about the difficulty of coming off methadone.

The thing with the methadone is, like at the start of the maintenance it's basically permanent and I don't want to be on methadone, it's still in that lifestyle even though you're not using. You know what I mean? You still look like an addict, and you still think like an addict. So I'd rather be away from it all. (Trish)

But the Phy is a lot worse than heroin. The Phy would be like, I'd rather come off heroin any day than come off Phy. I'd rather go through me sickness with heroin any day than go through sickness from methadone. You see methadone goes right into your bones and gets right into your body. (Úna)

I'd rather get strung out, God forgive me for saying it, on heroin, than that methadone. (Vera)

That said, some of the participants managed to remain on a methadone programme to successfully reduce their dosage and to enter treatment.

I was on a high dosage; I was on 100 or 110 mls of methadone ... So I done a slow detox in Domville House and I finished it off in Cuan Dara, Ballyfermot, Cherry Orchard. Because – [daughter] was about seven and I didn't want her to see me going through the end of the withdrawal, you know. My auntie took her; my auntie took us over to – and sorted me out more or less, gave me a good shaking. (Carol)

Sooner or later, all the study participants wanted to give up the use of drugs. Coming off and going back on to drugs is an integral part of the lives of drug users (Parker, et al. 1988; Pearson 1987a; Taylor 1993). Eileen explained how she got caught in this cycle as a homeless drug user:

... I was like going around and getting clean and then getting back strung out, and then being clean and getting back strung out. It would be my own fault 'cause I'd have nowhere to go ... when I was clean and after getting out of treatment, I'd actually go back to the places where I did hang around. I had nowhere else to go ... but that was like just running back to the same places where everybody was strung out and they were selling stuff ... I was like just going back to square one. (Eileen)

The majority of men and women interviewed had, over the course of their drug-using careers, periods where they ceased using drugs, often as a result of entering a rehabilitation programme. The motivations for becoming drug free varied, but a crisis point in life often triggered entry into treatment or renewed attempts to stop using. For example, Colm explained that when his mother was dying, 'I got my habit right down, because I was looking after her, because I used to stay with her, morning, noon and night.' For many of the women, pregnancy and/or becoming a mother provided the incentive to stop using drugs. Iseult said:

... then when I had him [son] like, it was weird because I was on methadone and I was using and I was still banging the coke. After I had him, I stopped and I went in to stabilise in Cuan Dara. It was ridiculous like, it just got to the stage where it was either him or drugs, social workers and all were getting called in, 'cause it was either him or drugs, so I went off and I did cold turkey off 90 mls. (Iseult)

Conversely, Eileen accepted the opportunity to enter drug treatment via the drug courts, rather than face a prison sentence.

I had a load of shoplifting charges last year and ... one of the court judges sent me forward to the Drugs Court in North Brunswick Street. You do a course, you go to school, you see counsellors, you give so many clean urines, it's a way for you to work around it instead of going to prison. (Eileen)

A similar pattern emerged among those who managed to become drug free: entry into a detoxification programme, followed by a period of time in a residential drug treatment facility.

I was in Beaumont and then I went into Coolmine. I was clean for a while but you get a bit addicted to the money from working on the streets ... (Áine)

However, entry into, and completion of, treatment were not always enough to guarantee success in participants' pursuit of a drug-free lifestyle. Most had, over the course of their drug-using careers, entered a range of drug treatment facilities. For the majority of study participants, remaining drug free upon completion of treatment entails sacrifices and letting go of their social networks. For some, like Carol, this also meant keeping a distance from her sister (an active drug user).

I knew for my own recovery, I know I was after relapsing but I knew for the safety of my recovery what I had to do. It was a tough graft you know. It was like the first time when I got clean, the hardest part wasn't getting clean it was telling – [sister] what I was doing. Because she was my sister, she was my friend, she was everything to me. That was the hardest part. (Carol)

5.2.2 Coping with Parenting

In order to reduce the risks associated with continued drug use during pregnancy and motherhood most of the women attempted to change their lifestyle and stop their drug taking. For example, Gráinne commented:

When I was pregnant on – [daughter] I stopped abusing drugs, I didn't even smoke or drink. Isn't it mad like, when you are pregnant, you wouldn't touch anything, you wouldn't drink or smoke or anything, but as soon as I had them ... (Gráinne)

However, for most, staying drug free after the birth of a baby was difficult; thus, the majority of women experienced prolonged periods of motherhood while being active drug users.

Research shows that drug-using mothers' experiences of mothering and their attitudes towards their children reflect the attitudes of mothers in other sections of society (Colten 1982; Taylor 1993). Drug-using mothers expect to adopt the traditional caring role towards their children. When the demands of their drug-using careers made this difficult or impossible, like ordinary mothers with jobs and careers, they try to ensure their children will be well cared for elsewhere, and like other mothers, they often feel guilty about abdicating responsibility from being a full-time mother because of commitment to a career (McClelland 2008; Taylor 1993). As in any random section of society, there are those who do not or cannot provide adequately for their children.

Many of the women interviewed, in an effort to reduce the risk of harm to their children, decided to put them in care. In most cases children were in the informal care of their grandmothers or other family members or, in two cases, the family of the child's father. The majority of these women were of the

opinion that their decision to relinquish full-time care of their child was in the best interests of the child. Even though these mothers were no longer full-time carers of their children, most were still actively involved in their daily lives.

My daughter is three ... and my son is seven ... They're in me mam's house, they live with my mam ... I go up every day, come home in the evening and go up, every day I go up there. Saying that, I wasn't there today because I had to go to court but I'll be up there first thing in the morning and be there when they come home from school. Probably collect them from school with my sister and just, just the usual, you know. (Evelyn)

I'd never take my daughter out of me mother's, I don't think. She's settled, that's her home, she has her friends, she has her school. She knows she is safe, instead of going from hostel to hostel with me. I lived there and she can come to me when she wants to. She knows she can do all that. (Angela)

She [daughter] was ten last week, she is well looked after, she lives between me and me mam's but I take her the weekends, and when she is not in school I'd have her, but on school days, me ma does have her, 'cause I live in – [city centre area] and me ma lives in – [suburban area], and her school is there, and I don't want to switch her around now at this stage, so she stays with me ma, she goes to school and then I take her when there is no school. (Gemma)

... they are with me mam ... but I see the kids every day and I am involved a lot in their life, you know when it comes to school and things like that, I know their teachers. When it comes to their health, you know, I'm involved that way. (Trish)

The downside to this informal childcare arrangement was that the women were not always allowed to have access to their children because the families tended to offer support for the sake of the children, and it was their interests that family members had at heart, rather than those of the women. For example, Zoë explained:

The oldest one [seven years] is with the cousin that reared me and the other one [four years] is with a foster family ... I don't get access to my older young one at the moment because my cousin doesn't agree with her coming up to prison. You know, I came in to see my mother when I was a baby. So she doesn't want history repeating itself again ... before I'd see her every two weeks, you know, but there were times for a couple of months when I wouldn't see her, where I'd be on the streets and I got drawn back into drugs and I didn't think it was fair to go out to her in the state I was in. (Zoë)

While the majority of women were happy that the children were being cared for by their parents, there are negative implications to this (Mariani 2002). A generation is skipped, in so far as the grandparents gain another child by taking the place of the parent, while maintaining a dominant influence over the drug-using mother, which puts her on the level of a child. Thus, the mother remains 'a girl' or, even worse, the mother lives as an older sister of her child, and the succession of lifecycles and the influence of a

generation on the generation below is lost. The drug-using mother then has to work hard to gain back her status as a mother and rebuild her relationship with her child.

Some of the women decided to place their children in formal care – usually with a foster family. The women interviewed did not take this decision lightly or for selfish reasons. Rather, they felt that they could not give their children the attention and care they needed.

I got them fostered, when they were younger, because I couldn't look after them ... I thought it would be unfair to keep them with me when I can't do anything for myself, let alone them ... They would have been thrown there, you know what I mean, God forbid, you know what I mean? But that's what the heroin does to you. So, before I really got too bad I went to the social worker in – and I asked her to find them a nice place. A nice house, not a convent or a school or anything, you know. So, that's what happened. They got a nice house out in – with a nice family, which I have met. I keep in touch with them. And that was it. So, I suppose you could say I ended up with a sort of happy medium at the end of it all, you know. (Molly)

I rang the social workers up and said I'm not looking after my kids properly and she says to me, 'Ah, you are a great mother', but I said, 'No, not any more, I was, but I'm not any more.' It took them about two weeks to fucking listen to me to say: 'Look, I wasn't taking care of the kids the way I should be.' Then I put them into family foster care. I had to have drugs and then the kids got their breakfast, I was number one and they came second, whereas before it was the other way around. But I remember like, that I was going on Dún Laoghaire Pier and I was crying to myself, saying, 'I'm after losing everything, me kids, me Ma, everything' ... but then after a few weeks, like, it was like right, the kids were getting looked after well, so, and they deserve that. So, at that time I thought it was the best thing to do. I still do believe it was the best thing to do, because they are brilliant kids. But I do regret it as well, I want for me to be living in a house with my kids. (Áine)

For most of the women, placing their children in foster care was 'voluntary' and their decision; consequently, while they missed their children, they believed that it was for the best. However, when the decision was taken out of their hands, for example, when the social services took the decision to place a child in care when the mother was not ready, it proved harder for the women to accept. Zoë explained:

... when I put my second daughter into voluntary care, me and the boyfriend were having trouble ... at the time I had a care helper, or a home help who used come down to help me with the baby. And I said to her, 'After Christmas I'm going to put her into voluntary care' which is the worst thing I ever done, because five days before Christmas, it was actually the next day, her and the social worker came down to take the baby, so I took that very badly. They wouldn't leave her until after Christmas 'cause they seen I was so depressed it wasn't fair on the baby ... She was ten months, you know ... I took that very badly, Christmas Eve I overdosed. Back from the hospital on Christmas Day I overdosed and then on Stephen's Day I overdosed again. (Zoë)

However, while the women interviewed decided to put their children in care to reduce the risk of harm to the child, losing children, either voluntarily or involuntarily, was often the impetus for further drug taking and further integration into the drug lifestyle for the mother. Áine explained how she changed after her child was taken into care:

... I think I got used to my freedom, got used to my fucking freedom again, so I was able to come and go as I please and work on the streets. So, as I said, I wouldn't be happy unless I had my head down between my knees, 'cause it just blocks everything out. I have to have an empty fucking head. (Áine)

5.2.3 Imprisonment

Many of the study participants, in particular the women, had been in prison; moreover, four of the women were in prison at the time of interview and two had recently been released from prison. By and large, participants used the opportunities, services and facilities provided within prison to reduce the harms in their lives. For example, most of the women interviewed ceased using illicit drugs while in prison, and made attempts to stabilise on and/or to reduce their methadone dose.

When I came in I was on 130 mls of methadone, and now I'm down to 25 mls of me own accord. I want to detox off it 'cause I think getting out there, going back on methadone, going around clinics, you might as well go back to square one. (Angela)

I'm detoxing at the moment, I'd got down to 5 mls ... but I had to go back up, I was getting twitchy and jumpy and sweaty ... and because I was in court a couple of weeks ago and I was supposed to be going to Coolmine, I was dead set on coming off the methadone and going in ... I didn't really want to go back up even though I knew I had to ... I ended up deciding to go back up to 40 mls a day, I feel a lot better. (Zoë)

I've been giving clean urines and those, so 'cause I'm trying to get out as well, I want to get out for Christmas. So I'll do whatever I can to try and get out. (Úna)

In addition, many of the women availed of education programmes within the prison.

I'm doing grand. Since I've been in here I've been doing my Junior Cert, studying for it, I'm doing it next year. I've been going to school and I've done courses. I'm actually getting on really well. My urines have been clean, I haven't touched anything since I came in; I'm off drugs. I think that should help. (Zoë)

I done me Junior Cert, I got a B in me English in me Junior. I done me VTEC levels ... I done the woodwork ... and the stain glass, I done the English VTEC level and computers. And I'm just doing the ECDL now on the computers. So I'm getting into more of that now ... I'm going for the hairdressing course. I hope to do a 16-week hairdressing course. I look at all the foreigners in here and they're just school, school, school. I think, 'Why are we so stupid sitting outside and not getting educated?' So I'm starting to come now more than I ever did. (Angela)

As previously discussed, all the women who were receiving treatment for HIV initiated their treatment while in prison. Many also took the opportunity while in prison to get tested for HCV and access other healthcare services, including hepatitis B vaccination.

I got the first injection [hepatitis B vaccination] when I was in prison, and then I got the second one done when I started the clinic in Trinity Court and the third one was five months later and I only got that in July. (Eileen)

In short, being imprisoned was perceived by many of the respondents as being a positive experience. It gave them respite from the streets, time to detoxify from drugs, stabilise on methadone, receive healthcare, enter education programmes and, in some instances, receive counselling. This 'time out' also gave them a period to reflect on their lives.

Working in a Risk Environment

This section provides an in-depth account of the working lives of drug-using sex workers. The qualitative data are analysed in order to explore how the physical, social and economic environments within which the men and women work give rise to and influence risk behaviour, and how risk behaviour is managed and reduced. It also explores how the work environment influences risks associated with drug use, and how drug use influences the risks associated with sex work.

5.3 Risk Production

There are certain aspects of the environment within which drug-using sex workers operate that produce risks to the individual. The key risk production features of study participants work environment are examined in this section, focusing primarily on the risks produced by the physical and social environment.

5.3.1 Inexperience

Inexperience and lack of knowledge produce increased risk. As outlined in the previous chapter, all participants were opiate dependent at the time of commencing sex work and many were still in their adolescence. Consequently, most of the men and women, when they first engaged in sex work were young, naive and largely unaware of the potential risks of selling sex on the street. For example, Hilda was first introduced to the possibility of commercial sex work at 17 years of age through a friend. With hindsight she was angry that her friend 'made it sound as if there's nothing to it. Not that, like, my God, you're going to be shitting bricks if the car door locks go.' She, like most of the study participants, entered sex work largely ignorant of the possible risks, and therefore ill-equipped to implement strategies to reduce the risk of harm.

Generally, participants spoke about lacking practical knowledge: not knowing where to go to get customers, how to attract customers' attention on the street, how much to charge or how long to spend with a customer. This was often compounded by fear and anxiety. As Mary explained:

I was sitting at a bus stop and a car pulled up ... So I looked up and down to make sure I knew no one. I was fucking like, I was very nervous, very nervous. I ended up getting into the car with the man. He drove me up past the Phoenix Park, I didn't realise it was that big! But it was quite nerve-racking ... I was more nervous and terrified, I really had not a clue of prices to what you done, really, you know. (Mary)

As outlined in the previous chapter, when most of the men and women first went out to work it was out of an urgent and immediate need for money to acquire drugs, to support their family and/or to pay off drug-related debts. Moreover, the necessity to engage in sex work was often preceded by a crisis (such as becoming homeless, or a split from a partner). Thus, in most cases it was a reactive, opportunistic action; consequently, most of the men and women were unprepared and ill-informed the first time they engaged in commercial sex.

5.3.2 The Physical Setting

The physical micro-environment for most drug-using sex workers is the street, apartments, or the customer's home. On the street the micro-physical environment where most sexual interactions take place is within cars or secluded lanes. These physical work settings produce a range of risks.

a) **The street**

Street-based sex workers have an increased risk of violence (Church, et al. 2001). Violence results in morbidity, disability, emotional scarring, psychological stress and low self-esteem (Rekart 2005). All study participants had direct and indirect experience of physical and sexual assault by a customer while working on the streets. The physical localities where most of the women sex workers congregated were commercial city centre areas (mainly along the canal) with few residential buildings. These areas, while very populated during the day, are usually quiet at night with a large number of unoccupied office buildings, poorly lit, and with no commercial night life. The male sex workers usually worked in the vicinity of the Phoenix Park. Although the Park is only 3 km west of the city, it is very isolated, poorly lit and largely devoid of traffic. Thus, the characteristics of the locations where street-based sex workers congregate place them at risk of physical and sexual assault in particular.

The men and women recounted harrowing narratives of aggression, violence and brutality from customers while working on the streets. The majority also reported being raped by customers:

There were times when I got broken jaws and black eyes and got raped. (Áine)

He ended up going for gold, trying to strangle the fuck out of me and then he ended up raping me 'cause I was trying to fuck him off me. (Carmel)

I got a hammer put to me head. I got a hammer put to me head in the Phoenix Park. And I was crying that much because he had a hammer, he was tapping it on my head, you know like that, and he was saying: 'Give me a blow job, give me a blow job.' And I was sobbing that much that I couldn't, I couldn't. So I said: 'If you drop the hammer and kick it away.' He says: 'Do you know what I'll do', he said, 'I'll hit you with the hammer and I'll throw you into the fucking lake,' he said. (Colm)

I got ripped inside and me backside as well, I got beaten up bad. (Helen)

I got a hiding off a guy in the toilet, and forced me to have the sex with him without the money, but there was, like when I say forced to have sex, the only way I would have got out of the toilet, would be stay there shaking, stay there and terrified, and just do what you want and hope for the best. (Barry)

Street-based sex workers are not only at risk of being attacked by customers, the women in particular are also at risk of being mugged, as they are usually unaccompanied on the streets late at night, in known areas of the city, often carrying large sums of money. A significant minority of the women reported being mugged or witnessed other 'working girls' being mugged. For example, Vera, a very athletic woman managed to fight off an assailant. She recalled, '... he tried to rob me bag and I grabbed me bag and gave him a box and he just ran then, and I just screamed.' Rachael however, was not so lucky.

I've been mugged four days ago, just on Manor Street there, a lad on a bike with a knife. The guards actually have him in the station now. Eight girls he got that night. He seems to be attacking all girls from the hostel. He knows there's no man about. (Rachael)

Barbara witnessed another working woman being attacked on the street for her money.

God love her, she had a pair of boots on ... and she had a little skirt ... And she must have been putting her money down her boots. And he was trying to drag the boots off her and she was trying to hold them. So it must have been a penknife he took out of his pocket 'cause he took it out and he just ripped the whole length of the boots and got the money on her. (Barbara)

A significant minority of the women also spoke about being intimidated by, and at risk of, violence from other working women. A minority of the men also reported being the victims of 'gay bashing' while working in the Phoenix Park. Darragh said:

I don't know how many hidings I got off people like that. I was fucking left in James Hospital for weeks and weeks because they beat me up so bad like. (Darragh)

An additional risk associated with street-based work was the risk of detection. The women in particular were concerned that family members would find out about their involvement in commercial sex. For example, Donna, who at the time of interview was trying to reduce the hours she spent on the street, explained:

... My daughter told me that she heard that I was down on the street, I said: 'I was scoring crack'. I'd rather her think that than that I was out soliciting. (Donna)

Two other women were specifically concerned that their partners would find out that they were working on the street. For example, Carmel's partner told her 'if he ever seen me [out working] he'd follow me and all and he'd slice their throats and all this bollocks. So he'd just cause a load of shit on the street.'

Finally, street-based sex workers are also at risk of detection by the Gardaí; the consequences of working on the street can mean arrest for both the sex worker and the customer. Olive explains:

They let you have three (customers) and ... You get one car you'd go after that, but one car is not enough like and they're thinking you're going. But then they do be watching you and then if they see you going, they follow you if you are parked. And then what's happened with me. They'd watch you, and they'd arrest both of you and they try to get the fella more so than the girl. The girl wouldn't care if she got the money, but if you don't get money and you're after being arrested and they don't let you out then until all hours of the morning, six o'clock. And that means at six o'clock you have to go back out on to the streets and try and get some money, it is so hard. (Olive)

b) Cars

The majority of street-based sex workers are approached by customers in cars; they are then usually driven to quieter, and often more secluded locations, such as the Phoenix Park, to avoid detection. Karen explained her work practices: 'generally it's in their [customers] cars, and depending maybe if they are looking for a hand job, blow job or sex, it would be depending on how far you would drive off. Like, if they wanted sex, you'd drive like a good bit off, like not miles and miles but, you know, a few miles, where if they only wanted oral, you wouldn't go so far like.' The sex workers are then usually returned back to where they were picked up.

Cars produce particular risks for sex workers; central locking in cars means that individuals may be trapped and feel that they are unable to remove themselves from a potentially dangerous situation. As Angela candidly said, 'When you get in that car and you don't know if you're coming back or not.' A number of participants recounted stories of being locked into customers' cars, incapable of escaping. For example, Barry said that after getting locked into a car in the Phoenix Park with a customer, 'the only way to get away from him was, I was just totally smashed out of my head, I actually kicked the window out, the screen, the front screen out on to the grass.'

Many of the women reported being abducted in cars and taken to the Phoenix Park and physically and sexually assaulted and humiliated. The following accounts clearly highlight the risks of street-based sex work and the risks posed by getting into cars, in particular.

... Then I got into the car and he was just driving. We stopped at the traffic lights and I was trying to get out. I couldn't get out as he had the door locked. God, he started beating the head off me so I wanted to get out and I was fighting with him in the car. I thought it was better to keep fighting with him in the car before we fucking got to somewhere that I hadn't got a hope. But he ended up bringing me into a forest and then raping me and then letting me go. But he wasn't letting me go easy like. I ended up in hospital black and blue that night ... That was the weird thing. He was throwing the money at me when he had me arms tied. And he was throwing money at me and calling me a 'dope bird'. (Angela)

I was after doing business and I was finished, I had enough money and your man grabbed me by the throat and took all my money, drove me, and left me in the middle of the Park and kicked me around. (Olive)

And I had a bad experience up there [Phoenix Park]. I was tied to a tree in the Phoenix Park. I was, mmm, they pissed all over me, treated me with disrespect. I got pulled into a car up in Benburb Street, up outside Manor Street, mmm, outside Arbour Hill Prison I was pulled into a car. And they brought me to the Phoenix Park, tied me to a tree and I was left in an awful state. (Úna)

c) Indoor work

While all but one of the interviewees had experience of street-based sex work, some also had experience of indoor work; either through working for an agency, being approached on the street and invited back to a customer's home, or being contacted by a 'regular' customer. While fewer accounts of violence occurred within this context, sex workers are nonetheless still at risk of assault within this setting. For example, Noreen was violently attacked and almost smothered to death by a customer in his home; Carmel narrowly managed to escape a very volatile situation in a house, and Yolanda was not so lucky – she was locked in a customer's flat and raped on New Year's Eve. Úna explained what happened while trying to remove herself from a potentially risky situation in a customer's flat:

... and I went to walk out of his flat and he grabbed me by the back of the heels and started killing me in his flat. He wouldn't let me go. He had me on the sofa and he was beating the head off me but he left me whole face black and blue and all. He wouldn't let me go from his flat; he kept me there for about two hours. Eventually then he let me go and kicked me down the stairs and all. (Úna)

Finola's account clearly shows that working for an agency did not necessarily ensure protection for sex workers.

... I was sent from – Agency on a call-out ... I kind of backed out at the last minute when I was there and basically he didn't let me back out, that is probably the best way to put it and I ended up throwing up in the bathroom afterwards. [She was raped.] It was horrible. And because the agency had their own taxi driver, the taxi driver dropped you off and picked you up, but he was going to be gone for an hour or whatever. And I had tried ringing him to get him to come back and I rang before all this happened, I rang and I said to the agency worker, I said: 'I don't want to do this; I don't want to be with him. I want to go back. I can't do this', just this one particular fella, I just couldn't do. 'No, you have to stay, you have to stay, he is paying x amount.' I can't even remember how much. 'You have to stay.' (Finola)

5.3.3 Unprotected Sex

Unprotected sex produces the risk of contracting and transmitting a range of sexually transmitted infections (STIs), including HIV (Darrow, et al. 1991) and HCV infection (Harcourt, et al. 2001). In addition, female sex workers run the risk of pregnancy from unprotected sex. All the men and women interviewed were aware of these risks and the vast majority of interviewees reported always using condoms while working. However, most said that although they did not have sex with a customer without a condom, they were aware that other sex workers did, for example, Iseult said:

... like you'd get a fella that would come up to you: 'Will you have sex without a condom?' and I'd say, 'No way!' and next of all, say a girl that was standing down there, a couple of yards away, she would jump into the car, but I know what he is after asking, and I do be thinking: 'Jesus Christ, she is going to bring that home' and he is bringing that home, and then he is going to come back out here next week. And the next stupid girl that gets in the car with him is going to. (Iseult)

Among the few who reported having unprotected sex with a paying customer, the enticement was always the prospect of getting more money.

... they say: 'I'll give you x amount if you do it without the condom', you do be saying to yourself: 'That extra few quid will save me coming up tomorrow like, you know what I mean?' (Darragh)

... I even let some young fellas use without a condom, but I used to put the price up, sure, they used to think it was worth it ... (Carmel)

Zoë, who said she had sex without a condom only once with a customer (for €200) explained: 'It was the worst thing I ever done because I had to get tests after that.'

The power dynamics and the inequalities in physical power between a sex worker and a client can rob the sex worker of the opportunity to negotiate condom use (Shannon, et al. 2009). The other occasions when sex workers reported having unprotected sex was when they were raped. Angela said, 'I never had unsafe

sex apart from three times when I was raped.’ Similarly, Molly said, ‘I always used my condoms, except for the times that I was either beaten up or whatever.’

5.3.4 Drug Use

All the men and women were actively using drugs while they were engaging in sex work. As outlined, participants’ drug use produced a range of risks; however, their drug use also produced risks in their working lives. Research suggests that for some sex workers, drug use enables them to work longer hours and to minimise the distress which they experience as a consequence of the ‘work’ (Young, et al. 2000). However, drug use has been found to reduce the likelihood of condom use and some studies found that drug use before and during sex (Logan, et al. 1998) impacts on a sex worker’s ability to successfully negotiate a safe sex encounter (Gossop, et al. 1994).

Many of the study participants spoke about ‘having to be stoned’ to work in order to ‘block out’ what was happening and in order to be able to provide the required services. Angela said: ‘All the times I’ve ever done prostitution, I’ve never done it sober; never ever went down there sober.’ Alan, who frequently engaged in domination and catered for fetishes, said:

... If they asked me to do reasonable things, then fine, I wouldn't be that thrashed, I would just do it, real normal, just get me fix and feel normal. But like when they start asking me to put out cigarettes on them and start whipping them or whatever, I would have to be out of it. I'd have to be off my head, you know that kind of way ...
(Alan)

However, working while ‘out of your head’ produces particular risks, as Karen explains:

... you would not be in control, and if you are not in control, they could do anything to you, they wouldn't pay you, they mightn't use a condom, you are not together enough to resist them, you know? And then if they get heavy you're like: 'Shite, I want to get out of here alive.' (Karen)

On the other hand, participants also spoke about the risks produced by working when ‘strung out’ and ‘desperate’ for drugs. In this situation, drug-using sex workers are very vulnerable as the following quotes illustrate.

I was going off, literally going off with anything that would pay me, and in male prostitution, which is also on the female side, when you are addicted it is a whole different story, when you are on the game. Punters and clients are working on your vulnerabilities, say, I am with a punter one night and he is giving me €50, he will see me the next night and, say, he'll know I am that desperate, he will offer me a tenner. (Barry)

Well sometimes I went out sick ... sick for the heroin, but I'd have no choice! There's no other way I would have of getting it. So I'd grin and bear it, and do myself as best I could and get there and wait until you get the first

car, hoping and praying that it's sooner rather than later. And the minute you get the money you don't care what happens even if the man was to turn around and give you a slap. You wouldn't part with it, you wouldn't part with the money ... You'd go through hell and high water, just to get the money; you'd do anything to get it. (Molly)

However, as Laura said, 'I'd obviously have to be that desperate to go out. But the only reason I would do it is if I was sick and I needed it and I had no other way of getting money. That would be the reason.'

Some respondents also reported taking drugs with customers. Carmel said she frequently 'did drugs' with customers, at the same time she highlighted the risks associated with this:

... but some of them used to think gear paid for it and you'd have to say, 'No', like, you'd need the cash and not the fucking gear, fuck the gear, 'I've got me own gear like, I'm sorted out and all', do you know what I mean? (Carmel)

Therefore, working while 'stoned' produces risks for drug-using sex workers; nonetheless, many reported needing to be intoxicated in order to go out and work. Similarly, working when 'sick' for drugs produced risks, often rendering the men and women desperate and vulnerable.

5.3.5 Stigma/Shame

Research shows that sex workers often experience discrimination and stigmatisation, which in turn can lead to abuse, violence, criminalisation, denial of services and low self-esteem (Rekart 2005; Vanwesenbeeck 2001). Drug-using sex workers are doubly stigmatised. Many of the women and men interviewed spoke about the stigma and shame associated with being a sex worker and being labelled 'a prostitute'. As Síle explained:

You see I got arrested one night and they charged me and the man. When I was brought to court and it was very embarrassing going to court 'cause standing up to say: 'Well, I arrested her, in such a place, Baggot Street, and she was with so and so, the man, and involved in prostitution.' It's very embarrassing. (Síle)

The main risk produced by this stigma/shame was an unwillingness to report incidences to the Gardaí because of embarrassment, which means that the perpetrator goes undetected. This reluctance was more commonly expressed by female sex workers. Zoë explains her reluctance to report an assault:

... I was kind of embarrassed to say it; I would have known a lot of Gardaí. A lot of them wouldn't have known what I was into, so it was just the embarrassment. (Zoë)

The stigma and shame felt by the study participants was often reinforced by their interactions with Gardaí. A significant minority of the men and women felt that the Gardaí are prejudiced and judgmental towards them as sex workers.

They just think you are a little scumbag and that's it, you deserve whatever is coming to you. (Brid)

... it's like they don't give a fuck about us, they think that they are only sluts or dirty prostitutes. (Helen)

Some reported being hurried from the streets: '... and then you get the bollocks that just come up and say, "You've ten minutes to get out of here", showing their superiority.' The women interviewed were particularly critical of female guards: 'Ban Gardas are bitches; Ah they are ... but some of the guys are ok, like, and they would kinda watch your back like.' A significant minority of the men and women reported not being taken seriously by the Gardaí when they reported assaults from customers. Úna was viciously attacked by a customer in his apartment and went straight to the Gardaí; she felt they did not give her the assistance she required. Darragh explained why he did not report an assault to the guards:

Ah the guards ... they had no interest in it. Ah sure, 'He's only a dirty old rent boy, up in the Park, fuck him, he deserves what he gets', that's the way they look at it. (Darragh)

However, participants were also concerned that reporting an incident might result in a case going to court and attracting unwanted media attention, which in turn could lead to their exposure as a sex worker. For example, the first thing that came to Noreen's mind when she was being violently assaulted by a customer was that her children would find out what she had been doing.

And all I could see flashing through my mind was what the papers are going to say: 'Prostitute dead. Prostitute choked to death with three young children and a 21-year-old.' And that's all that went through my mind. So at first I screamed and then I just went into this, that's it girl you're a gonner. 'Oh my God, your kids are going to find out what you're after doing; it's going to say "Prostitute".' (Noreen)

On the other hand, Olive did report a rape to the Gardaí. However, she didn't turn up in court. She explained why:

If I had of went to court he would have got a lot more (he got seven years). But I was strung out to bits, you know. That morning, if I had had me gear from the night's work, I would have went to court against him. But the police got mad at me 'cause I didn't go to court. But then again I didn't want it in the papers, you know, your name going in the papers. (Olive)

5.4 Risk Reduction

The men and women interviewed employed a range of strategies in order to manage and reduce the risks associated with the physical, social and economic environment within which they work. Broadly speaking, participants' perceptions of risk were based on their own direct and indirect experiences. While at an individual level working lives and, consequently, work experiences differed and accounts of working life varied in terms of their level of specificity, common themes emerged from the data. This section provides a detailed analysis of the strategies employed by participants to manage and reduce the risks associated with their working lives.

5.4.1 Forewarned is Forearmed

As outlined in the previous chapter, most of those interviewed were introduced to sex work through peer and social networks, often at a young age. However, only a minority of the women (and none of the men) spoke about being informed by other 'working girls' about the specifics of commercial sex on the street before they themselves went out working. For these women initiation into sex work was made safer by the advice and information provided by other working girls. For example, Molly said, 'I knew a few girls that was doing it, so I had it easy in that sense, like they told me what to do, what to ask for, where to go, you know ...'

On the other hand, Rachael, who at 18 went out to work after being threatened by a dealer into paying off her partner's drug debt, knew nothing about commercial sex on the street. In order to inform herself and keep safe she sought out advice from a sex worker living in the same hostel. As Rachael explained:

What I done was I knew a girl that was working on the street ... and I asked the girl 'How do you go about working the streets, what do I do, or where do I go even? What do I say to them, or do I have to say anything to them, do they just pull in or do they walk over to you?' ... I'm asking her because I didn't know what to do ... She told me, she says, 'I don't really want to be putting you down this road' because she was doing it from 12 years of age ... to this day she does blame herself that she told me where to go. But it was my choice ... and I did get the money to pay your man ... (Rachael)

Vera was also 18 and in debt to a drug dealer when she went out to 'try it and see what it's like'. She was completely uninformed. However, her first customer gave her valuable advice on how to keep safe. She said:

I went down to Lesson Street and a car stopped and I froze. And a fellow says to me 'Are you doing business?' and I says 'Yes' and I didn't even know the prices or anything, I didn't know anything at the time. He says to me, 'You never done this before, didn't you not?' And I said, 'No, I didn't.' He said, 'Make sure you always use a condom.' I had condoms on me at the time and he says, 'Don't get into cars that you think [the guy is dodgy].' He put me wise to kind of the, street-wise ... (Vera)

A significant minority of the women spoke about going out with other working women and 'tagging along' or 'taking car regs' prior to commencing sex work themselves. Although these women were not necessarily told the specifics of sex work, the experience of accompanying other working women and observing their practices gave them a certain insight into the business, the working environment (e.g. where to go, how to attract customers' attention, how to avoid detection) and reinforced the importance of implementing strategies to keep safe.

5.4.2 Moving off the Street

In an effort to reduce the risks associated with street-based work, in particular the risk of street-based violence and disclosure, many of the men and women interviewed made the decision to move indoors. The use of mobile phones has been central to enabling sex workers to change their work practices in this regard. Generally, customers make contact via the phone and agree on a suitable meeting place (in a hotel, at the customer's home, or in a car). However, in order for the women and men to work successfully off mobile phones, potential customers had to have their telephone numbers. Many of the men and women over the course of their working careers had 'regulars' with whom they had long-standing arrangements; these were invariably the type of customers upon whom those working off mobile phones relied. However, not all of the women considered working off the mobile phone a safe option; a significant minority said they would not give their mobile number out to anybody. Among the men, although most had regular customers, it did not eliminate street-based work to the same degree as it did for the women.

For most of the women who moved away from street-based work to indoor work, they were also moving away from working 'seven days a week, 24/7'. The advantages were clear:

Now I'd probably get three or more phone calls off clients, where I'd go out to people's houses now, so I don't have to go down the street, thanks be to God! (Mary)

... I have regulars, but often it used to be out every day. Like every night without fail. (Carmel)

I do a lot from my phone, and I'm trying to sort of broaden that so I don't have to come down onto the street. I'd rather not have to come down on to the street ... I do have regulars but when I say regulars it might not be every week, it might be twice a month. I don't have the same ones every week; if I did I wouldn't have to come out on the streets at all. (Donna).

Three of the women interviewed were exceptionally organised, in that they rented an apartment specifically for work. At the time of interview Gemma was living in the private rented sector with her partner and Helen was living in a hostel in the city centre. Both women decided after a number of years of working on the street to rent an apartment together and to 'work off the phone'. Gemma explains:

We have a little place to go, we rent, kind of, a bed-sit, just a bed-sit, it is one room and that's it. We don't live in it or anything; it's just for business. We're not on the street ... We just use it for business. That's the way of making ourselves safe. (Gemma)

These women have a highly planned working practice; they have separate customers who contact them via their mobile phones but they 'work everything together' and pool their money at the end of a day. Consequently, Gemma said, 'If I don't get work, I'd never be left without money, or Helen, the same way

around.’ However, one of the disadvantages is that they have to wait for customers to contact them. Helen said, ‘If we were really stuck and nobody rang like we would go down the street.’

Irene also works from an apartment which she rents; she lives elsewhere with her long-term partner (an ex-customer). She explains her successful move from street-based work to indoor work:

... going back for years ago, I worked morning, noon and night on the street, for years. I done me stint then, but not now ... I work on the phone now, and I work out of an apartment, mmm, more or less, the customers that I deal with now would be all customers that I dealt with over the last six or seven years, so some of them, I count as friends now. I've know them that long, they're all safe. (Irene)

Thus, in order for the three aforementioned women to work indoors it was essential that they were not only highly organised but that they had regular customers who had their mobile numbers. They all got these regulars after years of working on the street. Consequently, indoor work is something that usually only becomes an option for street-based workers over time. As Noreen explained, ‘I don’t have regulars because I’m not out enough to have regulars.’

Only one of the male participants, Alan, never works on the street. For Alan, fundamental to keeping safe, was ‘not becoming a street walker’. He said:

When you are on the street, anyone can kill you ... It's particularly rough for rent boys because at least in the city centre there is life and there is cameras, but when you are up in the Phoenix Park there is no lights, no cameras, just the Wellington Monument, you know. (Alan)

Alan works for an agency that contacts him over the mobile phone and lets him know where to go, who to meet and what the customer is ‘into’. He usually meets with customers in city centre hotels. For him there were a number of benefits to this mode of working:

... someone would always know where I was. It can be unsafe, but the thing is that when it is pre-booked, pre-destination and it's in a hotel, they know that they have a lot to lose and usually they're scared that if something happened, they'd be found out, arrested, and back to the wife, you know! (Alan)

The other three men all said that over the years of working on the streets they had acquired a number of regular customers who had their mobile numbers. However, all continued to work in other locations. For example, Colm has a few regulars but he also worked in pubs in Dublin where he socialises; pubs where, ‘You’d never walk out without having plenty of cash, because, you know, you could go into the toilets.’

Thus, with experience, many of the women and men interviewed were in a position to move away from relying solely on street-based work; those who did were of the opinion that it was a safer method of

working. Having regular customers was central to facilitating this move and most considered that having customers previously known to them was a preferable and safer option. Among the women sex workers in particular, there appears to be a degree of status associated with transitioning to indoor work. It appears to be related to maturation, length of time in the business and having regular customers.

5.4.3 Staying Safe on the Street

As outlined, moving off the streets, although preferable for many sex workers is not always a realistic option. It has been shown that the opportunity often only arises for drug-using sex workers after a period of time spent working on the street. Moreover, many of those who made the move to indoor work still, on occasion, had to work on the streets. Consequently, during interviews the men and women spoke about various risk-reduction strategies they employed in an effort to keep safe while working on the streets.

A minority of the women said that they worked in pairs in an effort to reduce risk. For some, like Gráinne and Hilda, who have been friends since childhood, this was an organised formal working arrangement.

Hilda explained:

... Like, if she [Gráinne] was going off in a car with a punter, I would actually walk up to the car and say, 'Look I have your reg number here, I'm going to wait here. If she is not back in blah, blah time I am just going to ring 999 and give them that reg.' And she would do the same for me ... it is one of our ways of keeping safe. (Hilda)

Neither woman has ever been the victim of violence; Gráinne maintains that this is because of their working partnership. However, for the other women who worked in pairs it was on a more casual basis; for example, a friend would, as Trish said, 'Keep her eye out for me, and when she's on a job I keep my eye out for her.' Among some, there was an assumption that street-based sex workers 'look out for one another'.

Darragh explained working practices in the Phoenix Park:

If you see somebody getting into a car you know we always take the registration number in case they don't come back. That way then if he went missing we would have the registration number of the last person he was with. We kind of do that, like you now. (Darragh)

However, a few of the women were more cynical about the camaraderie among sex workers and the assumption that they 'look out for one another'. For example, Donna, who prefers to work off her phone but still finds it necessary to do some street work, said she has always worked on her own, even though her friend Evelyn also works on the street. She explained:

I mean you are on your own; it's your own business. We talk and we walk round together and that, that's no harm ... but there is no taking regs. Years ago it used to be like that ... Everyone is just out for themselves. (Evelyn)

Similarly, Molly, who ‘always works alone’, recognises that ‘That’s where the risks come in.’ So she relies on her own ability to ‘memorise the reg of cars’, rather than assuming that others will do so. While taking car registration numbers was frequently mentioned as a risk reduction strategy by participants, a range of other strategies for keeping safe in cars were employed, including outright refusal to work in cars.

I'd walk around, I'd look in the back. I'd ask him what he wanted and if he sounded okay I'd take him. It wouldn't be him taking me; it would be me taking him. (Karen)

I'd always look in the back of the car like. (Darragh)

The only time I'd go in the car is if he parked up, and I sat in the driver's seat and had the keys in my pocket. (Trish)

Not in cars. Oh no! Jesus no! I'd go out to their houses. (Mary)

Despite the large amounts of money that can be made from sex work, a number of participants said that in order to reduce the risks associated with street-based work, they cut down the number of hours they spend working on the street and, consequently, the number of customers. Thus, participants often confined sex work to, as Laura said, ‘just when I’m really, really desperate for money’. She further explained, ‘I’d just go out once for what I needed to make me all right until the next day.’

Participants frequently reported that they would not go out and work if they had enough drugs. Consequently, the need to work was often associated with the nature, extent and level of drug use, which in turn, as outlined previously, was influenced by working practices. Others, like Karen, did not work at specific times; for example, she said that she never works when there’s a match on as potential customers ‘are drunk like that, they are too messy, you know, you are trying to get the money out of them, and they’re, it’s just not worth the hassle’.

Finally, a significant minority of the women interviewed (and none of the men) said they carry a weapon – usually a knife – when out working. Most were well aware of the limited protection this affords; ‘Half of them would just take the bleeding knife off you.’ Nevertheless, all the women who made this decision were of the opinion that there had been occasions when carrying a weapon had reduced their risk of being assaulted. For example, Zoë, who usually carries a knife, said:

Once, it wasn't really, really bad but this fella wouldn't let me out of the car, he wanted to drive, he actually started driving up to the Phoenix Park and drove right up to the back of it. I got panicky and told him to drive back. I went to get out of the car because he wouldn't drive back. He locked the door and wouldn't let me out. He was kind of dragging me and hit me a slap and you know. I pulled out the blade and he just let me out then. So if I hadn't had that, probably I'd have been murdered or something like that, you know. (Zoë)

For Olive this strategy backfired when she was arrested while carrying a scissors. As a result she has outstanding charges for loitering and being in possession of a dangerous weapon. Regardless, she said, 'To be quite honest, I think I need them 'cause a man is stronger than a woman.'

5.4.4 Staying in Control

The majority of men and women interviewed spoke about the importance of 'staying in control' and 'taking control' at all times while working. Central to initiating and maintaining control of an interaction with a customer was having work rules. As Alan explained:

You have to first and foremost set out rules ... because if they think you are a push over, they will fucking push you over.
(Alan)

There were a number of strategies participants employed to ensure that they exerted as much control as possible over the customer interaction.

a) **Not working when (too) stoned**

As previously discussed, for a variety of reasons participants were usually intoxicated to varying degrees when out working. However all the men and women interviewed recognised, particularly with experience, the importance of 'being alert' and 'vigilant' when working on the streets. Thus, many said they would try not to be too intoxicated when they went out. In particular, participants mentioned avoiding taking 'tablets'. Karen advised:

... just do enough gear [heroin] or whatever just to keep you from being sick, just to keep you together, because if you are out of your head, especially on tablets ... you would not be in control. (Karen)

Similarly, participants highlight the importance of not being 'too strung out' or 'too sick' when going out to work 'cause you would put yourself in a situation where you normally wouldn't'.

b) **Knowing what you will and won't do**

Some participants had clearly defined rules around what sexual acts they would and would not perform. A significant minority of the women interviewed stated that they would not 'have sex' with a customer, the majority said they would not 'do anal sex'. Others frequently mentioned acts that were considered out of bounds such as kissing, bondage and group sex. Other participants were less emphatic about what acts they would and would not perform as it was considered context-dependent, thereby leaving themselves room for negotiation with the customer. But all participants had a line they would not cross; for example, Darragh said:

... like it got to the stage when people used to say: 'Oh well, listen I'll give you €200 if you let me shag you.' I wasn't into that. I said: 'Oh no!' I said: 'No matter how much you offered me I wouldn't do it', and then they say, 'Right then I'll give you €200 if you do it to me.' I would, I'm not going to lie to you; I would do it to them.
(Darragh)

c) Setting prices

Another common strategy for taking control over an interaction with a potential customer was having 'set prices'. The majority priced individual acts (hand relief, oral and full sex) and prices were broadly similar across all the women interviewed. According to Iseult:

... usually what happens, say if there are three or four girls out, they'd say 'Right, what are you charging?' Like that's it, there is no undercutting and no over-pricing, if you get handed more money fair enough, but there is no over-pricing or under-pricing. (Iseult)

However, in setting their prices some of the women used other sex workers as negative frames of reference. For example, Karen said:

I do, I have set prices, sometimes they say to me 'Ah, you're too dear' and I say 'Go over to the other side of the canal and get it.' I know I used to say and I know like I'm on drugs but I'd say, 'Go over to the other side of the canal and you'll get a junkie for half that' and then they might say, 'Ah well, ok!' mmm, well I charge €65 for oral and €120 for sex. (Karen)

The women who worked indoors set markedly higher prices, primarily to cover their overheads. However, they usually spend much longer with the customer. Helen and Gemma were acutely aware of market forces and were critical of women who charged less than the going rate. Helen said:

And our prices are not cheap, but I'm not saying, there's some dears in Benburb Street, who make it bad for other, the other girls that actually do charge full price because some of them do €10, €20, €30 for full sex, which is disgraceful. (Helen)

d) Selection of and interaction with customers

Fundamental to controlling an encounter with a customer was having the power to decide who to do business with. In this regard many of the participants spoke about relying on their instincts, or gut feelings. For example, Barry said, 'Like your main gut instinct is telling you before you go off, "Shit, there is something about this guy, I don't trust" and you go with it. It's your gut feeling that you are listening to.' The men and women interviewed also spoke about the importance of being able to walk away from a customer if the interaction is not going their way. This, however, often depended on 'how desperate' they were 'for a fix'.

Among the women, a common strategy in customer selection was avoiding non-Irish customers; the data indicate that there is an unwritten rule, 'stay away from foreigners'. Vera, who considers herself 'cautious', explains the advantages of only selecting Irish customers: 'I'm judging my own ... you know who you're going with.' Thus, the women invariably reported avoiding 'foreigners' because they felt safer with Irish

men with whom they are more familiar and in a better position to judge (on the basis of appearance, dress, accent, etc.).

As a rule I don't go with blacks. I'm not racist but it's just ... I think people just feel a bit more secure with their own, that probably sounds a bit off line but that's how I feel. And I'm not racist either. That's just how I feel and I can't change the way I feel. (Evelyn)

I wouldn't go with foreigners ... none of them because, it's not that I'm racist, it's because of the fact that I don't know what their culture is like, what they'd expect. You know what I mean? So I'd be terrified. (Trish)

While only a minority of the women were the victims of violent assault by non-Irish customers, when they were, it was one of the first things they said about the perpetrator. Consequently, most of the women had heard of other women being attacked by non-Irish men. Rather than being an act of racism, which all the women were quick to point out, avoiding 'foreign' customers was an attempt to exert a level of control over a risky situation where control was limited. That said, for most, the rules that governed customer selection were based on personal experience, what they had heard from others or what they had witnessed. Thus, it was often a fluid, dynamic process. Mary explained: 'At one stage I wouldn't have ever done business with a coloured guy, but now I would, but I have a thing now about Polish guys I think they're very rough.' The latter judgement was formed after hearing about another sex worker being violently assaulted by a Polish man.

e) Safer sex practices

The men and women interviewed employ a range of strategies to reduce their risks of unwanted pregnancy and of contracting and transmitting sexually transmitted infections. A significant minority of the women were using injectable contraceptives to avoid unwanted pregnancies; for example, Gemma was getting 'Depo injection'¹¹ and Helen had a contraceptive implant.

... like I had the implant and it dissolved in the end, it's gone, it's out of date, but it takes a while for my body to get back, it is only out of date since March. It is going to take a while for me to get my period back, but I use protection ... (Gemma)

As outlined previously, a significant minority of the women interviewed only engage in non-penetrative acts that carry less risk of infection. In addition, one of the men, Alan, did not engage in penetrative sex; the customers he gets, through an agency, are usually 'people with certain fetishes'.

11 Depo Provera is a contraceptive injection that lasts for three months to prevent pregnancy. The injection contains synthetic progesterone and no estrogen. It is usually given in the arm, hip, upper thigh, or abdomen and delivers a high level of progesterone into the body and stops ovulation.

All the men and women who did engage in penetrative sex reported using condoms. Moreover, the majority were of the opinion that condoms are so readily available through services and from 'other girls' that 'There's no excuse really not to have a condom.' Consequently, most respondents seemed to be able to maintain a high level of safe sex practices and demonstrated responsibility and awareness of protecting themselves while carrying out sexual services for customers despite, as outlined previously, some customers offering higher amounts of money for unprotected sex.

A significant minority of the women also said that they used condoms for oro-genital and/or manual contact as well:

... even for hand jobs. I'd be terrified, terrified of catching anything, any kind of disease, like. (Trish)

Oh, Jesus, yes, all the time, even for hand relief. I know a lot of girls that don't, but I do. Because it's not all the time that I'd have a packet of wipes with me. I usually bring baby wipes with me all the time. (Mary)

... but I do use condoms even if I am giving oral with a punter I use it, even for hand relief, I'd use condoms. (Helen)

Most participants were also aware of the fact that they needed different types of condoms for different acts. Karen explained that the 'fruit flavoured ones are for oral, and the strong ones, the blue ones for sex'.

Although the majority of participants spoke about using condoms to protect themselves from infection, most were well aware of the risk of unprotected sex to others. For example, Úna spoke about the need to protect others because she is HIV positive:

I wouldn't do it, not without condoms, I wouldn't do it. Because the way it was with me, I found out I was HIV positive so I wasn't going to, it wasn't me I was worried about because I knew that I couldn't catch anything anyway. But some of them men had to go back to their wives and kids. So the way I see it, that's like dragging someone down and you're trying to give them a fucking death sentence as well. (Úna)

Only a minority of the women interviewed spoke about using lubricants. Finola explained the benefits:

I always use lubricant as well and it is the lack of lubricant that makes condoms burst. Oh, believe me, I researched everything before I went into it. My God! There was no way was I taking any chances. Oh God, no! (Finola)

Condoms were used by the women interviewed in commercial sex primarily to prevent sexually transmitted infections and HIV. Only two women, Noreen and Barbara, did not speak of the risk of infection, rather they said they used condoms as a contraceptive in their working lives. Noreen said:

I bring condoms. I know in myself, because I am so fearful of becoming pregnant ... I will not have sex without a condom because I will become pregnant if I don't have a condom. And I'm not in a position to rear a child, so they either use it, if they don't want to use they get a blow job, and that's it. (Noreen)

However, for Finola an additional benefit to using a condom was that it helped to remove any level of intimacy from the interactions; by using a condom she said: 'I'm not really touching them.' Other research has shown how sex workers use condoms as a psychological barrier which differentiates between sex as work and sex in private intimate relationships (Sanders 2005).

Another strategy used by the men and women to reduce the risk of contracting and transmitting STIs was accessing relevant services for screening and check-up. For example, Irene said that when a condom burst when she was with a customer she 'went to the clinic straight away, like maybe the next day or whatever, just seen Dr – and explained the situation to her, and just get tests done and whatever.' Most participants had contact with such services, and some, such as Trish, were regular attendees:

... like I'm in the Baggot Street clinic and I go in there every Wednesday without fail to get checked for, I'm just paranoid. It's probably paranoia with me but I don't want to catch anything, like you know. (Trish)

I have been going to Baggot Street, but I haven't been down there for a while. The last time I was down there everything was clear like. (Darragh)

5.4.5 Gardai

Although, as previously outlined, some study participants were reluctant to report violent incidences to the Gardai, many of the men and women interviewed were of the opinion that the Gardai played an important role in reducing the risks associated with street-based sex work in particular.

There's an awful lot of guards down there, I'd feel safe with the guards, I'd say to the guards 'Right I'm going up the lane here, but if you see me going with them, just let me go and make sure I get my money first and then come down and tell them to fuck off' and they would ... they do, they're not bad, really; they look out for you, the guards do. (Aine)

... if something happened and they were driving past you'd just stick your hand out and say look, 'Such and such is driving around, here is the reg.' They would follow it up (Karen).

Some of the participants recounted incidences where Garda intervention reduced their risk of being attacked.

There was one incident one night where I got into a car with a guy, but I had a detective following me in plain clothes, and he kind of looked after the girls on the street, and things got a bit heavy or whatever, but he dragged your man out of the car and called for back up and got him arrested and told me to leg it, you know. (Gemma)

There was one time, I got into a camper van, now, your man seemed fine and everything, and we drove off, but mmm, I looked and the police were behind, and they just stopped us ... and the Guard said to me, 'Do you know why we followed you? It wasn't just to do with you', they didn't do anything to me, they had reports about a dodgy bloke in a camper van. Now I don't know if that could have turned into something bad. (Karen)

The guards came, yeah, and he was very close to getting arrested but they just told him to get into a taxi and get out of the place and he cautioned us in front of your man but he gave us a wink as soon as he was gone ... the Gardaí are very helpful to us ... They'd always stop and ask if you're all right, do we need anything, if we need anything just ring straight away. They're good like that, you know. (Trish)

Molly explained a strategy used by the Gardaí intended to reduce the risk of harm to sex workers.

You have got them coming around. They'd bring you in, photograph you, and whatever, if they don't know you. Just to have it in their files if your body was ever found, God forbid. And, in that respect, that's why they bring you in and photograph you, whatever. You know. What tattoos have you, what scars, you know, blah, blah, your eye colour, hair, height, you know. The whole beeswax, like, just in case. (Molly)

Alan reduced his risk of arrest by treating the Gardaí with respect and adopting an air of compliance, thereby avoiding any confrontation. He explained:

The guards, if you can consider, are like an army. If you take one on, you are taking on the army. And they [other drug users] purposely go out and take one on to prove how hard they are. Where, if I'm caught, it's like, 'Oh shit, how am I going to get out of this? I'm terrible sorry!' Or just admit to what you did, say that you were grassed, a drug fucking user and not fucking debased person, I'm not socially acceptable, grant it, but I'm doing no harm on you and I'm doing no harm on others and that's what I think is the only reason why I haven't been locked up thus far. They don't see me as a huge danger like, you know, that kind of a way, where other people are sticking syringes in each other or you'd have a sense of that, you know. (Alan)

It was not only the female sex workers who had good relationships with the Gardaí. The men interviewed also spoke positively about their interactions with the Gardaí.

... and the gays we had a good communication, a good bonding with the gays, out in Cabra, they would have helped us a lot and, you know ... and we had the support of the guards in Cabra Police Station that were seeing us as being, I'll just give you an example, I was still up there for the year and the guards would stop me and say, 'Jesus, Barry, you look great, you are after putting on a bit of weight, you look great, what are you still doing up here?', you know, that I was still, I didn't know any other way of life ... (Barry)

The Gardaí sometimes give me a bit of hassle but mostly a lot of Gardaí were very helpful when I was in prostitution. When I was on the game they'd always come around, they had the names, addresses and our photographs and they looked out for us and they knew who were the queens and they knew who was the

baddies. And they were good. Now around this area, they're ok to me. You might get them shouting out the window. How are ye? Colm [Makes kissing sounds]. You know what I mean. Will you do me hair? (ha, ha, ha, laughs) (Colm)

5.4.6 Routes out of Sex Work

The concept of 'routes out' of sex work has often been applied to street-based sex work. For some street-based sex workers, social exclusion and the risks to health and personal safety mean that exiting may be the optimum risk reduction strategy for them (UKNSWP 2008). This, however, is not a linear one-way process (Williamson and Folaron 2003) and can take a long time (Hester and Westmarland 2004). The data clearly indicated that the men and women interviewed move in and out of sex work, often as a response to economic need and/or changing patterns of drug use. In this study, participants' motivation for exiting sex work included: pregnancy and/or the birth of a child, becoming involved in new romantic relationships, accessing drug treatment, forced 'exiting' as a result of receiving a custodial sentence or negative life event, and maturation, 'it was time to move on'.

As in other research, a positive life event, such as having a baby, falling in love or undergoing treatment, was often a catalyst to leave sex work because it was characterised by the possibility of a new role in a new context (Mansson and Hedin 1999).

I was going to – [service], I was doing all that and then I got pregnant. That is what happened, I got pregnant. And I thought: 'There is no way.' I know some people do until they are about five months, but that just wasn't me. I just thought I am pregnant now. The using didn't stop but the prostitution stopped. One doesn't outweigh the other really, the using got worse if anything. (Iseult)

Since I met John, I know John, well, I know John for 18 years, but since I started going out with him I haven't been working out on the streets and I don't intend to go back on them either. (Úna)

But, I'm happier since I got in on this fella here [the man she is living with]. Even though I still have bad days and whatever, you know. It's great when you don't have to think about going out. I love it. You know when I can say to myself, you know, I can sit at home and watch telly tonight, you know. I don't have to go down there. I hated it. Literally, I hated it. Every time I had to think about it. Oh, no, I used to hate going down there. And if I could spend the night in, it was great, like, I would say to myself now, I'll be going down for my methadone soon, yeah, very soon. And I'd say to myself, 'I'm getting 40 mls.' At least with that I won't have to go out. You know what I mean? I won't have to wait until it gets dark and do myself up and go out; like I can stay the night in my own place, like watch telly, have a bath. You know, it's great. I'd rather do that. (Molly)

Some sex workers exit when they have reached the limit of what is 'existentially unbearable' (Mansson and Hedin 1999). For some of the study participants this was prompted following a specific turning point or

an eye-opening event; for others there was a chain of events that gradually led to them exiting sex work. For example, shortly after Barry was diagnosed with HIV, his 12-year relationship with an abusive partner ended, and he subsequently entered treatment and left sex work.

I kept ending up in a prison. I kept ending up in the streets, hospitals, prisons, police stations, waking up after, fucking, probably putting a knife in someone's head, a bottle into somebody's head in the Park. And, you know, this was going on and on and on. My family were fucking sick of like, sick of hospitals, sick of prisons ... I was battling for 18 with it, 18 years like, 18 years on the drugs, the drink, 19 years of being a piece of shite, that's what I wanted to get away from ... like they diagnosed me with HIV, I says, 'That's it, that's not a problem.' That was my ticket off the planet ... But when I was diagnosed the doctor said to me, 'Barry, you're HIV positive', he says to me. I says 'nice one'. He was looking at me, mmm, I said 'No'. I says, 'I don't want to be here anyway.' I said 'All my fucking life I am taking tablets to try and get off the earth' and fucking and just unhappy, resentful, angry. (Barry)

Like Barry, Florence also had a turning point when she was admitted to hospital. With the help of professionals she managed to leave an abusive relationship which she had been in for three and a half years, access treatment for her drug use, and subsequently she exited sex work; she is now living in a hostel and receiving psychiatric treatment. Carol moved away from sex work when she believed it was putting her life at risk. She explained:

One man pushed me out of the car. He didn't want to pay. I didn't care. It was a chance to get out of the car. I wasn't going to take the risk of my life; I had a daughter at home sick. The way I was looking at it was I shouldn't be fucking doing this anyway. I'm stupid. I'm on drugs anyway like, putting myself in this predicament. I'm not going to get myself killed over €30 or €40 or whatever it was. There was no way ... I said: 'I'll never do this again. I'd rather go sick. I'd never try prostitution again.' (Carol)

However, some of the participants who exited sex work indicated that they may return to work, as the following narratives suggest:

I'm saying, 'No I won't.' I'm saying, 'No I wouldn't.' But we don't know like. I'm saying, 'I'll never go back into prison again.' And I really mean that from the bottom of my heart. I really mean I'm not going back into prison again. But we just never know, like, you know. But I don't think I'd ever work the streets again. No, they are too dangerous, they are. (Barbara)

I was fed up, I was fed up. It was like having a job, and you know the way people get bored in a job and they move on. Like some people have five years in a job. Prostitution was like a job to me. I still do an odd one now, now as I'm talking to you, now, if someone walked in and said 'Can you meet me?', or if someone rang me and said, you know, I'd still do it, but I keep me limits and make sure that I'm clean. (Colm)

But, yeah, that was all down to my first partner (entering prostitution), so, as I said, I am still on it, dabbling, and if it came to it, and if I missed a few nights on the methadone, I probably would, go out. (Molly)

Others, like Alan, believe that their involvement in sex work will cease once they gain control over their drug dependency.

But no, the further that I'm getting away from my drug dependency the further that I have got away from the prostitution to a certain extent, you know that kind of a way. Once I break free from my habit I would say that that's it. But then again, my option now is, when you get to a certain age that you are a street walker or you're fucked. Ideally the ages are between say 14 to 19, after that you are too old, you know that kind of way ... So, maybe it's not such a bad thing, this forced retirement. Maybe it's not forced retirement, it's not a great pension plan or a great health scheme, but you can only laugh or cry about it, one or the other. (Alan)

Of those interviewed only one man and three women appear to have exited sex work completely; they successfully completed drug treatment and have stable living arrangements.

a) Future vision

The men and women interviewed had experienced much adversity in their lives, including poverty, physical trauma, loss of their children, poor health, and involvement with the criminal justice system. Moreover, as illustrated, all had attempted at some point to control or cease drug use and to move away from sex work. Mansson and Hedin (1999) suggest that in situations where people consistently experience frustration and disappointment they often lose their ability to dream because they risk yet another failure. Conversely, those who can imagine another life and can think about how this life can become a reality are accessing a crucial survival strategy. Many of those interviewed had visions of an alternative reality. Their dreams for the future included the vision of a drug-free life, for some it involved exiting prostitution, getting an education, finding a job, getting a home and, for those who were mothers, the possibility of taking care of their children. This capacity to imagine a better future may enable them to effect personal change in an environment which offers the resources to succeed.

I'd love to be normal, not to have drugs around me. Have a nice house, have my kids back. Just normal things, getting up, bringing them to school, collecting them from school, making their dinner, bathing them and putting them to bed; going on holidays, having a job. (Zoë)

I don't know what kind of job. I'd like to do something that I can do, you know. I wouldn't really mind, any kind of job, just to sort of get me on me feet and then, I'm not really sure what I'd like to do but a sewing factory or a café or pub, lounge girl, anything for the time being, even a cleaning job would do me, anything. Just to occupy my mind as well, you know. It would be something for me to do in the daytimes as well. (Úna)

If I could get a job tomorrow I would take it, you know, and I would stop going up there. (Darragh)

In the next few years, well hopefully I'll get off drugs ... I'm going to go through FÁS. You see, when you have nothing to do and all day to do it, you have to try and keep something to occupy you in your mind. So, I'm going to pretty much going to go through FÁS, kind of build up a little more of my computer skills, because I don't have a great education. I'm going to further my education, first and foremost ... I'm going to go to FÁS and you know build up some of my computer skills and I found that, you know, there's like diploma courses you can do part-time for a year. So, maybe save up and do one of them in DIT, you know. (Alan)

5.4.7 Barriers to Reducing Risk

The men and women identified a number of barriers to their attempts to reduce the risk of harm in their daily lives. The first hurdle for anyone accessing social care services of whatever kind is to gain information about what services are available. The majority of study participants were well informed in this regard; having said that, all were long-term drug users and established sex workers. However, two of the men were not aware of, or linked in with, the specialised services for men who have sex with men. Many of the barriers identified by study participants were around accessing appropriate drug and homeless services in particular. The main themes to emerge are presented below.

a) Navigating complex systems

Many individuals find navigating their way around the social care system complex and frustrating (Rosengard, et al. 2007). The men and women interviewed have a diverse range of information and service needs; consequently, they had to negotiate their way through various sectors and systems, including homeless services, drug treatment services, other healthcare services and the criminal justice system. Many expressed frustration at the complexity and bureaucracy of social care systems. For example, Alan explained some of the practical difficulties and frustrations he has encountered:

You are living your life with no meaning or control. Sitting in places waiting on numbers and they're telling you to go one place and then you've to go to another place, then you go to another place, then you go to another place, you don't get anywhere. It's just a constant fucking circle ... There is too much bureaucracy, there really, really is. And they expect you to keep all these papers and documents, when you have nowhere to live! Do you know what I mean? You have no folder. And you have people saying, "The state of that document! You can't be handing me that!" I don't know how many times I've been down in Lombard Street getting a copy of my birth cert. I think they're sick of me at this rate, you know. Too much bureaucracy! There should be a direct link and a direct route. I actually find that some of the voluntary services can be ten times better than the statutory. (Alan)

b) Stigmatisation and discrimination

The literature indicates that the extent to which service users are treated with dignity and respect by front-line staff is important in determining whether they decide to use a particular service (Rosengard,

et al. 2007). Clients with a broad range of problems and needs are more likely than others to report that services stigmatise them and discriminate against them. Generally, participants felt that there should be greater tolerance and understanding from agency workers such as doctors, social workers, nurses, etc., when dealing with drug users.

... when my brother passed away that time Dr X turned around and said to me 'Do you know what, it should have been you instead of your brother, you're nothing but a dirty fucking junkie, you are a drug pusher.' And I snapped ... I got fucked down to Pearse Street I did, over assaulting Dr X. He's well-known for saying things to people. So many people put complaints in against him, and he's still there, he is. (Darragh)

Stigmatisation and discrimination can also contribute to low aspirations and expectations among clients, which in turn can act as a barrier to services and place constraints on their life opportunities.

I used to go to loads of places but when they don't seem to do anything for you, so you just don't bother trying. (Mary).

c) Inflexible access criteria

Organisational factors can have a strong impact on how easy or otherwise it is for individuals to access services. Individuals can be excluded from services because of the criteria applied for service users.

I suppose, you see, I got thrown out of a hostel and nowhere else would take me in. So I was basically living rough ... I think there should be places for people who do use, you know what I mean. There's places for people, if you're not using, you can go there. But I think there should be places for people who do use ... places where you are allowed, not allowed use, but like active users' places, you know what I mean, instead of throwing them out on the street like. (Yolanda)

Appointments and opening hours (in particular the lack of out of hour's services) can also inhibit engagement with services as the following quotes illustrate.

... this happened to me a few times over the year, you'd ring up, you're put through to - [service name] 'You wanna get off drugs?', you are given an appointment two or three, even four months down the line, that appointment comes up, that's if you even remember it, and if you are dying sick that day, the last place you're going is to go in and keep an appointment, you are going looking for money to get drugs, you know, where they should even, you might, if you rang up and say, 'Right, can you get in this afternoon? Or could you get me in tomorrow, or what day could you get me in, in the next two or three days? You know, 'cause when you're in a frame of mind to get drugs, you might very well do it, but if you're told to wait two or three months, even to see a doctor, and then you get to see a doctor and then you have to give so many urines and they, you, might get on to the clinic, or you might get put on to that night bus ... I'd like to see them doing something with drug services ... as regards when you ring up for an appointment, you're given an appointment there and then. (Karen)

... the - [names service] bus and like it used to be, it used to go around every night, but it doesn't now, it only goes around three nights a week. And, like it's grand in the winter, you know like, and you do be freezing, but I think if they, even if they had condoms as well on the bus and even if they were allowed to carry works like it would stop like the spread of a lot, I think anyway, personally. (Barbra)

d) *Waiting lists*

Long waiting lists for services have been identified as a major barrier to accessing services (Neale, et al. 2006). In the course of their drug-using careers all participants had accessed drug services. Participants' dissatisfaction with the drug treatment systems were primarily around lengthy waiting lists for methadone treatment and the lack of a rapid response.

I don't want to use any of the services because the HSE has a lot to answer for in this country. First and foremost, you know, I don't know who fucking runs it, but there is something severely wrong with it and there are no legitimate services there, you know, and the queues are so long. You know I was signed up for – [prescribing service] and they didn't get back to me for fifteen weeks and I didn't hear from them since. Well I tried ... but, no, the waiting list is too long and it's not a nice place at all, do you know what I mean? (Alan)

... I approached the clinic ... and I was on the waiting list for, God, about two years or something. I ended up going into hospital, I nearly lost a kidney and that's how I got on to the clinic. (Finola)

e) *Limited service options*

The lack of appropriate services to meet the particular needs of individuals was identified by a number of participants as being a barrier to reducing harm. A number of participants spoke about the lack of detoxification places and services for cocaine and or crack use.

The best thing that could be done would be to have somewhere for us to go into and do a detox in there to get off heroin and then try and get our lives back in order before we come back out. That is what I would like ... (Darragh)

... it fucking annoys me, don't get me wrong, I know I went on drugs, I was the one that went on drugs, but there should definitely be more detox places ... I know some people say, once a junkie always a junkie, but I don't believe that ... it's ridiculous because you have to be on certain clinics to get your detox place, like once you're in the detox place, you will 90 per cent be taken off to somewhere else [names residential rehabilitation facilities] ... it's ridiculous – Mary Harney is it? (Trish)

There's only one bed in Cherry Orchard for crack cocaine! One bed! And if you think of the amount of people who have been listed for that one bed. The waiting list for one bed! I was in it twice; I got two good chances then. They have 20 beds; one of them is for crack cocaine. One bed! (Donna)

Well I have my clinic for my methadone; I think there should be more services available as regards helping people with the psychological part of cocaine and crack cocaine and things like that. There's not that much services available for it. (Evelyn)

The lack of safer injecting facilities was also mentioned:

I think they should have them here [safer injecting facilities?], yeah, where you go in and they'll even get you a hit, definitely, 'cause I was living, after my boyfriend died, I was living on my own, and I was still using. I had one or two, you know, funny little turns, but if I had OD-ed, I was there on my own, there was no one there, but if there had been a place where you could have went to, like ... (Karen)

Conclusion

Appreciating drug-using sex workers' lived experience of risk assists in developing interventions to reduce the variety of harms associated with both drug use and sex work. The qualitative data presented in this chapter provide in-depth accounts of how drug-using sex workers perceive risk in the context of their living and working environments, how particular aspects of the 'risk environment' give rise to risk and influence risk behaviour, and how drug-using sex workers implement strategies to manage and reduce the risk of harm.

A recurring theme to emerge from the data was that one person's harm may be another's benefit. For example, among drug-using sex workers, their work is an important variable in the management of their drug use as it provides much needed financial resources. However, it is also a site of risk management in its own terms. As in other studies, participants' entrance into sex work was often to support their financial needs (Cusick, et al. 2003); moreover, within participants' working life, risk taking (e.g. sex without a condom) was related to financial need, and debt is a factor that reduces the likelihood of individuals leaving sex work (Rekart 2005). Similarly, some participants considered drug use before or during an interaction with a customer as being 'risky', but others viewed it in different terms – as a means of enabling them to manage the interaction with the customer.

The data presented in this chapter show that individuals' risk perceptions and risk behaviours may be substance dependent. Although the vast majority of study participants were engaged in drug treatment, many of them continued heavy patterns of illicit drug use. Cocaine use in particular has been associated with significant blood-borne virus risk and sex risk behaviour among injecting drug users (Hudgins, et al. 1995; Tyndall, et al. 2003). Its use has also been found to be significantly associated with involvement in sex work (Kuyper, et al. 2005). Consistent with other research, the men and women interviewed reported intensive periods of cocaine use (Degenhardt, et al. 2006; Roxburgh, et al. 2008) and a significant minority

reported daily crack cocaine use. Among study participants, injecting cocaine use in particular was associated with a range of injecting related problems and extensive vein damage. The risk of vein damage was seen as a particular 'risk priority' for these study participants as it had immediate implications.

The social organisation of risk was also highlighted. Drug use is a social activity, and social networks and the social relationships therein give rise to and influence behaviour (Bloor, et al. 1993; Rhodes 1997b). What from the outside may be perceived as being 'risk behaviour' can to members of the social network serve to symbolise and maintain social ties on which the individual network members are dependent (Rhodes 1997b). Thus, social networks may increase the risk of harm to the individual members through shared social and group norms. For example, social etiquette, reciprocation and the display of trust may require individuals to share drugs and paraphernalia.

Moreover, it is through social networks that drug users were introduced to the possibility of sex work. However, these same social networks, through the sharing of knowledge and experience, play a vital role in enabling drug-using sex workers to implement risk reduction strategies, particularly for the young and inexperienced and those not accustomed to survival on the streets. Sex work, like drug use, is a learnt behaviour; consequently, novices and naïve individuals can unwittingly put themselves at risk of harm. The majority of the men and women interviewed changed their behaviours over time and with experience. Participants developed strategies to manage risk which, from their perceptions, made their lives less stressful and safer. The strategies implemented were based on personal experience and knowledge gained from social networks.

Although intended to reduce the risk of harm, some strategies, however, placed the individuals at further risk. Risk is relative, and there is an acceptability associated with certain risk behaviours (Rhodes and Cusick 2002). For example, many of the men and women spoke about moving from street-based sex work to indoor work. Participants primarily rationalised this move in the context of reducing the risk of violence and the risk of detection. Generally, participants were of the opinion that there was an acceptable level of risk associated with indoor work, given the alternatives.

The data also highlight that structural forces shape risk and vulnerability in the socially marginalised population of drug-using sex workers. Risk behaviour is not simply the outcome of individuals' knowledge, beliefs and behaviours (Rhodes and Quirk 1998) but is also influenced by the physical and economic environment within which individuals live. For example, the majority of men and women interviewed had experienced periods of prolonged homelessness. Research indicates that not only is the experience of homelessness common among injecting drug users (Cox and Lawless 1999) but that homelessness is associated with elevated risk of unhygienic injecting practices (Lawless and Corr 2005), of HCV and HIV

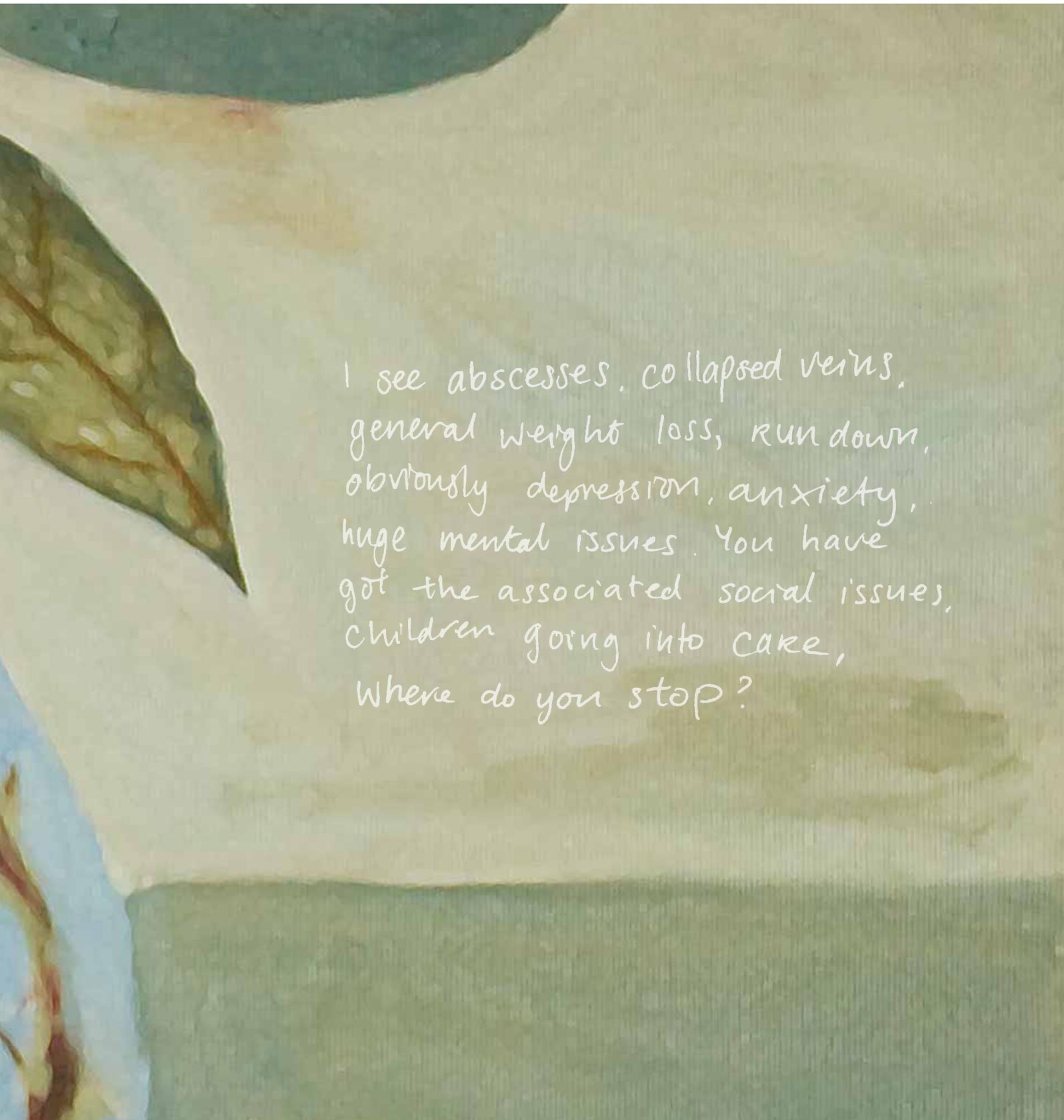
infection (Rhodes, et al. 2006a) and of entrance into sex work (Weber, et al. 2004). Within the context of homelessness, the data indicate that there are certain acceptable levels of risk, such as semi-public injecting and groin injecting. Managing and reducing the risks associated with homelessness complicates the daily lives of drug-using sex workers.

Gendered risks associated with drug use and sex work were also identified. The majority of women interviewed were mothers; while pregnancy and pending motherhood offer an opportunity for detoxification and exiting sex work, for the majority the physical and financial demands of parenting alone contributed to relapse or a return to problematic drug use. All the women struggled to balance their desire to be good mothers with the demands of going out and sourcing money for their children and their drug dependency. Most found it difficult to balance these demands without support. In order to reduce the risk of harm to their children many of the mothers had to ensure that their children were cared for elsewhere, either with their own families or with foster families. For some of the women, losing their children either voluntarily or involuntarily exacerbated their drug use.

Arrest and incarceration in prison can afford opportunities for harm reduction or can conversely increase the harms to the individual. Prison can provide respite from the streets, an opportunity for detoxification from drugs and access to further education; on the other hand, for some, prison can be a site of risk management, and receiving a criminal record makes it difficult to get future employment. Female prisoners have a higher rate of mental illness (Quakers 2007) than the general population. Both drug use and HIV infection are more prevalent among women in prison than among imprisoned men (UNAIDS 2008). In this study, some of the imprisoned women were mothers and the main carer of their children; the experience of imprisonment can have damaging effects on their relationships with their children (Quakers 2007). They are separated from their children and the care giver outside may not wish to bring the child/children into prison on visits. Once released, there is the danger of relapse and overdose, and if a person is being released into homelessness, there is a risk of returning to the streets.

This chapter has presented drug-using sex workers' accounts of their living and working environments and the strategies they use to reduce their risks of harm. The next chapter will explore the professionals' perspectives of them as a client group.

Chapter 6. The Professionals' Perspectives



I see abscesses, collapsed veins,
general weight loss, run down,
obviously depression, anxiety,
huge mental issues. You have
got the associated social issues,
children going into care,
Where do you stop?

Chapter 6. The Professionals' Perspectives

Introduction

Risk and responses are relative phenomena; to varying degrees they are situationally and structurally dependent on the environments in which they occur (Rhodes, 2002). Consequently, the relative success of individual and/or community interventions to reduce the risk of harm is shaped by the local risk environment. Likewise, the policy environment influences the local risk environment; for example, shifts in drug policy may have a harm reduction impact (Pearson 1987a) as may housing/homeless policy and a variety of micro-economic, employment and other community development initiatives. However, the local risk environment can be produced (in part) by policy, legal and financial obstacles to the development of appropriate harm reduction interventions.

The influence of the physical, social and economic environment on risk production and risk management for drug-using sex workers has been highlighted. This chapter explores how policy influences the risk environment of drug-using sex workers in Dublin. The qualitative data gathered from professionals working directly or indirectly with drug-using sex workers were analysed to explore their perspectives on drug-using sex workers as a client group, how services respond to their needs, and the structural obstacles to effective service delivery. Thereafter, the local drugs and sex markets and their influence on the local risk environment are explored. The data are then analysed to examine the influences of drug policy and housing/homeless policy on reducing the risk of harm to drug-using sex workers.

6.1 A Client Group with Complex Needs

The overriding theme to emerge from the analysis of interviews with professionals was that drug-using sex workers as a client group are vulnerable people who have multiple and usually intractable problems who seek help from a wide variety of agencies on many occasions. Thus, they are people with complex needs, as opposed to individuals who have a 'single' need and present at one agency with one problem (Keene 2001). As a client group they move more or less continually through social, mental health and healthcare agencies; homeless hostels; drug and alcohol services; and the prison system (Rankin and Regan 2004). They often (re)present with minor immediate needs at several services, none effectively tackling the complexity and interconnectedness of their needs (Keene, 2001). What's more, it is often the

most vulnerable and socially excluded¹² members of society who are at the greatest risk of their needs not being met. This phenomenon has been described as the ‘inverse care law’; the more complex¹³ a person’s needs, the more likely they are to fall between the gaps in the services that society provides (Rankin and Regan, 2004).

This section explores the complexity of the problems drug-using sex workers present with, from the perspectives of the professionals. Thereafter, the implications for service delivery are examined by exploring the constraints on service provision for this client group, and the obstacles to effective interagency and interdisciplinary working.

6.1.1 Complexity of Problems

The previous chapters illustrated how the majority of men and women interviewed were homeless, had a history of criminal offences and antisocial behaviour, as well as having drug dependency issues. All had serious economic and employment problems, and had family and social relationships that were limited and subject to conflict. Most also had a range of physical and mental health problems. Because of their wide spectrum of multiple and complex needs, drug-using sex workers as a client group cross professional boundaries, including health, social care and low-threshold self-referral agencies; and the criminal justice system.

The professionals interviewed were well aware of, and often overwhelmed by, the complexities of the issues drug-using sex workers presented with, although frequently approaching it from different professional perspectives.

... out of the 23 of those women [drug-using sex workers] I would say 18 of them probably have serious issues, child care, homelessness, violence, psychiatric issues ... The family was another issue ... their family cut them off, some of them were just cut off completely, they wanted nothing to do with them. Brothers and sisters, mothers, fathers, aunts, uncles, they had no contact with anybody out of their family. (Int. 13, Key Worker, Drug Service)¹⁴

... I see abscesses, collapsed veins, general weight loss, run down, obviously depression, anxiety, huge mental health issues. You have got the associated social issues, children going into care, where do you stop? ... and I

12 Social exclusion refers to the consequences when ‘individuals or areas suffer from a concentration of linked problems such as unemployment, poor skills, low income, poor housing, high crime, bad health and family breakdown’, page 62, **Khan, K., Zervoullis, K., Carpentier, C. and Hartnoll, R.** 2000 ‘Mapping available information on social exclusion and drugs, focusing on ‘minorities’ across 15 EU member states’ *Volume 1. EMCDDA Scientific Report*, Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

13 Rankin and Regan (2004) argue that the evidence suggests that it is the complexity rather than the severity of needs that means people get inappropriate services.

14 Interviews with professionals are numbered 1 to 40. Int. is an abbreviation of interview.

suppose you have homelessness too, because it gets confusing, as, how do you separate out which is drug use and which is homelessness, in fact there is no clear division. (Int. 20, Prescribing GP)

They're [drug-using sex workers] very unhealthy because homelessness usually comes with it in this area where we are working, and their health has gone down. They don't eat properly, they don't have time to wash their clothes, they have nowhere to have a shower, they can't take care of their personal hygiene and they have nowhere for them. (Int. 2, Specialist Outreach Worker)

The problem with homeless services is that, and for any other service that deals with these women specifically, is their needs are so complex. When prostitution comes into it and mental health, physical health, addictions, it's really hard, I don't know. Their needs are very complex and vast ... (Int. 9, Homeless Service Provider)

I mean they are a cohort of people who have lost all ability to care for themselves. They don't care about anybody and they don't care about themselves. And it's totally tragic. And I don't even know that going out and meeting their health needs where they are at is even the answer. That's just sticking your finger in a dyke. The need is greater than that. In a sense that is fiddling while Rome burns. (Int. 8, Doctor)

... they have multiple problems, drugs; drugs and alcohol are very much a feature of many of the women coming in here, along with other multiple problems – abuse, violence, homelessness and child protection issues, relationship issues, all of those issues. So we are working with a lot of these high-need, high-support women. (Int. 17, Manager, Criminal Justice Intervention)

The women have multiple problems so we try to engage with them ... they will be women who have committed a crime ... and are serving sentences. We work with women who have a lot of social work and child care issues, child protection issues. (Int. 30, Probation Officer)

While the professionals may not necessarily have used the term 'complex needs' to define drug-using sex workers as a client group, it is clear from the above quotations that the majority were aware of the interconnected nature of this client-group's multiple needs, and that their needs were closely related to factors in the wider community such as poverty and social exclusion.

Some authors use the term 'complex needs' to describe an individual's characteristics, others, such as Rankin and Regan (2004:1), define complex needs in terms of an 'active framework for response', whereby the term offers a 'framework for understanding multiple, interlocking needs that span health and social issues'. Such an approach highlights the importance of the risk environment, in particular the effect of wider situational and structural factors such as poverty, unsuitable housing, limited education and poor employment prospects on the needs of the clients.

6.1.2 Fragmented Service Response

Clients with complex needs are often referred to as a 'revolving door' client group as they consistently reuse different services, often receiving inadequate and/or inappropriate care (Keene, 2001). A metaphor used in a Turning Point (2005:13) publication captures the experience of many such service users: 'Imagine trying to get your car fixed after it breaks down and finding that you have to take it to a different garage to fix each part – one to change the brake cable, another to fix the windscreen, a third to change the tyres and so on. Even worse, each garage is in a different area and none of them share information, so you have to repeatedly explain the problem and fill out separate forms at each visit.'

It is widely accepted that many individuals with complex needs fail to receive the comprehensive help and support that they require despite making repeated demands of a wide range of services (Keene, 2001; Rankin and Regan, 2004; Rosengard et al., 2007). Their needs are often extremely challenging to services; consequently, as a client group they can experience inappropriate service responses, often due to the lack of suitable alternatives. Some of the professionals spoke about the fragmented nature of service responses to drug-using sex workers.

Their very basic needs sometimes just aren't met. They are caught between different services, they might be homeless, they are drug users, they might be moving from bed and breakfast, to bed and breakfast ... (Int. 9, Social Worker)

... there are women there and they keep going from, what I can see, there are services that want to get involved with them and want to help them. But for whatever reason it is just not the right thing for them and I suppose the reality of it is that some people don't want to move on to anything else. And for those people that are a bit more chaotic, it can be quite hard because they just end up moving between accommodations all the time and they are thrown out. And there is nowhere that they quite fit in, but they don't want to go as far as going into detox. They don't want to do that. And then it is riskier for people like that. They are the ones, the women, who could fall through the cracks in one way, because they don't want to do what we think they should do, get clean and stop working and do all this stuff. (Int. 11, Specialist Service)

Sometimes I think there are too many services involved, I do. I sometimes think, there are too many people involved in our clients' lives and sometimes I wonder, 'Do we actually enable them to stay not functioning 'cause we all have our job to do?' (Int. 19, Social Worker, Drug Service)

6.2 Need for Interagency and Interdisciplinary Cooperation

As highlighted above, individual services are frequently not designed to, or capable of, dealing with people with multiple and complex needs; they are not always able to assess and treat such clients in relation to their 'whole needs' (Rankin and Regan, 2004). Consequently, the provision of care for clients with complex needs, such as drug-using sex workers, is usually undertaken by a large and varied number of statutory and voluntary agencies, including the criminal justice system. In order to deal with the complexity of the clients' needs and in order to provide an effective coordinated response, the professionals were aware of and supported the need to engage in interagency and interdisciplinary working.

We identified ourselves in our own strategic planning a year and a half ago around the need for us to link in more with other service providers. And we definitely have been doing that and that's been more inserted into the outreach workers' brief – the need to alert other service providers as to what we do and the support we can give to the women and have them referred on. And also to alert them to the women's needs as well ... So, that certainly is happening more ... we have very good cooperation linkage with a lot of organisations in a very informal way, on a case by case basis, but whether that should be a more formalised, structured approach, it might be more beneficial all around. It would allow for our presence at an earlier point in a woman's story in terms of trying to respond as well. (Int. 15, Specialist Service)

I am not sure what there is that can work, as it sounds to be such a huge multidisciplinary approach you actually need rather than training ... the multidisciplinary approach may be more effective and then any training could be provided. But it would be how you would work with a multidisciplinary team? (Int. 20, Doctor)

I would think there are some fairly well developed services, both voluntary and statutory. Just across the board, whatever the issue is, I think interdisciplinary communication, interagency communication really makes or breaks all attempts to help ... So my own sense would be that what helps is when there is interagency training, contact, communication, training maybe, seminars, anything that helps to ease the difficulties that can arise in communicating across disciplines and across agencies in an appropriate way, not breaching confidentiality when it is inappropriate ... So that would be one thing I would say, that agencies need to have systems of communication that don't rely just on the personalities that happen to be in leadership positions within those organisations. (Int. 34, Social Worker)

... there is little coordination between psychiatric services, medical services, addiction services, and then nobody else knows what is going on. (Int. 11, Specialist Service)

While the professionals largely recognised the joined up nature of drug-using sex workers' needs and the appropriateness of interagency and interdisciplinary working to address these needs, this does not

always translate into practical strategies to address needs. The degree of interagency cooperation, planning and support necessary to deal with this client group is often greater than that usually needed, as a wide spectrum of service involvement is often required (Keene, 2001).

6.2.1 Obstacles to Effective Interagency and Interdisciplinary Working

The identification of specific obstacles to effective interagency and interdisciplinary working with drug-using sex workers provides a greater understanding of the types of problems that may be common to service providers. The literature indicates that service provision for clients with multiple problems can be fragmented and uncoordinated, handicapped by philosophical difference, incompatible treatment methods, inadequate staff training and lack of funding (Keene 2001; Woogh 1990). The key obstacles to emerge from interviews with professionals are presented.

a) Differing professional roles

Each agency/sector working with drug-using sex workers has a different role, a different set of expert knowledge and priorities; focuses on a different primary cause; and identifies different causal directions between problems. These differences can have a significant impact on service delivery. Consequently, working with clients with complex needs in general and drug-using sex workers in particular is difficult because professional perspectives can differ from each other and from the clients' views of their own problems and needs.

The professionals interviewed had different criteria to determine who they provide help for. While all the professionals interviewed worked in one capacity or another with drug-using sex workers, their roles varied. Among those involved in direct service delivery many did not consider it their role to actively determine whether a client was involved in sex work; rather it was something that was left to the client to disclose. For example, drug services primarily deal with their clients' substance use. Related issues are addressed to varying degrees but, drug service providers seemed reluctant to explicitly discuss and assess sexual practices and sexual health in general and involvement in sex work in particular with their clients.

I suppose, maybe, even though we say we like to have an atmosphere of openness and trust and all of that within the clinic, I don't know how comfortable all of the staff actually are about addressing this issue [sex work], because if you don't ask, you don't have to deal with it, or maybe people just don't think, because it is an addiction service, where we are dealing with addictions. I might be doing a gross injustice to some of our colleagues but ... I think they are so busy getting on with the day job that, there are so many issues that come into addiction anyway, that perhaps this doesn't get the importance that it deserves (Int. 31, Addiction Counsellor).

In terms of identifying people who are working in prostitution I'd say we are probably not very good at that. We do ask people on a routine basis who are attending the HIV clinic 'Are they in a relationship?' and 'Are they having sex?' to identify if there any partner at risk from HIV. But we don't specifically ask people who are using drugs if they are engaging in prostitution. I think it is a difficult question to ask and I think that we probably have to identify some method of asking. I think it's really important (Int. 8, Doctor).

I do an initial assessment for the clients ... and issues of prostitution would come up when we deal with their forensic background. Now some might disclose their histories, I suppose maybe later on in their pregnancy when we begin to develop a little bit of a trust and bond ... I would rarely address it with the client themselves ... As I said, my role is specifically regarding the pregnancy ... so the whole discussion around prostitution wouldn't be as direct as it should have been I suppose (Int. 36, Midwife).

The failure to adequately assess individuals' engagement in sex work is often compounded by the stigma and shame associated with sex work which can inhibit clients' willingness to discuss issues around their sexual health and their work practices (Rosengard et al., 2007).

I think our clients are so marginalised by their drug use anyway, that if you have another issue such as working in prostitution to deal with, as well, they get embarrassed, they are afraid 'Will it affect their treatment?' They don't want anybody else in the clinic to know because all of them know each other, because they are all from the same catchment area. So they are seeing each other every day in the clinics ... so it's a very sensitive issue. (Int. 31, Counsellor)

For other professionals their ability to work effectively with this client group was hampered by their clearly defined professional role. For example, the Drug Liaison Midwife explained that even though many clients are polydrug users and drink in excess, their core business does not extend to include alcohol.

... unfortunately, my brief really would be with the addiction services and alcohol would mainly be dealt with in the psychiatric services. We are trying to liaise between the two so it is making things a bit more difficult ... (Int. 36 Midwife).

This 'silo mentality', compounded by lack of skills among staff (e.g. in dealing with sexual health), can restrict professionals' frame of reference and consequently their responses, as it ignores co-occurring problems, such as drug use and sex work (Rosengard et al., 2007). As a result, service providers can end up focusing on people's problems in isolation from the rest of their lives. This in turn encourages singular problem responses rather than a holistic whole-person approach (Keene, 2001; Rankin and Regan, 2004).

b) Different professional philosophies/ideologies

Differences in professional philosophies and ideologies were observed across specialist agencies for sex workers. This in turn can result in differing views among service providers on appropriate interventions,

and successful outcomes. Some of the professionals working specifically with sex workers raised concerns about the appropriateness and effectiveness of harm reduction interventions for this client group, favouring a 'violence against women stance, that is, looking at prostitution as a harmful profession, if you want to call it that', and exit strategies, rather than harm reduction. The harm reduction approach created personal anxieties and worries for some service providers because it was seen as actually facilitating men to abuse women and was actually endorsing and facilitating prostitution and not dealing with the actual harmful consequences.

I feel we are almost facilitating them to go out and to have sex. It is not them, if you take the focus off them and look at the demand for sex, what we are facilitating is actually the men out there to have sexual gratification on some poor young girl's body, that is what I see more and more and I feel very unsettled about that. There is an increasing dissatisfaction with actually what we are teaching in terms of harm reduction, if I may say that ... I can see of course you want to protect women from getting infections but at the same time you have to think: 'What are the consequences of that? What are you actually facilitating all of the time? And perhaps we should be saying to the women 'Actually, really, that is not great for you, this is harming you' ... in our attempt to be so non-judgemental and not to stigmatise further, we actually have become a bit blind to the reality of what is happening in the sex transaction ... and it is from my heart out we have real problems with the harm reduction. (Int. 14, Specialist Service)

There are very many different viewpoints around what is the best way to work [with sex workers]; we would avoid doing that [harm reduction] but actively encourage women to use condoms ... there are so many other organisations doing that [harm reduction] and we wanted to keep that piece of what, that we have been doing, which is about trying to assist women to move out of it [sex work]. (Int. 15, Specialist Service)

We are quite unusual in providing harm reduction services within a health promotion context; however, our experience and analysis of the personal trauma to women in prostitution and the effects on women of the globalised sex industry, leave us in no doubt that prostitution is exploitative and very harmful to women and to that end we seek routes out/exit strategies. (Int. 14, Specialist Service)

Conversely, other specialist services for sex workers were of the opinion that harm reduction interventions were the most appropriate way to work with this client group.

Our reading is very clear, it is around harm reduction ... and whether they want to stop or not that is fine, we would facilitate all that, but it is not our agenda. It is actually a false economy and a false agenda in the sense that it is not really tackling the problem. I mean we are coming from the point of view that it is the needs of the people we are working with; their presenting needs, that is where it is at. It doesn't mean I would do stuff where they could form part of a discussion but as part of delivering a service it is pointless going out and offering cups of tea if they are not offering condoms. It just defies logic. (Int. 35, Specialist Service)

None of us are saying that exploitation doesn't happen but what we are saying is that it is not the only way of looking at sex work and that there is a broader discourse needed and there is a significant population of the people involved in sex work for whom this represents a choice. And indeed there is also this myth that involvement in sex work is like a life sentence and we seem to forget the nature of the industry, which is that probably for the majority of people it is something they dip into and out of as and when it suits them. (Int. 28, Specialist Service)

Keene (2001) stresses that many people with complex needs want help essentially with 'maintenance' and sustaining their current situation, including ongoing support. Conversely, professionals tend to prioritise change in the life of the client, which some clients may be able to achieve in the long-term.

c) *Knowledge, skills and competence deficits*

Skills and competence deficits emerged in the data as barriers to interagency and interdisciplinary working. Service providers, working with drug-using sex workers with complex and multiple needs, are required to be aware of a range of services in order to ensure appropriate referral. Some service providers demonstrated a lack of knowledge about what other agencies are doing for this client group, which hampers effective working.

I am not 100 per cent clear on what is exactly on offer for them [drug-using sex workers], but clearly the need to support them through the whole process, I imagine it is a very long and sustained process trying to get them out of drug abuse in itself. (Int. 15, Specialist Service)

At the end of the day I think that especially for the likes of our women, there are so many agencies involved, there are so many agencies available, and we're not able to tap into the various resources that are available for them. (Int. 36, Midwife)

Different professionals receive different training. A need for awareness training emerged from the interviews with professionals across disciplines, to ensure that all staff have an adequate understanding of the spectrum of clients' needs and their interconnectedness. This lack of awareness is highlighted by the following quotes:

... but one or two of them [staff] were quite shocked that some of the women might be working and said, 'Would they have Aids and would we need to be using gloves, what about hepatitis?' A staff member that is working here a good few years didn't [know], kinda said, 'Would we get it from sitting on the toilet? I thought that stuff went out a good few years ago, stuff like that, basic stuff to me. Now I'm trying to get somebody up to do a talk on HIV and hep C for agency workers. People's faces drop when they hear that women are working, it's nearly like, 'Why do they have to do that?' It's like, 'Oh God I don't want to be near them', they won't even go into some of their rooms in case they'll pick up something, so there is that as well ... and it is like mental

health, they don't know what they are dealing with, they think somebody is going to explode on you and attack you (Int. 23, Homeless Service).

There's obviously lots of areas I haven't received any kind of formal training on, I think a lot of it has been experiential training. So my knowledge of women who would go out and work would be something from my experience. Drugs and addiction, no, I have done a few workshops but my education wouldn't have been around that (Int. 17, Criminal Justice Intervention).

I have got training in sexually transmitted diseases, which I think is one of the big issues from our perspective. The other perspective is in terms of how you deal with the treatment of methadone and how you deal with sex work. I could say I have no training. I suppose I am wondering if there are interventions out there that work. If there is, then we need training, if there isn't then I'm not so arrogant as to say, 'Well I know everything.' (Int. 20, GP)

I think we can't avoid needing some training in the area. Most of us in our generic training would have touched on addiction but the degree of depth of that will vary. So the short answer would be, 'Yes.' (Int. 32, Specialist Service).

Moreover, lack of training not only hampers effective working but it can also lead to frustrations, demoralise staff and contribute to staff burnout. It can also foster a belief that this client group cannot be helped due to the high levels of non-engagement and non-compliance with services, common among clients with complex needs (Keene, 2001).

I also sometimes question at times that maybe we as workers in the drug service, we don't have great hopes for people at times. Sometimes I feel that because we don't have great hopes for them, we feel: 'Oh, there goes Mary Anne again, she is going around, same oul', same oul', because we don't feel they are ever going to get out of this, do we kind of instil that in them? This is your lot! (Int. 19, Social Worker).

A lot of the staff here and maybe in other services are burnt-out so they don't take the prostitution very seriously, it's like, 'Ah, it's up to them, and they are going out working', and there doesn't seem to be that shocking factor any more. It's not, 'They are going out and will they be okay?' When I started first that was the attitude, 'God, mind yourself', but now it's nearly 'They are going down to the shop'. They have become desensitised and I don't think there is much compassion for women that are working, from some professionals ... I don't see the compassion or concern that I used to see from the services. That is quite worrying. (Int. 23, Homeless Service)

I think it's the most difficult part of the caring field. Because there is so much relapse, suicide, depression. There is, I suppose, you are talking about mental illness, and all of that. You have so much that you are not going to let it get you down but it's not going to stop you from feeling. You can't numb yourself from it because you are a

human being, so are they. People have feelings so it's going to touch you. But to be able to leave it there and to be able to go and live your own life as well, because if it's gradually taking you down, draining you, you are going to go down under and who are you going to be any good to then, after that? You'll be in A&E. (Int. 5, Outreach).

d) Inconsistencies in working practices

In addition, non-uniformity of working practices was identified as hampering effective interagency and interdisciplinary working, as 'inconsistencies make it very difficult for some of the clients'. These inconsistencies primarily related to working practices and record keeping.

... I have to say it's quite inconsistent in our areas ... you could have a social worker or a team leader who might be well experienced in the area of drug misuse and those who mightn't be. And they might take a different view ... we had a girl there last week who was a regular heroin user but she is well capable of managing her family at the moment. And it certainly doesn't raise any child protection concerns at the moment. However, some mightn't look upon it that way. And certainly here in this area we would consider that anyone with a history of substance misuse would automatically need to be investigated as to their capability to looking after their child once it is born ... So it's quite inconsistent. (Int. 36, Midwife)

This is a bone of contention with the outreach workers. There is no recording. We record all the stats [statistics] but at the moment here in the south west we are not on the DAIS, the east coast outreach workers would have the DAIS in their needle exchange. I think they bring their stats and they go to a central point with the DAIS. But this is all hand recorded and those stats used to always go to Stevens' where there was a person literally keying all that information into the machine. That hasn't happened now for five years. So we have no, absolutely no drawdown of information as to who is, I mean, on the needle exchange cards you write down how many used works they bring back in, how many we give out ... But it's outrageous. Personally, I think it is outrageous. For task forces and to get more needle exchanges we have to trawl through all this paperwork to get figures. (Int. 1, Outreach)

6.3 Changing Drugs and Sex Markets

Environmental conditions and different local risk environments shape the introduction of (harm reduction) policies and responses, as well as their implementation and impact. From the professionals' perspectives, changes in drug and sex work markets have a direct impact on their ability to deliver effective services to reduce the risk of harm to drug-using sex workers.

6.3.1 Changing Drug Trends and Patterns of Use

The changing nature and patterns of drug use in Dublin were considered by most of the professionals interviewed to be producing increased risk of harm to drug-using sex workers, and, or changing the nature

of the risks produced. Historically, problem drug use in Ireland has been associated with opiate use. While it was recognised that most problem drug users are polydrug users in so far as they have used a range of different drugs over the course of their drug-using careers, the combined or sequential use of a range of drugs was considered by all professionals to be a particularly risky feature of current patterns of drug use among drug-using sex workers.

I think before it was just heroin and alcohol. Now it is heroin, alcohol, crack, cocaine, depending on the time of the week and depending on what is available on the streets. So I think they have more polydrug use in that sense, of perhaps stopping one thing and starting something else, stopping again, using something else; much more chaotic in their drug use. That is my sense of it. (Int. 11, Specialist Service Provider)

Moreover, multiple drug use (both sequential and concurrent) complicates the understanding of dependence problems and their assessment and treatment; it also has a direct impact on clients' behaviour and consequently on service delivery (Darke and Ross 1997).

While the use of other substances such as benzodiazepines, cannabis and to a lesser degree alcohol has always occurred among the opiate-using population (if not always recorded), the increased availability and use of cocaine (and crack) was the most noted change in drug use patterns reported by the professionals. International (Hassen, et al. 2004; Hunter, et al. 2006) and national (NACD 2007) research indicates that over time cocaine use by opiate-dependent individuals has been increasing. The negative health and social consequences of cocaine use by opiate-dependent individuals is particularly severe. As cocaine is often used intravenously by this population (Joe and Simpson 1995) and because of its short half-life, the frequency of injection is high. This in turn can lead to increased drug using and sexual risk behaviour and thus, heightened risk of contracting and transmitting HIV or HCV. Furthermore, cocaine use inevitably makes the drug consumption of an opiate-dependent individual more expensive.

I think a lot of women, particularly the working women have gone from opiate use and heroin use to cocaine and crack. And of course that has other effects, the cocaine use, they probably use a lot more, so they need a lot more money, and they are out working a lot more ... we have had a couple of women who have been attacked because they have been absolutely out of it. And the other thing as well because of the high use of cocaine or crack and because they need a lot more money, they are willing to take a lot more risks. And they will tell you that themselves. You know that they needed to get as much business as possible so they were willing to take a lot more risks, safety wise and sexually wise. (Int. 3, Outreach)

... Cocaine is very prevalent. A lot of women are smoking cocaine and when you ask them, 'So, you're smoking crack cocaine?', 'No, no, no, it's just cocaine.' So they're in denial about smoking crack cocaine. Also, a lot of them now are going back to smoking heroin because they would have no veins left from injecting cocaine. (Int. 2, Outreach)

And I suppose, just on the cocaine use, we definitely have seen a rise in people saying, 'Oh, I've kind of got my sex drive back again.' So all the heroin users, for example, that moved into cocaine use have now said, 'Oh yeah, they're coming in for condoms'; people that never would have come in for condoms before. (Int. 10, Specialist Service)

From the perspective of the professionals involved in direct client work, the increase in levels of cocaine use has resulted in a parallel increase in the levels of aggression among clients. As one outreach worker said, 'I think maybe people are getting that little bit more aggressive because of the cocaine.' Similarly, a prescribing GP was of the opinion that 'cocaine leads to more aggression' among his patients. Homeless service providers also reported cocaine-related aggression among their clients.

They would become quite aggressive; a lot of paranoia and I suppose the women I have known who have used coke would have mental health issues anyway so it doesn't help. (Intv 23, Keyworker, Homeless service)

Sometimes you can see their behaviour has changed; they become more aggressive and they may be good one day and they might be really aggressive and highly strung out the next day. (Int. 24, Manager, Homeless Service)

Aggression was also associated with alcohol use by clients. One hostel worker was of the opinion 'most times the aggressiveness I would find comes with alcohol more so than with drugs'. All services have policies on violence and aggressive behaviour which can lead to the exclusion of clients for a period of time.

The high levels of benzodiazepine use among this client group were also mentioned. Many of those involved in direct client work were of the opinion that benzodiazepine use can make it difficult for people to engage with services, for example:

... but at the moment now ... compared to last year heroin and unfortunately benzodiazepines; benzodiazepines I feel is the biggest among our pregnant drug users at the moment ... of the 64 deliveries that I had last year I would say only 10 of them would have been solely on heroin alone ... It all depends on the quantity [of benzodiazepines] that they are taking. Mood swings are associated with it, they can become quite aggressive, but more importantly, they just totally disengage. And once you get that they are just not willing to engage at all. (Int. 36, Midwife)

6.4 Changing Nature of Sex Work

Many of the professionals interviewed reported that sex work is becoming less visible in Dublin due to a number of factors. The previous chapter explained how the use of new technologies such as the mobile phone and the internet means that drug-using sex workers no longer have to work on the streets but can maintain contact with their regular customers via their mobile phones. One outreach worker explained,

‘A lot of the women have started to work off their mobile you know, and work out of their apartments and all of that. So they were disappearing off the streets.’ Another outreach worker further explained:

... There appears to be less women on the street but we are aware the women have much more access through the internet now and they can work through sites like Brassers.com and things like that. They can advertise through it. We are also aware that women have built up client groups, and they are often working from their mobile phones. So they are much more mobile and less obvious on the street. It’s not that it’s gone away; it’s just that it has changed. (Int. 4, Outreach worker, Specialist Service)

Similar to its female counterpart, male sex work also appears to be disappearing from the streets and from its previous locations in the city, one consequence of which, a professional explained, is, ‘In one way because it is hidden more and it’s done a bit different, there’s less awareness of it, or people are less inclined to know that it is going on.’

In addition, the regeneration and gentrification of parts of the city have disrupted some long-established street sex market locations, for example:

The LUAS had a big impact ... because a lot of the girls’ clients, the trucks used to come up this end and used to park up there opposite the barracks. They would come off the boats and a lot of them would pull in to have a rest, whatever they were doing. A lot of the business for the girls was from them, and of course when the LUAS was started that all stopped. (Int. 3, Outreach)

I think, initially when I started, firstly the women were much more visible ... and the women were more accessible ... And then I think as the place has changed I think the area geographically has changed and the demographics of the area has changed ... the drug use has changed too. (Int. 11, Specialist Services)

The main implication of these changes in working practices is that it has become increasingly difficult for specialist services, in particular outreach services, to identify and locate sex workers, learn about their practices, assess their needs and provide appropriate interventions to reduce their risk of harm. As one outreach worker explained:

They are less visible ... I think because there are fewer on the streets, when they are there, they are picked up very quickly because there are fewer of them. So they move very quickly ... by the time we are there they could be gone and you could have just missed them five minutes ago (Int. 11, Specialist Service).

Consequently, men and women engaging in sex work are increasingly likely to remain unidentified, especially given the reluctance of professionals who are working in related areas such as drug services, health and homeless services and harm reduction agencies to engage with their clients around the issue of sexual health and sex work, even when they suspect a client’s involvement in the business.

6.5 The Policy Environment

It has been illustrated in the previous chapters that the local risk environment (i.e. nature and structure of drug-using networks, the immediate social settings in which drugs are used, the physical and social context in which injecting drug users live) can limit the potential impact of harm reduction interventions. Similarly, the policy environment can impact on the effectiveness and success of harm reduction strategies. This section explores the impact of various policies (drugs and housing/homeless) on the risk environment of drug-using sex workers, from the perspectives of the professionals.

6.5.1 Drug Policy

Over the last 20 years, drug policy in Ireland has shifted substantially towards harm reduction practices. The main harm reduction strategies in operation include needle exchange provision, opiate substitution programmes and outreach programmes; as well as changes in the style of service provision, such as the establishment of locally based services and the regularisation of the role of family doctors and community pharmacists, which may be considered to constitute a form of normalisation of addiction treatment (Butler and Mayock 2005). In this section these key harm reduction practices and drug treatment provision are reviewed.

a) *Needle exchange*

The first needle exchange was officially established by the Eastern Health Board in 1989 in Dublin inner city (Mullen and Barry 2001). Since then the number of exchanges has grown steadily to meet demand for increased and localised services. Within Dublin city there are now a range of statutory and voluntary services that provide needle exchanges. These programmes play a vital role in curbing the spread of blood-borne viral infections (e.g. HIV and to a lesser extent HCV) through the provision of sterile injecting equipment (Cox, et al. 2003). Moreover, they also function as a point of referral into services.

What we do on the practical side of the exchange we would give out the paraphernalia and the needles, condoms and all that. The other side is we would find out if they are linked into services, if they are linked into a clinic, if they are linked into a counsellor, what area they are from, what area they are living in, and then what we do is we follow up with that either through our colleagues, contacting colleagues in their area, if they are living in their area or a lot of the time because we have a service for the working women which is the mobile bus over in Dr Steevens, we make the appointment for them to go and have an assessment with the doctor over in Baggot Street to try and get them on to the mobile bus ... (Int. 3, Outreach)

In the city centre, fixed-site needle exchange programmes are available in low-threshold drug services. Opening hours vary; only one service in the city provides a five-day week (10 a.m.–4.30 p.m.) service; other services operate from one to five hours one day per week (Cox and Robinson 2008a). One specialist

service for female sex workers provides a needle exchange, and during the course of this research, needle exchange services in a second specialist service for female sex workers were withdrawn. In addition, the methadone mobile unit (bus) for drug-using sex workers provides needle exchange to the attending clients. Two of the homeless hostels in the city centre also provide needle exchanges to their residents.

However, research shows that the provision of needle exchange programmes in itself does not necessarily reduce HIV and HCV transmission rates (Ashton 2003b; Mansson, et al. 2000). A range of other factors can limit the effectiveness of such interventions in curbing the spread of blood-borne viral infections, including inadequate distribution of injecting equipment due to restricted opening hours or strict one-for-one exchange policies (Bluthenthal, et al. 2007); changes in the local drug markets, in particular the increased use of cocaine by injecting drug users (Patrick, et al. 2001; Steffen, et al. 2001; Thorpe, et al. 2000); poor treatment access and lengthy waiting lists (Bardsley, et al. 1990); and the local risk environment.

Many of the professionals interviewed spoke about the limited and patchy needle exchange coverage in the city, in particular the lack of out-of-hours access to sterile injecting equipment. This is of particular concern given the high level of injecting cocaine use among the drug-using sex workers interviewed, which in other jurisdictions has contributed to an escalation in HIV and HCV transmission rates.

We all shut up shop at 5.30 and there really isn't anything after that for people who need a bit more in the evenings. (Int. 10, Specialist Service)

... I think in Dublin, be it for the working women on the streets or for the homeless on the streets or even the clients that attend clinics on a regular basis, the service is cut off too early. We don't really cater for the homeless or the people living on the streets or the sex workers that are out on the streets. (Int. 3, Outreach)

... services seem to be not built around the women or drug users; they are built around people working in the services. So even say needle exchange, Merchants Quay shuts at certain times and you can't get them. Even for people who are actually working and using drugs, not working in prostitution, it's hard to get to a needle exchange. (Int. 6, Outreach)

... an adequate needle exchange, in terms of just the night time being a very active time obviously for people and maybe not being able to access during the day for whatever reason. So I think that people working in prostitution would have access in the evenings to that, along with everybody else. It's just that sometimes we have found that people have said that they just can't be doing everything else during the day that they can't do at night. So they are just taking the kids to school or doing whatever else so they can't access a needle exchange. (Int. 10, Outreach)

... But very often we find we are left with absolutely nothing and for the core hours you might be doing fine, but then once we are out on the street at night, late night, 11, 12 o'clock at night, or even come six o'clock in the evening, (1) you have a problem getting needle exchange and (2) you have a problem getting housing. So very often we have no solutions for people and that is the real horror. We just don't have any solutions. So it is very difficult to work with circumstances. (Int. 14, Specialist Provider)

Moreover, needle exchange programmes in Dublin specifically target individual behaviour change, but the social context of injecting risk behaviour highlights the importance of working with networks of drug users (Rhodes 1997b). Alternative models of needle exchange provision such as secondary exchange or peer exchanges have been developed in other countries, to reach diverse groups of injectors within their social networks (Voytek, et al. 2003). These models have proved to be effective in reaching homeless injecting drug users and those involved in sex work (Sears, et al. 2001). Needle exchange programmes also have a role to play in reducing sexual risk behaviour. However, they have been less than successful in this regard, in part due to the lack of sufficient knowledge and experience among staff in addressing sexual risk (Bogart, et al. 2005; Weiss, et al. 1993).

b) Methadone maintenance

Methadone maintenance is the cornerstone of harm reduction policy in Ireland. The first maintenance programme was introduced in 1992. In 1998 the health service introduced the methadone protocol to control the prescribing and dispensing of methadone. Under this legislation, and in an attempt to normalise drug treatment in primary care, general practitioners are encouraged to become involved in the treatment of opiate users. There are approximately 8,300 individuals in Ireland receiving methadone treatment. There are over 77 methadone treatment clinics in the Dublin city area, and approximately one-third of individuals are placed with community GPs. National (Cox, et al. 2007a) and international research (Darke, et al. 2006; Gossop, et al. 2000a; Gossop, et al. 2003a) consistently highlights the effectiveness of methadone maintenance in reducing the risk of harm to opiate users.

Despite the massive expansion of methadone treatment over the last decade, accessing treatment can be slow. As illustrated in the previous chapter, the path to treatment is not always quick enough for drug-using sex workers attempting to reduce their risk of harm. Many people with complex needs (such as drug-using sex workers) have a chaotic lifestyle, and making the decision to contact services can be a turning point. However, failure to get an immediate response can undermine their motivation and make approaching services even harder in the future (Regan and Rankin, 2004). Once an individual recognises they need help, anything less than an immediate response can be a setback. As one professional explains:

... we need services that are accessible quickly. No waiting, because when there are waiting lists, people lose their momentum. They get up one day, they've hit rock bottom; they need help that day, not six weeks, not six

months from now. Because things just get worse, because they actually need to be able to walk in somewhere one day, be seen by someone, be assessed by somebody and a plan made. At least they have something in their hand, they are walking away with something and can say, 'Right this is my first step to change.' But it needs to happen like that. People are in the depths. They need that plan, they need that proof that, 'Yes, this is going to change.' Now they may not need to start the work immediately but they need an assessment, they need proof, they need the plan; they need something in their hand, some hope. (Int. 4, Outreach)

Although priority is given to homeless drug users, individuals who are HIV positive, pregnant women and drug-using sex workers (through access to the mobile unit), many of the professionals still expressed concern about the long waiting list for methadone treatment.

... there is still a very long waiting list ... well the quickest I have ever seen anyone getting on [methadone] was six weeks, which is not bad, that is if you are very motivated and they keep to all their appointments and if their assessment goes through quick enough, six to eight weeks, which is not bad ... but it could be six months, it could be longer. I know they haven't got the facilities, they haven't got the doctors, it really is difficult. But there are long waiting lists. (Int. 24, Manager, Homeless Service)

... the waiting list is a very difficult thing, to get an idea of how long it is. One team might be a bit quicker to get onto than others, depending on the locality and the amount of drug use in particular areas, because different consultants work with different community care areas and there might be some areas that have less drug users in them than others. Some people can get on within a few months and I know there are some people who are on it for a year, around that length of time. We always look at it and look at what factors are involved, if a pregnant woman attends looking for treatment she will tend to be taken on quicker. It tends to be the single men who don't have children would be very much at the bottom – I feel very sorry for them because they tend to be well down there at the bottom of that list. The people who are HIV positive who are very ill, they are going to be taken on quicker, people with mental health issues. We look, I suppose, at what are the overall factors, what is the presenting problem of the client and a decision is made. But at the same time we are taking on people all the time. (Int. 19, Social Worker)

Some of the professionals reported that it was particularly difficult for homeless drug users to access methadone treatment, largely due to the inflexible policies and procedures in place in clinics.

And if they are homeless, getting into clinics is an issue then as well because they have to be in a certain area at a certain address for a certain number of months before they become eligible for a clinic in that area. And if they are homeless like that they are constantly moving around. Now I know they do have a clinic, I think it is in Trinity Court for the homeless drug users but there's waiting lists and stuff like that and some of the clients don't want to be going in there, into Trinity Court. They want to go to one in their own area because it is easier

for them to access. But they have to be living at a certain address. So there is loopholes I think they have to jump through, you know, to get into these places. (Int. 21, Outreach)

Drug use is still a huge problem in this area ... We are getting a lot of new drug users, particularly through the homeless service. Ten years ago we weren't working with the homeless so it is hard to be clear if there is a difference because obviously we have changed so we are seeing different categories of people but we are still seeing a lot of people who are trapped in that stage and who are not on methadone. On the grounds that the waiting list is huge, a lot of people say they can't get onto methadone waiting lists. Some of them will say they have been in and put on the waiting list and they just heard nothing for months. So we still have a lot of people coming in. (Int. 20, GP)

... If they are not in a certain area they can't get on to a clinic. If they go to a clinic that is out of their area and they miss days they could end up being thrown off that clinic. So there isn't a huge amount of facilities for them. I think with these particular women I think they need a specific centre, I think they need a designated support agency. Because they are a marginalised group, they have completely different needs to the women I would see down in my clinic, the treatment centre where I work. The women who come in there would have a home, they have a family, their partner could also be an IV user but he could be working. They could have the support of their family, their mother and father, all of that. These women don't, because a lot of them have been out on the streets since they have been 15/16. Because of that they have a lot of cross-addictions. Alcohol is the biggest thing at the moment I think for the women on the streets. I think that's probably just part of their whole make up. (Int. 3, Outreach)

If they are not on a methadone programme we would link them in ... but part of the criteria there [particular clinic] was they had to be staying here a year, which is a bit difficult, especially if they are newly homeless. But we try and work around that and we did get many people on the methadone programme down there ... It might be an emergency on the bus but still it was something ... (Int. 24, Homeless Service)

One of the recommendations of the mid-term review of the National Drugs Strategy is to make access to treatment available no later than one month after assessment (D/CRGA 2005). However, it is unclear what progress has been made in this regard.

An innovative response to the primary healthcare needs of homeless drug users – the Primary Health Care Safetynet Services – was launched in 2007. The Safetynet Services, by outreaching to hostels and services used by homeless people, provides healthcare for the subset of homeless people not accessing mainstream care. The team includes nurses, local GPs, chiropractors, dentists, psychiatrists, counsellors and occupational therapists, and they operate flexible opening hours that fit into the lifestyle of drug users. Part of the service provided is a methadone prescribing programme which facilitates fast access to methadone for the homeless population (Mills, et al. 2008).

Although there is a body of research supporting the effectiveness of methadone maintenance programmes, research suggests that concurrent substance use, in particular the use of alcohol and the use of cocaine among individuals maintained on methadone is not appropriately addressed by prescribing services (Gossop, et al. 2003b). Given the increased prevalence of cocaine use among (methadone maintained) opiate users in Ireland and among the drug-using sex workers interviewed in this study, it is vital that effective interventions such as contingency management (Ghitza, et al. 2008b) be implemented to reduce the risks of harm to individuals in treatment.

c) Outreach work

In the wake of the HIV epidemic, outreach services were set up to target groups that were not in contact with low-threshold services. Outreach work is, by its nature, at the frontline of drug services, dealing with people at a grass-roots level. The first outreach programme in Ireland was established by the Eastern Health Board in 1988 (Corr 2003) and between 1991 and 1996 the number of community outreach workers increased by 250 per cent (Smyth, et al. 2000). Since then a number of outreach services have been set up across sectors, targeted at specific groups such as injecting drug users, sex workers, men who have sex with men, and the homeless.

Outreach is a service as well as a method of service delivery (Europap Tampep 1998). Theoretically, outreach workers differ from workers in mainstream drug services in that they go out to areas where drug use occurs (Sterf-Elifson 1993). That said, many of the outreach workers in the HSE staff the needle exchange programmes in satellite clinics and some are also on sub-groups of Regional and Local Drugs Task Forces. The outreach workers who were interviewed spoke of their frustration due to staff shortages, staff embargos and cut-backs, which in turn impacted on their ability to deliver an effective service, and to actually do outreach work.

Also, for myself, I would love to do more night work but I can't do it because of staff embargo and I can't get the time back then to take it off. (Int. 2, Outreach)

We are down to four outreach workers so it is hard to cover the mobile bus every evening and the street work, so you can't do that with four staff. You have to do as best we can and if we had more staff we would do other things. (Int. 14, Specialist Service)

A few years ago we would have had a larger outreach team; we would have had four outreach workers and one counsellor. Now it is just reduced to me; last year we had two outreach workers and one counsellor and now it is just me. We would have done a lot more when we had four outreach workers. We could do a lot more through trying out new stuff and it was through stuff like that we were in touch with a lot more men who were selling drugs; as we have had to contract our services, we have lost staff and they haven't been replaced. That is one

of the areas that has been lost. There is just no way now we could have an outreach presence in the likes of the Phoenix Park, either cruising areas or selling sex, night time locations like that, it is simply not possible. (Int. 38, Outreach)

No [don't have outreach], we did for a little while ... we set up outreach teams to go out, but now we just don't have the resources. (Int. 7, Drugs service)

As with needle exchange provision, a recurring theme to emerge from interviews with service providers regarding outreach was the lack of out-of-hours services; this was identified as a particular issue for drug-using sex workers.

I do think they would need a lot more support out of hours as opposed to the nine to five. There's not enough services, I mean, if you are a drug user and you stay clean and you are not working in prostitution, then you have all the services you need nine to five, coming up to your clinic. If you are working in the evening there's no services there. We only have one drop in a week, which is one night to come in and sit down if you needed support. And then the Women's Health Project is Thursday night so they've only two nights where if anything happens on those nights they know where to go. But other nights they don't and it has to be maybe the next morning before. And depending on the relationship they may have with their clinic they may not want to disclose that they are working or if an incident happened, or whatever. So I do think, yes, they need more support out of hours. (Int. 2, Outreach)

I feel that the services that the women need should be available to them today, that they shouldn't have to wait two or three weeks to get into treatment. I think because the Health Board have trained me they are not using me to the best of my ability. (Int. 2, Outreach)

There are a number of models of outreach work (Corr, 2003). The most commonly used approach in Dublin is based on the public health model aimed at individual behaviour change. Conversely, the community outreach model recognises the importance of the risk environment, and in particular the influence of peer networks on risk behaviour and managing risk reduction strategies. Community outreach often uses peer education, working within a social diffusion model (Rhodes 1997a), and has proven effective in reaching drug users not in contact with services. Moreover, this form of outreach is one of the first steps towards community change and collective action (Rhodes and Stimson 1998).

d) Rehabilitation

Over the last decade, inpatient detoxification and residential rehabilitation interventions have not expanded at the same rate as harm reduction interventions. Consequently, the coverage of rehabilitation interventions is inadequate and inconsistent. Many of the professionals interviewed spoke of the

lack of treatment places and the resulting lengthy waiting lists to access detoxification and residential rehabilitation services in particular.

There's just not enough beds then for people to go into residential and there's a couple of months waiting list for Cuan Daire. (Int. 23, Keyworker, Homeless Service)

You only have 20 detox beds in the country at the moment ... at one time the waiting time for getting into a detox facility was six months. So if you are a drug addict and you are working in prostitution and you know you have a six months waiting list, come on! So there needs to be hope that if someone wants a way out that can be provided ... (Int. 26, Counsellor)

Well, I suppose there will never be enough spaces. I think things have improved and there are more agencies now and that referrals are being made from HSE. Sure, one floor of Keltoi isn't open because of lack of resources; Cuan Dara isn't fully operational because of lack of nursing staff. We are in times that are pretty tight and tough, I suppose really at the end of the day the ordinary person on the street has fallen foul of that, because it does make waiting lists longer; we are hoping here for a new premises to be opened in Clondalkin and I think it will make it a little bit easier from the day treatment point of view, but the residential can be difficult. (Int. 31, Counsellor)

Embargoes and staff ceilings mean that existing rehabilitation services are under-staffed; service workers spoke about the difficulty of providing a service with skeleton staff.

The original allocation of staff to - was 16 residential care workers and six counsellors, and because of staff cutbacks and staff ceilings, presently, we have five whole time equivalent residential care workers and five counsellors. So it is becoming increasingly difficult for us to provide the service that we are providing, particularly as clients move into the aftercare part of our programme. We have to continue to resource that with a fixed staff base, with a reducing staff base and an increasing client group. So that is becoming increasingly difficult. We have 20 beds in - and the initial plan was that we would utilise those 20 beds but at the moment because of resources we can only operate eight of those beds. So that is really difficult. (Int. 27, Manager Specialist Service)

The Working Group on Drugs Rehabilitation arose from a recommendation in the Mid-Term Review of the National Drugs Strategy (2005) (D/CRGA 2005). While acknowledging that the current aims and objectives of the Drugs Strategy are fundamentally sound, the review highlighted the need to re-focus priorities and accelerate the rollout of some of the strategy's actions; in particular rehabilitation was identified as an area that needed to be developed. It suggested that an adequate level of treatment provision is central to rehabilitation. It recommended an expansion of the range of treatment options, including an increase in detoxification beds which are essential for recovering drug users (D/CRGA 2007).

6.5.2 Housing and Homeless Policies

The physical environment within which drug-using sex workers live influences their health vulnerability and their susceptibility to drug-related harms. Moreover, the physical environment influences the efficacy of public health interventions that aim to reduce the risk of harm (Editorial 2007). Non-health interventions such as housing and homeless policies form part of a harm reduction praxis (Rhodes 2002). All the professionals interviewed identified housing as a primary need of this client group and the cyclical nature of homelessness among this client group.

One of the things I think is a huge problem with the kind of group that we work with [drug-using sex workers] is homelessness. That has a huge effect on how they are and their drug use and their whole well-being ... I think as well there's a lot of barriers put up for these women; if they are homeless and they go to agencies where they are given temporary accommodation, there is a lot of restrictions on them and a lot of rules put on them and if they don't adhere to them then they are out. They are back out on the street again so they just, I don't think that they are given a chance to form stability in their lives to be able to have a structure in their life. I do think that's a big neglect, that there's only a couple of agencies that can cater for women, like women on the streets.
(Int. 3, Outreach Worker)

As illustrated in the previous chapters the majority of drug-using sex workers interviewed had experienced periods of persistent homelessness. Moreover, homelessness was identified as a key factor that facilitated risk behaviour. People who are homeless or living in vulnerable accommodation also have a higher than average risk of complex needs (Regan and Rankin, 2004). The chaotic roofless nature of life on the streets or the insecurity of living in temporary accommodation means it is easier to fall through existing services or to lose contact with services altogether. Furthermore, it is often difficult for homeless people to link in with mainstream services. Problems of exclusion and unmet housing needs have generated a range of policy responses. The implications of these responses are explored from the perspective of the professionals interviewed.

a) **Emergency accommodation: hostels**

The provision of hostel accommodation has been an important policy and practical service response to homelessness in Dublin. Current hostel provision in the city is extremely diverse. Hostels are provided by the statutory and voluntary sector; some consist of high-quality accommodation and some are low-quality accommodation. There are also a number of specialist hostels that accommodate particular groups, such as 'wet hostels' and hostels for ex-offenders. Although hostels are not the preferred form of accommodation for the majority of homeless people, they do meet the needs and preferences of a minority (Neale 1997). The previous chapters showed how the majority of study participants had accessed hostel accommodation in the past and a significant minority were living in hostel accommodation at the time of interview. Arrangements for referral, acceptance policies and practices and intake procedures vary between hostels.

However, rules and regulations are a common feature of all hostels, and many conflict with the lifestyle of drug-using sex workers, as illustrated by the following quotations:

The drugs policy is, that there's no drugs allowed on the premises, you are not allowed use on the premises. We are a low-threshold service. We don't exclude drug users but we ask them if they have any drug paraphernalia like syringes or citric or whatever to leave it in the locker downstairs but inevitably they are not going to do that because they have to use. They probably use in their bedroom and if we walk in and find them using, they will be excluded for a week. I suppose we are just saying that we are not going to collude and say you can use on the premises, we can't allow that but we know that a lot of the women coming in are a little bit all over the place ... The main rule is no violence or threats of violence, no using drugs or alcohol on the premises, no smoking in the bedrooms – you can smoke outside, and pay your accommodation charge. Because it is emergency accommodation, women are not allowed stay out at night. But some do and they ring the next day for their bed. If it was continuous they would be asked to leave because it would be deemed they have somewhere else to stay. They are the main rules. (Int. 23, Keyworker Homeless Services)

... they are used to being out on the streets, they are used to not having to conform to accommodation regulations or conform to rules and so a lot of the places that they would go into, like the hostels for women and that, would have, that they have to be in at a certain time, they would have to adhere to their rules and I think a lot of them find it quite hard, particularly that they have to be here at a certain time, they have to be out at a certain time. I think they are just expected to cope with that but a lot of them never had the skills. They were out on the streets since they were 14 or 15 years of age. So they don't know what skills are needed, they don't have the skills to cope with that. (Int. 3, Outreach)

Some of the professionals highlighted the difficulties in accessing emergency accommodation for this client group, particularly out-of-hours. This is compounded by the fact that, as clients with complex needs, drug-using sex workers are more likely to have problems complying with the rules and regulations and many may have been excluded or barred from hostels.

Again, you are left looking to see what is available there so there is no clear line of, 'Okay we have got a person who is looking for accommodation tonight, where can we go?' We are left ringing around to see if there is a duty/staff rota/housing officer, somebody you ring if you are looking for accommodation that night and they will ring back ... But very often we find we are left with absolutely nothing and for the core hours you might be doing fine, but then once we are out on the street at night, late night, 11, 12 o'clock at night, or even come six o'clock in the evening, (1) you have a problem getting needle exchange and (2) you have a problem getting housing. So very often we have no solutions for people and that is the real horror. We just don't have any solutions. So it is very difficult to work with circumstances. (Int. 14, Specialist Provider)

It's not easy to get somewhere for people. An awful lot of people have been kicked out of places; they've been barred from places, so their options are dwindling all the time. (Int. 6, Outreach Worker)

The lack of financial resources, staff cuts and embargos were also identified as impacting on the quality of accommodation and ancillary services that hostels can provide.

I think cutbacks as well. I know they are building new [units], like Haven House is lovely and it's all done up and it's beautiful and the women love it, but they can't fully staff it because of the embargo so therefore the whole mother and child unit has not been opened. So they have beds there but they are not being used. We could do with more places like Haven House. It is very hard for a woman to stay in Haven House and then leave and go to a B&B. Regina Coeli that wouldn't be as up to date as Haven House. (Int. 2, Outreach)

That said, while hostels can be inadequately and insufficiently funded, they can and do provide a valuable form of accommodation. At a minimum level they provide shelter, food and a safe(r) environment for residents.

... there are cooking facilities downstairs in the kitchen. We give out cereals, bread, tea, coffee, milk – emergency supplies. Some of the women put in money together and they buy groceries. Other women just use all the different food places around. Nobody will go hungry in Dublin – Focus Ireland and all the other places, they give breakfast, lunch and dinner. We get a lot of donations in as well. There is a guy who comes up once a week with yogurts and drinks and ham and cheese, all fresh. So they are all given out as well. I think every second night we get in bread and cakes from Superquinn, so we are very well fed. (Int. 23, Homeless Service)

At best, residents can consider themselves 'at home' in hostel accommodation. Research indicates that this increases with residents having some choice about being in the hostel, feeling secure, and comfortable, having a degree of freedom and control over their daily living environment, being accommodated on a more permanent, rather than short-term basis and have established good inter-personal relationships (Neale, 1997).

There are some models of good practice in operation in the city. As previously discussed, two of the city centre hostels provide needle exchange. In addition, there are a number of specialist hostels.

In Dublin there is what is called the specialist hostels, so the likes of Simon, the de Paul Trust, etc., Crosscare, and they have specialist hostels. And they have staff in place. And a lot of the specialist hostels tend to have people who predominantly present with addiction related issues and mental health related issues, all of them are in some way or shape or form linked in with the addiction services, usually the statutory ones. (Int. 33, Homeless Service)

Moreover, one city centre hostel for women (NOVAS) has introduced an innovative harm reduction intervention for drug-using sex workers, which allows residents greater flexibility in the times that they

use the beds; if they are out working at night they can sleep by day. They have 24-hour access, and every two weeks they are allowed to have two nights out. The manager of the hostel is aware that most of their clients are problem drug users and the policy is not to evict women for drug use; 'sharps bins' are provided in the bedrooms for safe disposal of needles. Hostel staff also liaises with the local drug clinic and Gardai on behalf of the residents. The manager explained:

Now we haven't actually evicted anybody for drug use but we do have to keep reiterating that it is illegal and they shouldn't be doing it. Originally when we started we did specify that we wouldn't be evicting for drug use. That worked really well because when the clients came in they felt comfortable about using sharps bins and disposing of their needles appropriately and stuff like that because they felt they didn't have to hide them. So that worked in our favour. The drug use did increase then though I think on that basis. So trying to find a balance on that is quite difficult. It went through phases last year of a peak and then it would calm down and then peak and calm down. (Int. 9, Manager Homeless Service)

However, research indicates that there are biased, negative images of hostels and hostel residents (Neale, 1997), which in turn can compound the shame and stigma already felt by drug-using sex workers.

Although it did not emerge as an issue in interviews with professionals it is important to reiterate that from the perspective of study participants, hostels were also a risk-producing environment, most notably in terms of how living in such an environment impacts on individuals' drug-using behaviour, and as the physical and social environment within which many drug-using sex workers are introduced to, and become initiated into sex work.

b) Emergency accommodation: B&Bs

Another form of emergency accommodation is bed and breakfasts (B&Bs). The increase in the use of such emergency accommodation has been associated with a lack of appropriate hostel places in Dublin city (Houghton and Hickey 2000). The literature shows that certain groups are more likely to be placed in B&B accommodation; there is a clear relationship between the use of B&B accommodation and the presence of additional needs or housing requirements. Those with substance use problems, mental health problems, and ex-prisoners are among those over-represented within B&B accommodation. Irish research shows that lone parents were the largest group in this type of accommodation (39 per cent), followed by single adults – reflecting the lack of appropriate emergency accommodation for these groups (Houghton and Hickey 2000). Only one of the women interviewed in the study was living in B&B accommodation at the time of fieldwork; however, a significant minority spoke about living in such accommodation in the past. Some of the professionals spoke about the inadequacy of such accommodation for this client group, in particular mothers with new born infants or very young children.

... a lot of them would be on the homeless register living in various B&Bs and that is a massive concern as well. I have women living in B&Bs with their children and it is certainly not an ideal situation. When you are dealing with addiction, they are never going to deal with their addiction when they are in such housing, especially B&Bs ... But I have noticed from those who have gone ... into B&B accommodation always, and this is across the board, 100 per cent, every single one of them have destabilised on their programme. Their whole life becomes a lot more chaotic and a lot more complex than it had been before ... I would think ... that when they go into these accommodations you would have other individuals as well who would use [drugs] quite regularly who don't have, I suppose responsibilities such as pregnancy to cater for or also other families and I think drugs would become more readily available and also as well money is more readily available as well. I think sometimes when they are living in these accommodations they haven't had before, they tend to neglect themselves quite a lot – they tend to get their meals around the city area rather than trying to cater for themselves. (Int. 36, Midwife)

In relation to our clients ... a lot of time they are living in dire circumstances. They are living in bed and breakfasts where they might have to be out during the day ... if they don't have a nice comfortable home what chance have they got of making life better for themselves? (Int. 19, Social Worker)

There were two girls who were working together and the two of them were homeless. One of them was black-listed from the out-of-hours line that you ring up. When she came in one evening ... I rang up the hot line and they said 'No, sorry she has caused trouble in a number of hostels' and they refused to accommodate her ... I think it took about three weeks but eventually they said they'd give her a B&B in Swords ... the problem was that she was working, they had to be in at a certain time, and couldn't go out and work. It might have been a good thing; it might have been a bad thing ... But it kind of hampered her going out and working late at night. (Int. 13, Key Worker)

However, according to the Homeless Agency the use of B&Bs as an emergency accommodation option has reduced.

It used to be that B&B, bed and breakfast, was the default position for giving people accommodation in the absence of housing and in the absence of there being a bed in the hostel. Through Section 10 funding that comes into Dublin City Council, the council is in the position to actually purchase apartments, flats, buildings, etc., which is technically private emergency accommodation, but there are no supports attached to it. It is purely a roof. Technically, they are supposed to be linked in with the clients, that is, linked in with the Homeless Persons Unit, that is the Community Welfare Section. (Int. 33 Homeless Service)

It is worth noting that two of the professionals spoke about the inappropriate use of B&B accommodation to house vulnerable homeless young people.

c) Private rented sector

Increasingly, the private rented sector is being used to house the homeless. Research from the UK shows that private landlords prefer not to let to tenants receiving housing benefits; they are considered 'undesirable tenants' (Bevan and Rhodes 1996). As illustrated in Chapter 3, more than one-in-five of the drug-using sex workers interviewed were living in the private rented sector at the time of interview. Data from professionals showed how the main issues to emerge in relation to the use of this form of accommodation for drug-using sex workers were: the lack of support that is provided to tenants in the private rented sector and the fact that individuals in this type of accommodation easily fall out of contact with services.

Our fear and our concern really is that we have huge cohorts of people with needs in private accommodation and we are not getting at them, we do not have initiatives as yet to get at them. So, therefore, the net effect of that is you may have people who are not getting appropriate assessment and who actually should be in the emergency hostels, because in the emergency hostels there is a better chance at stabilisation because in the normal fashion, staff working in hostels are well qualified to work with the issue. (Int. 33, Homeless Service)

Sometimes they go into the private rented accommodation and at that time that is where the struggle is, because although they may be able to do that independently, there is a level of support they still need and they are not going to get it. (Int. 17, Manager Homeless Service)

We had one woman ... and Dublin City Council are saying they won't put her on the housing list because in effect she has made herself homeless and she has three children. So she has been told she has to look for private rented. And she is very young ... and it would appear that she would need some support with her children. But we are not going to be able to do much work with her; she has to get private rented. We may do a referral for an assessment to pick it up in the area. (Int. 23, Key Worker, Homeless Service)

d) Transitional accommodation

As opposed to emergency accommodation, transitional supported accommodation is usually provided for a fixed period of time for individuals requiring a low to moderate level of support as they become ready to move into independent accommodation. Thus, transitional housing can act as a stepping stone between emergency accommodation and independent living. It generally involves the provision of both medium-term accommodation and a support programme that helps residents to develop the skills and capacity to establish themselves in a home and address any issues that might make long-term housing unsustainable. While beneficial, some professionals were of the opinion that inflexible selection criteria can mean that it is not an option for many drug-using sex workers.

For people who are stable, the transitional housing can be a very, very good step which means that they are stable for a certain length of time, they go into transition housing, they are working on a programme and have certain classes to attend and would get a lot of support and would eventually be accommodated by the City Council. But the number of people who go through on that road are very, very limited. A lot of our clients don't stabilise for long enough to be considered for transition housing or to be moved on to permanent council accommodation. (Int. 19, Social Worker)

The women that have been here for a year, their behaviour has definitely changed, has definitely improved. Their hygiene has improved, their health has improved and their stability on drugs has improved. So, if transitional housing were to lower its threshold there is scope to work with these people. It just seems to be a fear – 'Oh no we're not working with active drug users and active drinkers' and stuff. (Int. 9, Manager Homeless Service)

By and large, the professionals were of the opinion that there is a lack of transitional accommodation in the city. This lack of appropriate move-on accommodation has contributed to silting up in hostels, and to the institutionalisation of hostel residents.

In terms of the move on: we have ten clients who have been here for a year and there is definitely, once the clients go over a certain period, there is definitely a sense that they have become too comfortable. One thing that can be said about this service is everything is free, there is no rent, there is no charge for food, and there is no charge for the laundry, so everything is free. And that was one of the stipulations about running the service. We would have less reason to exclude people. So, basically, clients who have been here for a year they are not paying any rent, they have no major outgoings, it becomes a block, you know, it's like, 'Why should we leave here?' (Int. 9, Manager Homeless Service)

I think women become very institutionalised. There is a lot of support, there's staff on at night time and there are options for people to move out of homelessness and look at maybe their addictions. They are not forced to do it. But we would motivate anybody coming in to have some sort of plan; it's not long-term housing. They have to be working around something. (Int. 23, Key Worker, Homeless Service)

They find it harder to move on to transitional housing or private rented ... If they are registered as being homeless the Homeless Unit will refer them down to us so then we meet them and take their details and a history of their drug abuse and mental health problems. And they probably could stay with us for years, to be honest ... Since I am here now altogether eight years, we still have some of those people. (Int. 24, Manager Homeless Service)

We are definitely not the only ones because we go to the meetings in the Homeless Agency and all the emergency services have the very same problem, there is just no next step. I think it is a lot harder for women because there is less women's services than for men. I worked in men's services for six or seven years in an

emergency shelter and you could always move the men on to Maple House or Oak House, you know, just other transitional projects. For women it just doesn't seem that easy because there isn't really that next step. I don't think there is any transitional service that would have a 50/50 balance. I think it would always swing in favour of having more men clients. (Intv 9, Manager Homeless Service)

e) Preventing re-entry into homelessness

In relation to drug-using sex workers, the housing needs of two specific populations were mentioned, in relation to preventing their re-entry into homelessness: women leaving prison, and individuals leaving inpatient drug treatment. Recent research highlighted the need for appropriate accommodation for women leaving prison, in particular single space units with low to medium threshold supports (Comiskey, et al. 2006). The lack of appropriate accommodation for women leaving prison not only increases the risk of harm to the women, it has implications for the prisons service as the following quotation illustrates:

It's an absolute disaster, a huge problem with the women, I don't know why it is but there never seems to be proper accommodation for the women, okay there is B&Bs ... But sometimes after being in here they are so used to so much support, then when they go outside they don't have the support, they don't have anything to do during the day and, yes, it is a big difficulty. About two weeks ago we had eight women here who would not go out because they had nowhere to go. We had to keep them here. The place was very overcrowded and they were getting temporary release and there just was no accommodation for them. There is not a chance you would throw them out on the streets because the weather was so bad, you just couldn't. We kept them here until we got accommodation for them. (Int. 16, Criminal Justice System)

In addition, the need for appropriate transitional accommodation for individuals who have completed inpatient drug treatment in order to reduce the risk of relapse was highlighted.

For sure, this environment [hostel] didn't help them. If a person goes in for treatment and then coming back here, you can see that the level of motivation is really good in the first week or two weeks and then it goes completely down. They are surrounded by potentially [x number of drug users], I think out of the 22 clients here, there is always about 80 to 85 per cent minimum who are drug users. The rest would be drinkers. So the risk of relapse is massive. But then they are faced with situations where they present to Wellington Quay in which case they will end up in another emergency hostel – the likes of either ourselves, Haven House, Regina Coeli or some in Harcourt Street or they are going to wind up in a B&B and I'd say in any one of those circumstances relapse would be quite high. The problem is that in terms of referring clients on to say the likes of transitional housing where they would work with drug users and stuff like that if they are stable, they are essentially looking for three months minimum of stability after a programme. For most clients, speaking about our clients in particular, it's hard to get that feeling of stability because there is nowhere for them to get that feeling of stability. (Int. 19, Homeless Service)

The issue here would be housing for a lot of them; to be able to access safe housing whenever they leave. If it is an emotional issue for their family so they can't go back there. If they have a destructive partner they can't go back there. So, if they haven't somewhere safe to go, they are at risk again. (Int. 26, Counsellor)

Conclusion

The relative success of policies and interventions to reduce the risk of harm are shaped by the local risk environment. Similarly, the policy environment – for example, shifts in drug and housing/homeless policy – influences the local risk environment. The qualitative data gathered from professionals working with drug-using sex workers presented in this chapter provide an account of their perspectives on drug-using sex workers as a client group, how services respond to their needs, and structural obstacles to effective service delivery. In addition, professionals' perspectives on the impact of changing drug and sex markets on the local risk environment were examined, and drug and housing/homeless policy responses to reducing the risk of harm were outlined.

The dominant theme to emerge from the data was that drug-using sex workers, as a client group, are vulnerable people with complex and multiple needs that span health and social issues. As a client group they cross professional boundaries and move more or less continually through drug and alcohol services, homeless hostels, other social care agencies and the criminal justice system. Due to the complexity of their needs and the challenges they present with, service responses are often fragmented. By and large, individual agencies are not capable of responding in a holistic way to the complexity of needs of drug-using sex workers.

While all professionals were aware of, and supported the need to engage in interagency and interdisciplinary working to address the needs of drug-using sex workers, this did not always translate into practical strategies to address needs. A number of obstacles to effective interagency and interdisciplinary working were identified. All the professionals interviewed worked in one capacity or another with drug-using sex workers; however, their roles varied. The data revealed that professionals/agencies have their own roles and their own set of skills and knowledge, which often lead to a narrowing of their focus and a failure to assess clients' whole needs. For example, drug service providers may not see it as their role to adequately assess and identify clients' sexual risk behaviour and, more specifically, their involvement in sex work. In addition, different professional ideologies/philosophies can result in differing views among service providers on appropriate interventions and successful outcomes. For example, those who consider 'prostitution' the exploitation of women consider exiting a successful outcome, while those who endorse the harm reduction ethos consider the reduction of harm associated with sex work as a positive outcome.

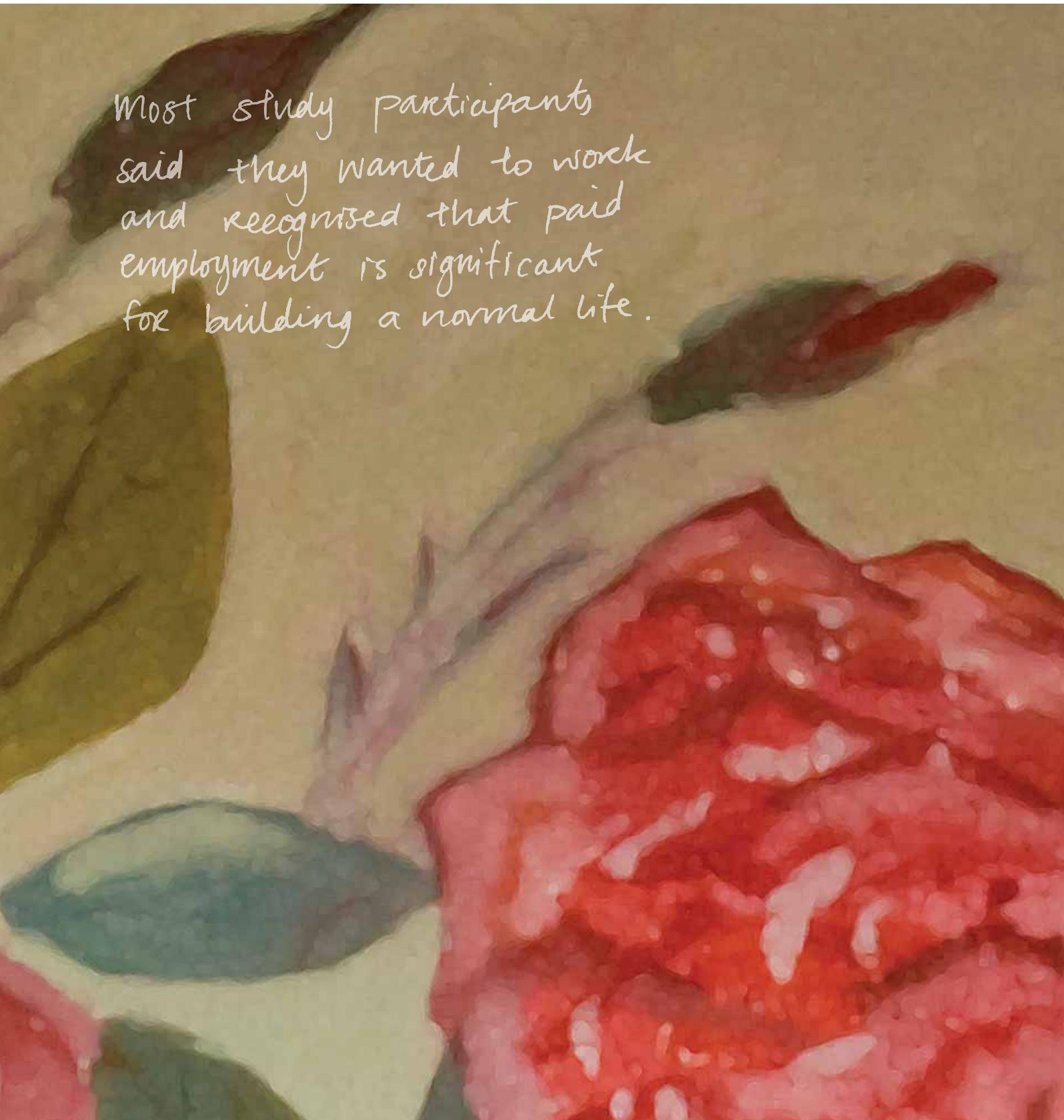
Deficits in knowledge, skills and competence also emerged as an obstacle to effective interagency and interdisciplinary working with drug-using sex workers. This in turn can contribute to frustration and burn out among staff and fosters a belief that this client group is beyond help due to the enormity of their needs and their lack of compliance with services.

The data also illustrated that changes in drugs and sex markets have a direct impact on the ability of professionals to deliver effective services. For example, the movement of sex workers from established sites in the city due to technological developments, changes in work practices, and regeneration and gentrification in the city, have rendered sex workers less visible. Consequently, the professionals reported finding it harder to make contact with street-based sex workers, assess their risks of harm and implement effective interventions.

Over the last decade, Irish drug policy has supported the implementation of a range of harm reduction strategies, including needle exchange provision, methadone treatment and outreach work. In the interviews with professionals, a number of factors were identified as limiting the effectiveness of these interventions in reducing the risk of harm, including the restricted opening hours of needle exchange programmes, lengthy waiting lists for methadone treatment, and the slimming down of outreach services due to cutbacks and staff embargos. Restricted treatment options, in particular the lack of in-patient detoxification and rehabilitation beds, were recurring themes. Professionals identified housing as a primary need of drug-using sex workers. The provision of emergency accommodation (in particular hostels and B&Bs) has been an important policy and practical response to the homeless among this client group in Dublin. While many homeless services have implemented a range of creative responses to the needs of this client group (e.g. needle exchange in hostels, access to primary healthcare and methadone treatment), the lack of move-on or transitional accommodation has contributed to silting-up in emergency accommodation. The needs of two specific groups that were identified as at risk of re-entry into homelessness were those leaving prison and those leaving in-patient drug treatment.

Chapter 7. Conclusions and Recommendations

Most study participants said they wanted to work and recognised that paid employment is significant for building a normal life.

A watercolor illustration of a hand holding a large red rose. The hand is rendered in soft, muted tones of pink and purple. The rose is a vibrant red with white highlights, and it is surrounded by several green leaves in various shades of green and yellow-green. The background is a light, textured beige color.

Chapter 7. Conclusions and Recommendations

Introduction

In conclusion, the findings from this research suggest that, drug-using sex workers particularly those working on the street are a vulnerable client group who have multiple, interlocking needs that span health, social, economic and legal issues. Therefore, addressing their wider social and situational needs such as poverty, housing, educational needs and employment prospects are as fundamental to reducing their risk of harm as addressing their drug use. In order to enable individuals to effectively reduce their risk of harm, policymakers and service providers need to focus and redirect interventions towards the risk environment, in particular the social situations and places in which harm is produced and reduced.

Despite the recognition of environmental determinants of health, the primary focus of harm reduction interventions for drug-using sex workers in Dublin centres on individual risk behaviour change. This emphasis on individualism (and behavioural interventions) overlooks the importance of the wider social situations and structures within which individuals find themselves and their impact on the construction of 'risk' and 'harm'. It has been shown in other jurisdictions that relying solely on models of individual behaviour change has limited impact on the transmission of blood-borne viral infections, particularly HCV (Ashton 2003a). Conversely, a focus on the risk environment encourages us to think about the social situations and places in which harm is produced and reduced (Rhodes, 2002). This approach assists in identifying the conditions that give rise to harm and seeks to maximise the harm reduction effect at the community (rather than the individual) level. With this in mind, the conclusions and recommendation arising from this study are presented within the broad framework of the risk environment. Although the research findings touched on many issues, the recommendations presented in this document are confined to what are considered key areas of concern to emerge from the data.

7.1 The Policy Environment

Despite some diversity in the interpretation of the term, *harm reduction* is expanding globally and has been adopted explicitly as the principal national drug policy in a number of countries and is embedded in international policies and commitments.¹⁵ It has been argued that the ambiguity in Irish drug policy

15 In 2001 the UN General Assembly set a target for countries to make available 'harm reduction efforts related to drug use' by 2005 **UN** 2001 'Declaration of Commitment on HIV/AIDS' *Break the Silence United Nations General Assembly Special Session on HIV/AIDS 25-27 June 2001*, New York.

regarding harm reduction has contributed to the failure to facilitate the emergence of more tolerant and respectful attitudes towards drug users and contributed to the delayed introduction of a wider range of harm reduction practices (Butler and Mayock 2005). Given the risks of blood-borne viral infections and the impact of the resulting morbidity and mortality on the individual and the community, it is recommended that:

- **harm reduction be explicitly stated as a principle for national drug policy in the new National Drugs Strategy**
- **the National Drugs Strategy states the need for a continuum of harm reduction activities;** the overall effectiveness of harm reduction interventions such as needle exchange programmes to reduce HIV and HCV infection among injecting drug users is dependent on adequate and appropriate community-wide interventions, such as adequate access to substitution treatment, detoxification, residential rehabilitation and counselling. The effectiveness of stand-alone interventions such as needle exchange and methadone maintenance are compromised in the absence of a continuum of harm reduction activities.
- **the National Drugs Strategy provides an operational definition and strategy for harm reduction** by providing a model package of harm reduction interventions, minimum standards for services and an optimal level of service coverage, recognising that a thorough understanding of the local context is required in selecting the most appropriate mix of harm reduction interventions and the most efficient models for their delivery.

In relation to policies and procedures at service level, a number of issues emerged from the research, regarding drugs services and interagency/interdisciplinary working:

Drugs Services

- One model does not necessarily fit all: Services should provide a range or stream of programmes. It is vital to ensure that drug treatment is not provision-led – with access being dependent on criteria that clients with complex needs may not exhibit. Consequently, there is a need to design services that are easy to access and hard to be excluded from.
- Waiting lists: The deleterious effects of delayed entry into methadone treatment and the benefits of treatment, including a reduction in mortality risk, highlight the need for speedy entry and re-entry into treatment (through structured interventions targeted at treatment drop-outs).

- Multiple drug use: Specific drug use patterns are associated with different levels of adverse health outcomes. Multiple drug use is associated with a high rate of drug-related mortality, and blood-borne viral infection. Methadone programmes must address clients multiple drug use, in particular their use of alcohol (given high HCV prevalence rates), benzodiazepines and cocaine. Concurrent treatment of alcohol-related problems should include systematic monitoring of alcohol use, and should form part of the treatment plan for individuals on methadone maintenance.
- Care for those with BBV should form a key component of a comprehensive health programme for drug users, especially given the high incidence of HCV infection among drug users and the low level of treatment take-up.
- Sexual risk behaviour: Drug services must recognise their role in identifying and addressing sexual risk within clients' personal and commercial relationships and providing advice on safer sex practices.
- Service providers and user groups should actively challenge institutional stigma which can lead to discrimination (through policies, culture and work practices) and stigmatising language (through challenging the media's use of language and promoting public debate) associated with problem drug use.
- Integrated training should be provided for those working in drug and homeless services, particularly in relation to clients with complex needs.

Interagency and Interdisciplinary Working

- Care and case management: In responding to the needs of people with complex needs a care and case management approach has been shown to improve the delivery of services to clients, reduce duplication of services and improve individual care plan outcomes. In essence, case management involves the implementation of an interagency system, based on a common understanding of how a lead agency is agreed, assessment is conducted, care planning is progressed and cases are referred and closed.
- Interagency and interdisciplinary cooperation and communication is absolutely essential. It is imperative that alliances are forged between harm reduction and other social movements oriented to tackling vulnerability, as a means of promoting public health. A forum for regular communication among service providers should be established to ensure a coordinated response and to improve the effectiveness of interagency collaboration.
- Leaving prison and residential facilities: Increased coordination of services (homeless services, drug and alcohol services) is needed to ensure a continuum of care for those leaving prison and rehabilitation programmes. To this end, improved networking within the relevant services is essential to ensure ease of communication, and specific protocols are needed to guide this work.
- Explore the use of (volunteer) advocates, trained in advocating for clients with complex needs, to assist them in navigating the social care system.

- Reducing risks to males: This research showed that the needs of drug-using male sex workers were the same as those of females. However, there are specific separate issues for males, namely addressing homophobia and hetero-sexism within service provision; the recognition that not all males involved in sex work are gay; outreach to male sex workers in all settings in partnership with the Gay Men's Health Project, and using peer workers.

7.2 The Social Environment

The social environment includes the contextual forces, norms and social relationships within which individuals interact and function. It has been illustrated in this study that drug taking, sex work and the associated risk behaviours are affected by social processes and that the health of drug-using sex workers is a product of both drug and sex work behaviour and social determinants. Moreover, these associated social determinants are not necessarily consequential to drug use and sex work, rather they are circumstances that are inextricably intertwined with drug use and sex work patterns and they shape the health of individuals involved. In short, it has been shown that the social environment influences health and vulnerability in general as well as drug-related harms in particular.

Peer and friendship networks were identified in this study as key micro-social environments that influence risk behaviour and risk management. Extensive drug-using social networks are vital to the survival of drug-using sex workers given the uncertainty surrounding many of their relationships. However, these same social networks and relationships can influence patterns of risk behaviour, in so far as risk behaviour is shaped by shared social and group norms as well as the structure of social and injecting networks. The social organisation and context of risk behaviour highlight the importance of working with networks of drug users (and sex workers) in order to bring about changes to reduce the risk of harm in the immediate micro-social environment. To this end it is recommended that:

- **existing peer networks and peer-based learning strategies are continually funded**
- **secondary or peer-based outreach be developed, piloted and evaluated in areas of the city with known networks of drug users and drug-using sex workers;** existing (specialist) services for drug-using sex workers in conjunction with drug services should devise and deliver training to a core group of peers to deliver harm reduction interventions, the primary aim being to reduce vulnerability among sex worker entrants and to ensure that sex work does not introduce further vulnerabilities to their lives.

Drug-using parents: The majority of women interviewed were mothers.¹⁶ The findings illustrate that in the daily lives of the drug-using mothers, their relationship with their child(ren) is an important aspect of risk management. Many of the women found it difficult to balance the demands of parenting with their drug-using lifestyles (and work practices) and in an effort to reduce the risk of harm to their children many of the women decided to put their children in the informal care of other family members or in foster care. This is not necessarily the experience of most drug-using mothers; however, research indicates that the majority have primary childcare responsibilities (Cox, et al. 2008b). Drug use by a parent in itself should not be a reason for considering a child to be at risk of significant harm or to initiate any childcare proceedings. However, parental drug use can cause harm to children at every stage from conception to adulthood (ACMD 2003). To this end it is recommended that:

- **services working with problem drug users ensure that the well-being of the child is of paramount importance** by recognising the need to support clients' children, by providing services that are accessible and welcoming to drug users who have children, and by ensuring adequate provision for family and carer support services through including this in service specification
- **research be carried out with drug-using parents and their children** to assess the impact of parental drug use on children and to inform the development of strategies to ensure that mothers and fathers are successful in maintaining and/or re-establishing their role as parents during drug treatment.

7.3 The Physical Environment

The physical environment within which drug-using sex workers live and work can exert considerable influence over risk behaviour, the course of blood-borne viral transmission within this population and the effectiveness of harm reduction interventions. The data presented in this report identified two key local market shifts in Dublin's inner city which have impacted on the risk environment within which study participants live and work: the local drug market and the local street sex market.

Local drug market: This study highlighted the marked shift in local drug availability in the inner city, in particular increased availability and intravenous use of cocaine (and to a lesser degree crack cocaine use) among drug-using sex workers, and its impact on increased risk behaviour. The drug-using sex workers and professionals alike associated injecting cocaine use with increased injection frequency, unhygienic injecting practices, increased likelihood of injecting-related risk behaviour, increased vein damage, and

¹⁶ As only one of the male participants interviewed was a parent, and his children were not living with him, it was beyond the scope of the research to explore the experiences of drug-using fathers.

increased involvement in sex work and sexual risk behaviour. In other cities (e.g. Vancouver)¹⁷ a similar change in the local drug market contributed to an increase in HIV and HCV prevalence rates among injecting drug users. Although the vast majority of study participants were in receipt of methadone treatment, their cocaine use seemed to go largely unaddressed. It is recommended that:

- **contingency management** (whereby individuals earn rewards for clean urine samples for drug/cocaine abstinences)¹⁸ – **a strategy proven to be effective in reducing cocaine use in methadone-maintained opiate and cocaine use outpatients – be implemented in all methadone prescribing clinics**
- **a system of continual monitoring of local drug markets via the establishment of a drug trends monitoring system be established;** the expansion of methadone maintenance treatment will have limited impact in communities where heroin use is being replaced by cocaine use, therefore, it is vital that local drug markets and drug trends are monitored on an ongoing basis, as there can be substantial variation between areas (Mheen, et al. 2006), to ensure that appropriate policy, care and prevention strategies are in place.

Local street sex market: The findings highlighted that the regeneration and gentrification of parts of inner-city Dublin and new technological advancements (such as the mobile phone and the internet) have led to the disruption of long-established street-based sex markets. As a result, sex workers are less visible on the streets, thus making it difficult for (the under-resourced) outreach workers to identify and locate sex workers, learn about their practices, assess their needs and provide appropriate interventions to reduce their risk of harm. It is recommended that:

- **continued funding be provided to specialist services for (drug-using) sex workers**
- **adequate funding of drug and specialist (sex work) outreach services be provided to ensure their ability to carry out detached work**¹⁹ in the evenings, at night and at weekends in particular.

It is recommended that outreach teams invest at least 65 per cent of their time on detached outreach

17 Studies of syringe exchanges in Vancouver (and Montreal) revealed an inability to counter the spread of HIV and HCV as an upsurge in cocaine injecting overwhelmed the constricted needle exchange services (Hagan, H., McGough, J., Thiede, H., Weiss, N., Hopkins, S. and Russell, A. 1999 'Syringe exchange and risk of infection with hepatitis B and C viruses', *American Journal of Epidemiology* 3(1): 203-213, Patrick, D., Tyndall, M., Cornelisse, P., Li, K., Sherlock, C., Rekart, M., Strathdee, S., Currie, S., O'Shaughnessy, S. and O'Shaughnessy, M. 2001 'Incidence of hepatitis C virus infection among injection drug users during an outbreak of HIV infection', *Canadian Medical Association Journal* 165(7): 889-895.)

18 Studies have shown how contingency management is effective in reducing supplemental drug use. (Ghitza, U., Epstein, D. and Preston, K. 2008a 'Contingency management reduces injection-related HIV risk behaviors in heroin and cocaine using outpatients', *Addictive Behaviors* 33(4): 593-604. Griffith, G., Rowan-Szal, G., Roark, R., Ryan, R. and Simpson, D. 2000 'Contingency management in outpatient methadone treatment: a meta-analysis', *Drug and Alcohol Dependence* 58(1-2): 55-66.)

19 Research indicates that outreach services are most cost effective when full-time staff coordinate and supervise small teams of part-time workers or volunteers consisting of indigenous and non-indigenous workers (Rhodes, T. 1996 *Outreach work and drug users: Principles and Practice*, Strasbourg: Council of Europe).

work (Rhodes et al., 1991). These outreach services should target existing and developing street sex markets and peer networks of drug users and sex workers rather than individuals. They should also distribute sterile injecting equipment, paraphernalia, condoms, lubricants, etc.

- **the Gardaí, working in partnership with local drug and specialist (sex worker) services in Dublin city, continue to develop strategies to reduce the risk of violence to street-based sex workers;** to that end it is important that Garda trainees receive training in order to increase their awareness of issues surrounding male and female drug use and sex work.

Homelessness is a key social factor that facilitates risk behaviour and health differences among drug users (Galea and Vlahov 2002); however, it also influences the immediate physical environment in which drug users live and use drugs because homelessness is a physical environment that produces risk and limits the effectiveness of harm reduction interventions. For example, homeless drug users are often required to inject in a public or semi-public setting; if sterile injecting equipment is used in such highly un-sterile environments (such as toilets or derelict buildings) the individual is likely to experience serious adverse health effects, irrespective of the cleanliness of the injecting equipment used. Research indicates that the combined experience of homelessness and problem drug use increases life-threatening behaviour (Kemp, et al. 2001), including polydrug use, the risk of overdose, HIV and HCV infection and involvement in sex work. The majority of men and women interviewed had long-standing problems accessing suitable housing and consequently experienced numerous periods of homelessness, often moving from one inappropriate setting to another. The findings of the study reiterate the importance of structural interventions, such as improved access to housing, in creating an enabling environment. Over the last decade, homeless service providers in Dublin city have been creative and innovative in implementing harm reduction strategies. Based on the interventions currently in place it is recommended that:

- **on-site hostel needle exchanges are rolled out** in order to ensure that homeless drug users residing in emergency accommodation in Dublin have adequate access to sterile injecting equipment, paraphernalia, sin bins, condoms, etc.
- **funding and support be given to integrated primary care services for the homeless** to ensure adequate access to on-site primary healthcare for hostel residents and specialist support for hostel staff
- **flexible hostel accommodation is provided for homeless drug-using sex workers as part of a range of suitable accommodations, from low-threshold facilities to accommodation that facilitates recovery and rehabilitation;** drug-using sex workers' lifestyles often conflict with hostel regimes. One city centre hostel (NOVAS) provides an innovative example of working with this client group.

7.4 The Economic Environment

Research has highlighted the uneven distribution of harm according to material, as well as social inequality (Bourgois, et al. 1997). Economic dislocation can produce an environment extremely susceptible to the rapid spread of HIV and HCV. The economic environment can also hinder or prevent the development and implementation of appropriate harm reduction interventions, or limit the potential impact of such interventions. All study participants were unemployed and their main source of income was through sex work. Employment has been shown to be an important component of rehabilitation and reintegration into sociality for (ex) drug users, and reduces the likelihood of relapse. Most study participants said they wanted to work and recognised that paid employment is significant for building a 'normal' life. It is recommended that:

- **programmes (such as specialist CE schemes for drug users) aimed at getting drug users (back) to work should be continually funded and evaluated** to provide robust evidence of effectiveness, identify models of good practice, and prevent potential unintended negative consequences.

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