Basis yorkshire

Leeds Third Sector Health Grant

Project Evaluation: Basis (formerly Genesis) Sex Workers, Health Support and Advocacy

1.0 Background

Leeds South and East Clinical Commissioning Group commissioned Basis to undertake an innovative piece of work with sex workers resident in Holbeck, Beeston, Armley, Wortley, East End Park and Belle Isle. The project involved testing out ways of working primarily through targeted outreach and support to improve the health of these workers. This project would also explore, identify and establish care pathways within local health services through better understanding the real or perceived barriers sex workers face. It was also asked to support health workers better understand the health issues of those in this type of work. The original application written by the previous Chief Executive of Basis was therefore wide ranging and covered many aspects of the issues sex workers face not merely accessing health services. The value of the commission was set at £42,194. Ongoing discussions between commissioners and the new Chief Executive served to refine the project and narrow its scope following the commencement and first stage of the development of the work. The sex workers that came forward to participate in this pilot did indeed face complex health issues reflecting those that were identified within the original proposal. However, these needs appeared to be best met through individual support and supported referral as opposed to creating or easing care pathways through a set framework.

1.2 Methodological approach

Following initial meetings to scope the approach to the evaluation with the Chief Executive and the Health Advocacy Worker, an assessment of the requirements of the original commission, and understanding the refocusing of the work, a mixed multi-methods approach was adopted. This approach was taken due to the apparent nature, complexity and seemingly interrelated factors which appeared to be impacting upon these women's health. Recent and relevant reports compiled by the worker and other Basis staff with expertise in this area were analysed. These included:

- Winter Warm and Health Needs Survey conducted with 30 participant sex workers
- Reports outlining the number of sex workers that had taken part in the pilot and summaries of interventions including the range of services accessed
- A broader needs assessment report covering both indoor and street work with 63 participant sex workers
- A violence and harm audit following the murder of Daria Pionko
- Anonymised case studies were constructed outlining the factors impacting upon the project's participants and their health

Semi-structured interviews were conducted with sex workers that wished to talk about their health experiences and the support provided by Basis through the worker. These were conducted by a highly experience researcher in this field of work – Dr Billie Lister from Leeds Beckett University.

Extensive semi-structure interviews were conducted with Gemma Scire, the Chief Executive of Basis, and Nicky Pickup the Health Advocacy Worker funded by this commission. Broader general conversations were conducted with other Basis staff working with the participants

and other agencies as were available at the time the evaluation was being conducted e.g. housing support and welfare benefits.

A bank of data generated was analysed using a framework that reflected the refined project brief. All data was anonymised prior to analysis to protect the identities of the project's participants. The outcomes of the evaluation are presented under the following headings:

- The context – the health needs that emerged through this work
- What the project achieved – in terms of engagement with the target group
- The learning from the project - about the target group and 'what worked' to support health improvements
- Recommendations – using the evidence base generated through the project with the aim to inform those working with sex workers of how their health needs may be better met in future

3.0 The Context: health of women engaging in sex work in south and east Leeds.

What are the health needs?

Health Needs Assessment Report

This report provided data concerning women who are engaging in sex work but expressed considerations of leaving sex work. The assessment covered both indoor and outdoor work and engaged with 34 and 29 women respectively covering a 12 month period.

The data sets demonstrated valuable insights into the broader health profiles of the women central to this project. The average age of sex workers is 24 years covering at range of 13 to 45 years. The average length of time sex working was 9.7 years for street workers and 12.8 years indoor for indoor workers. Therefore this sample indicates some of the key needs of women engaged long term in sex work within Leeds.

Overwhelmingly indoor workers were British white 73.9%, 17% white other, 4.3% Asian/Asian British the remainder White/African Caribbean. Outdoor work consisted of 96.7% British white and the remainder White/African Caribbean.

64.7% of those working outdoors said they did so to pay for their drug habit. 32.4% were influenced to do so by their peers to engage in sex work. Women working indoors provided a much more diverse rationale as to why they were engaging in sex work. The largest factor being 40.7% due to pressure to pay bills which was directly related to poverty.

As regards health and access to services 94.1% of street workers were registered with a GP as opposed to 88.89% for indoor workers. But, as we will see verified later resulting from more conversational generated data, a majority of these women did not inform their GP of their profession. Outdoor workers were more likely to declare at 59.83% whereas indoor work were less likely to declare to their GP at 79.17%. Triangulated by further data featured later in this evaluation a key factor that consistently emerged was the fear of these workers becoming stigmatised by health workers via labelling within the health and welfare systems. The sex workers suspected this information could be shared across a range of services.

In terms of sexual health screening 79.4% of street workers and 96.30% of indoor workers had attended sexual health screening within the recent past. These more specialise health orientated services were considered friendly, confidential, understanding and non-judgemental. For women working outdoors, bus fares was a reason provided as to why they

would be less likely to attend and indoor workers discussed the issue of opening hours of these screening services.

Turning to broader physical health, the audit strongly suggested that the participants were in good health. However only 55.8% of indoor workers considered themselves to be in good health and outdoor less healthy at 51.52%. But data drawn from conversations with sex workers and semi-structured interviews with Basis staff suggest that sex workers accept issues such as heart disease or mobility are acceptable on a day to day basis. Women talked of pains in the chest, bronchitis and lack of mobility as everyday issues they dealt with without medical intervention. This report stated amongst the 63 women that took part that street workers reported high levels of abscesses and blood clots (32.35%), heart issues (12.12%), mobility (24.2%) and Hepatises C (26.47%). Further questioning the notion of their health status as being 'good'.

Mental health was identified as an extremely important issue for both indoor and street workers. 87.88% of street workers expressed their mental health to be of concern to them with 72.73% confirmed through diagnosis. Indoor workers identified this issue as much lower levels at 40.72%. However this is a significantly higher incidence than that experienced by women generally within the Leeds population. Anxiety and depression were the most frequent factors raised. Street workers identified personality disorders and psychosis as their main issues in terms of mental health.

Drug use is a significant factor amongst street workers with 78.13% stating they were regularly using and of these 84% said this was a serious problem. Indoor workers declared much lower levels, although against the general population of the city this was higher with 33.33% using and of these 22% said it was a serious problem. None of the indoor workers were heroin users with cannabis being the most popular substance used at 57.1%.

Alcohol abuse was not particularly prevalent in either group with 71.88% of street workers and 84% of indoor workers saying they had no dependency issues. However, further analysis demonstrated that 55.56% of street workers were engaging with alcohol recovery support services. A significant factor.

The final area covered by this report concerns feeling safe. Both indoor and street workers reported high risks in terms of safety with 60% of street workers attacked in the last 12 months and 37.50% of indoor workers. Street workers had experienced high levels of verbal abuse 65.5%, physical assaults 55.6% and objects thrown at them 55.2%. This compared to indoor workers verbal abuse through telephone, texts and emails 75% and verbal abuse face to face at 55.2%. Hence street workers are at high risk of physical attacks whereas indoor workers are more likely to experience digitally or verbally based abuse. Of great concern for street workers were the high levels of robbery, rape, physical and sexual assault they encountered. There was no detailed evidence to support this however it was a theme readily raised and one the sex workers felt strongly about.

3.1 Winter Warmth Needs Assessment

A further comprehensive assessment was conducted in 2016 by the Health Advocacy Worker through engagement with 23 sex workers that were engaging or considering engaging with this pilot project. The purpose of this work was to further gain insights into the broader needs of the workers as it had become clear that there were many basic issues these women faced outside that of the traditional or stereotypical approach to sex work such as considerations of sexual health.

88.46% of those consulted said they were in receipt of benefit and that poverty was a key factor in terms of their health and well-being. Poverty expressed itself as poor diet and a lack of heating in the home during the winter months. While street workers talked of keeping warm at work by using lots of layers of clothing they said although they understood that keeping warm was important to their health that this also 'puts off loads of punters'. Those working indoors keeping warm was less of an issue while working, but they were struggling to pay heating bills at home. This issue of poverty and paying the bills, in particular heating bills consistently resonated through both groups of workers throughout this assessment.

Aside from issues associated with working in the sex industry as mentioned previously, those that participated talked of their concerns as regards long term conditions that impacted upon their well-being. However the levels of long term health conditions were much higher than when compared with the population of the city with 30.77% of women experiencing morbidity issues including deep vein thrombosis, pulmonary embolisms, asthma and nerve/muscle damage. Deeper engagement with participants revealed 72.73% had asthma drawing a clear link with previously highlighted report, 27.27% from COPD, 18.18% had diagnosed long term heart conditions, 50% with either Hepatitis B or C, 18.18% with diabetes controlled by insulin, 27.27% experienced seizures and over 50% of women suffered with bronchitis or chest infections, thus underpinning the content of the previous report on health needs of sex workers.

Adding to health issues are the high proportion of mental health issues as again reflected in the earlier report and triangulated via the outreach work with the women that participated in the project. 84.62% of women have been diagnosed with a mental health issue. Participants particularly highlighted Bipolar Disorder, ADHD, PTSD and anxiety and depression.

Concerning the engagement with GPs, the universal gate keeper to health services, a similar low level of disclosure of their profession was revealed echoing the previous report. Though 88.46% were registered with a GP, there were over 10% that were not. Only 21.74% of those registered disclosed to the GP the nature of their work and the remainder chose not to do so. A majority of participants were happy with the service provided by their GP. However further data collected through conversations highlight that these discussions with GPs did not relate to health issues connected with sex work. Only 69.23% were registered with a dentist, the remainder did not seek dental treatment.

The two health needs assessments conducted by Basis, one using an externally commissioned resources and the second via the Health Advocacy Worker appointed to develop this project, set a evidence based context within which the work on health advocacy was being implemented. Traditional or perhaps more stereotypical responses to groups such as sex worker are directly challenged by this context. Their health needs mirrors the broader needs of the population of the city however these needs are complex, interrelated, and compounded by many multifaceted issues that impact upon them daily of which poverty is one that is consistently highlighted. Hence issues such as heart disease or seizures or bronchitis are ones that significant proportions of those engaged with through the project accept as a normal part of everyday life. Hence as well as responses to basic health needs such as screening, the women that contributed to this contextual setting exhibited many long term and general health issues perhaps not usually or readily associated with sex work. These health conditions are entrenched within sex workers alongside unacceptable daily experiences such as violence and abuse. Added to this are the street workers' issues with substances and the prevalence of mental health concerns across both indoor and street workers. Further to this how women choose to not disclose the nature of their work to their GP. The GP in effect is the hub or the central figure for referral for all using NHS services.

Whilst being identified as a sex worker is perceived as perhaps a negative label by those involved in the work, this obviously means that GPs are referring or guiding these sex workers around their health issues without understanding the full picture.

4.0 What the project achieved

Basis has been through a fundamental review of services and staffing since the original proposal for funding was placed with the Clinical Commissioning Group in 2015. Basis continues to offer high quality support to girls at risk or subject to CSE and engages with women street or indoor working in the sex industry. The original proposal was refined following the employment of the Health Advocacy Worker and the initial work to create pathways for this group into health services most relevant to their needs. The primary focus has been to provide intensive support and advocacy work to a relatively small case load of women to help them navigate and stay engaged with health services in south and east Leeds. This role has involved networking with and on behalf of those that volunteered to join the pilot with the maze of agencies that work broadly in the health, welfare and social care fields. This has included agencies such as Forward Leeds and the host of services that work under this banner. Further to the initial base lining of health needs as outlined above the following engagements took place over the year 2016:

- 19 women participated with the project. These engagements involved one to two hours per person of the worker's time to provide support with relatively shorter term responses such as a visit to prison, dental treatment or harm reduction visit to more in depth support which involved many multiple and a complex number of interventions. These multiple interventions took many hours and lasted over periods of weeks and months and included housing assessment, prison visits, mental health assessment, medical assessment, multiple hospital appointments, GP visits, drug and alcohol service assessments, meetings with professionals (confidential).
- In order to gain a relationship with this sex workers outreach commenced at the onset of the project on the street or indoor places of work. 404 outreach sessions were recorded outdoors with a further 17 sauna sessions, 27 drop in sessions across the year and 2 prison pre discharge visits were made.
- The worker appointed to this role discussed how relationships were important and that a strong sense of trust had to be built with individuals so they would start to engage in an honest and open dialogue. The worker had to overcome the sense of distrust such those highlighted earlier about GPs in that judgments could be made concerning sex work. The semi-structured interviews conducted with the sex workers emphasised this aspect of the work – that the worker 'did not just show concern for me, but also my family and the issues they had'. The existing profile of Basis and the organisation's relationships with sex workers was initially critical in terms of encouraging women to volunteer.
- It became apparent early on in the development of the project that alongside a trusting relationship generated by Genesis and the worker, these women almost universally would not access the health services they needed for important treatment unless they were supported to do so. While the worker realised and fully understood that an empowerment model should be the aim or the eventual aim of the work so that women would have confidence to access the health services they needed without support, the reality is that without support in the short term these participants would not continue to access the service or services required. The smallest barrier would be perceived by some of the sex workers as a valid reason why not attend health appointments. This could be financial such as bus fares through to confidence

to access and was considered to be an illustration of a deep distrust of professionals from all services, not just the health sector.

- Two anonymised case studies are outlined in Appendix 1 and 2 which provides an insight into the types of engagement and the positive outcomes that have been produced as a result of the work of the Health Advocacy Worker and reflect the wider work carried out throughout the life of the project.

5.0 The learning from the pilot project

The project set out to facilitate and support the health needs of sex workers and help ease or develop pathways that would support others in future to enjoy improved health. So the learning, while identifying the health needs of sex workers as an important outcome, perhaps more importantly also providing a better understanding of how commissioners could better meet these needs through future approaches are also considered important outcomes of the project.

The following themes have emerged as key areas of learning distilled from the experiences of the Health Advocate worker, other workers from Basis and its partners that have been engaged with these services users that participated in the pilot, the views of health workers that have engaged and most importantly in continuing Basis's approach in the context of their core value of co-production the views and experiences of the participants themselves.

The following wide ranging themes have emerged:

- The health needs of women working both indoors and on the street are complex. These women face the same health needs as those not working in this environment, however the factors that influence those working in this environment work to concentrate issues seen in the wider population but with a much higher prevalence. These concentrations of need encompass both physical and mental health. Hence the health issues as seen in case studies provided coupled with a lack of confidence and potential for stigma lead to a great deal of time spent with individuals so that the complex and inter-related factors are understood and can be acted upon. They are not simply occupationally linked, but the product of a series of complex and interacting factors.
- A majority of the participants access NHS services through their GP. But a high proportion of women fail to disclose the nature of their work to their GP. The GP therefore does not have a thorough understanding upon which to take the best course of action.
- A majority of those engaged with the project were concerned that disclosure may lead to labelling and that this would be recorded on their NHS record and work to further stigmatise them.
- The street workers when compared to indoor workers are readily engaged in substance and some with alcohol misuse. Their work was said to aid paying for their usage. Both groups though are in an environment or settings that interact to create multi-dimensional adversity. Often health needs such as bronchitis and heart disease are masked in terms of more immediate health priorities. The nature of the relationship forged through this pilot work demonstrates that deeper understandings of the situation or positioning of those working in these settings needs to take place as opposed to responding to the immediate issues that could be very apparent such as substance misuse.
- The result of the above is that these deeper health needs are often disregarded by women and viewed as part of the price to pay for working in these settings rather

resonating with the view that verbal or physical abuse is acceptable. Those that formed a strong and trusting relationship with the worker realised that heart disease or issues associated with breathing are can be treated and are not something to carry with them. Identification of these deep seated health needs were not evident prior to commencement of the project.

- The relationship with the Health Advocacy Worker and individual women is important and this trusted relationship and support to access the right services for individuals is key to improved health. The relationship is client centred, non-judgemental and replicates a humanistic approach of unconditional positive regard. This is clearly central to the whole project.
- This relationship also encompasses a holistic approach where the women are viewed as part of families. The worker appreciated the women have broader personal roles and responsibilities as a parent/carer or partner and that this has to be taken into account. Hence the worker also supported the wider family needs which acted to gain confidence and trust but also reduced some of the interrelate issues that impacted upon the sex worker's health.
- The worker discussed the consequences of individual's actions upon their health as well as providing support accompanied by a non-judgemental holistic approach. As the project was coming towards the end of 2016 some of the participants were demonstrating that they were starting to build their own capital and knowledge in terms of talking control of their health as opposed to being fully supported. This is an important development. But some needed continued support as these were for many the first steps towards improved health.
- Further to the above point the worker was also taking the first tentative steps to create an environment where sex workers could collaborate to support each other in defining and responding to their health needs. This again is an important development which requires further consideration and development. If the improved health of the workers is to be considered as something that is sustainable as opposed to the response from a one off intervention, then the confidence and peer support networks need to be further developed and perhaps funding provided in the longer term for peer support as opposed to purely professional advocacy. Using a facilitator approach would broaden the reach in terms of number of women that could be helped in a sustainable way.
- This project has been funded for one year. There are always issues when funding to support vulnerable people is on a short term basis. An exit strategy or sustainable approach appears to be needed for this project. The key learning from the project is the development via a highly skilled and experienced worker to form a trusting relationship with each sex worker, overcoming the barriers and perceived prejudices and labels that can be readily attached to those working in this environment. For this group of women's health to be improved on sustainable basis, longer term funding is required which will allow these participants to start to take more control and feel confident alongside the remainder of the population to access services to help them. Further it this the development of a peer support project facilitated by a professional would support longer term improvement. Improving the health of this group of women is not a simple referral process. A majority of women would not access services if Basis had provided a simple signposting service.
- The training of NHS or other relevant staff did not formally take place during the year of the project. However individual staff that came into contact with the Health Advocacy Worker, who has become an expert in her field, did engage health staff to openly discuss the issues women she works with face in a depersonalised manner.

Linked to this as described above is the deep knowledge Basis staff team has in this area of work. This expertise formed a springboard upon which the project could build quickly and gain results in terms of positive interventions concerning the health of sex workers and has served to develop further their capital as an organisation in terms of knowledge a base of the core client group and to inform broader thinking eg the 'Leeds Prostitution Strategy'.

6.0 Summary:

The project has clearly met its aims in the two main areas agreed with the commissioners:

1] It has served to improve the health of both street workers and indoor workers through mainly individual intensive support. These interventions range from fairly straightforward signposting with support to ensure that women accessed the service through to multiple and complex longer term help for those with more complex and interacting issues. Building confidence and trust has been central to this success.

2] Through the project the health needs of a much wider group of women than those that directly participated in support mechanisms offered have become known to commissioners and partners in other related services. This projected has significantly contributed to this understanding. These sex workers should be considered as women with, like other women, with fairly everyday health issues such as asthma, heart disease and chest infections. But due to the nature of their work and the environment they find themselves in other complex issues interact to serve to mask or hide very basic health needs

3] Mental health is an issue that effect a vast majority of women working in the sex industry. The project did not have the capacity or time to discern whether this was as a result of the work, the labelling and the factors that are apparent in this environment or whether this was related to other factors such as substance or alcohol misuse or poverty or issues in childhood. Whatever the factors that bringing about this almost universal issue of mental health to the forefront, mental health is as important consideration for the NHS, if not more of a priority than the physical health of the women. That is the service user generated narrative as opposed the Basis or the Health Advocacy Worker. A fundamental piece of work appears to be needed to ascertain a much deeper understanding of the correlation between sex work and mental health.

4] Having stated there are common themes in terms of health needs, each participant had like the remainder of the population of a city such as Leeds, a different story with different approaches needed to resolve these complex health issues. Therefore the notion put forward in the original proposal of smoothing or customising care pathways would not seem to be a workable proposition due to the needs of individuals and the complexity of contextual factors that impacted upon those that took part in this project. Therefore the project cannot provide simple or readymade responses to this aspect of the original proposal.

7.0 Recommendations:

This pilot project has been successful in producing responses to much of the requirements placed upon it. However the health of this group of women is like all women living within the city not one where there are simple solutions can be offered. The Health Advocacy Worker and the Basis team have served to aid learning about the health of sex workers. The following are suggestions drawn from the experiences of those employed on the project

including the management team of Basis, those involved in this evaluation and the participants in the project. These recommendations are put forward in the spirit of improving the health of this seemingly extremely vulnerable group of women.

- While the number of women engaged in sex work in the city is relatively small their health needs are high and it is evident that due to many complex factors they are not being fully met. The factors that influence their health are individual and personal to them and as we have seen there are no simple tailored health orientated solutions. Therefore the role of the expert agency – that is in terms of sex work provides a firm basis upon which to develop further an advocacy model. The number of service users are small, yet their needs are high and there is a clear understanding that confidence and skills of these women needs to be developed over the longer term so that they can navigate a complex landscape of service provision.
- Adopting a case-management system through a non-judgemental, user centred and trusted agency such as Basis would provide health workers with a central point of expertise upon which they can draw on trends, and also a bank of expertise in terms of complex health needs related to the complexity of factors related to the environment these sex workers are positioned within.
- Briefing sessions to be offered health workers in areas where there are significant concentrations of sex workers to be undertaken by experts in this area. These using the case studies as evidenced based examples of the complex nature of needs. It is apparent that women are highly concerned about judgements and the associated implications of labelling. But, more importantly the project has demonstrated that due to whatever reason the basic health needs of a significant proportion of sex workers are not being met. Example such as heart disease are perhaps lower on the list of these workers' concerns, and are being masked by perhaps the more immediate needs such as screening and day to day survival.
- Mental health could be described as almost a universal health issue amongst this group of women. It would appear that mental health over rides or is seen by this group of workers as more of a priority than many aspects of physical health and wellbeing. Therefore it is recommended that further work should be carried out to better gain insights into why this is such an important issue. By using the existing expertise such as that of Basis and their ready access to these women that a project is established which can learn about this issue further and bring about ways of supporting improved mental health.

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APPENDIX 1

Service user interviews – qualitative data

Originally, 4 service users were booked in to see the researcher. However, as this group of sex working women were so chaotic it was possible to do just 2 interviews. The content provides a rich picture and insight into the issues faced by women.

Service User: Chloe

At the time of interview, Chloe was forty-one years of age. She became involved in street based sex work at approximately twenty-six years of age, and has been in contact with Basis Yorkshire for the past seven years, when she needed help to exit an abusive relationship. Chloe became aware of the health and support worker's role in Basis Yorkshire after being informed by a benefits and housing advisor at the organisation that a new member, Ms. Nicola Pickup, had obtained the post of Health and Support Worker. This support worker was helping Chloe with problems around benefit claims and noted that she had problems could be further supported by the health and support worker. Chloe was familiar with Ms Pickup already as she had been volunteering on outreach before taking up the post. The actual referral to the service offered by Ms Pickup however came from the health needs assessments, as other members of the Basis Yorkshire team did not have the capacity to deliver work of this nature.

Chloe mentioned that knowing who Nicola was before becoming one of her cases assisted with her feeling comfortable enough to talk about her previously unaddressed health problems;

Did it help you in any way - the fact you knew who she was before you started working together?

"yeah. A little bit, yeah. She is a good person but she does it from the heart, you know what I mean? It's not just a job"

The above quote draws attention to the requirement Chloe has to work with someone who she perceives to genuinely care for her welfare, as well as performing the stipulated role as health and support worker.

Chloe's health raises cause for concern. She was advised to seek help from the Health Advocacy and Support worker due to the emergence of abnormal cancer cells. This means she was require to undergo a colposcopy. In addition, Chloe presents severe issues with oral health and requires surgery to address a growth in her mouth.

As evidenced below, Chloe had chosen to ignore her health problems, indeed prior to contacting Ms Pickup she had not obtained any help with these problems from her GP or any other organisation. Therefore, the impetus for tackling the issues arose from the relationship with the Health, Advocacy and Support Worker, who encouraged her to seek medical assistance.

"But I was supposed to go for the colposcopy and I didn't go for three years. And the dentist I put off for the last two years"

Chloe's justification for not seeking help - particularly for the gynaecological problem - was in relation to, in her words, constantly "putting it off". This may in part have been due to the fact that the issue was not causing any physical discomfort. However, cancer has presented a pattern in Chloe's family history and it is a known medical fact that cervical problems can

manifest for sometime prior to becoming a physical problem. However, it is imperative abnormal smear results are addressed by a medical professional and are not neglected.

It transpired that Chloe was also nervous about addressing the issue which had contributed to her unwillingness to return to the GP. Therefore, her initial claim that she kept "putting it off" was underpinned by a fear of returning in case of a bad outcome. When the health and support worker took on the case, she forced the importance of addressing the issue to Chloe, which essentially was the catalyst for she needed to persuade her to take action;

"She was just in my ear all the time, saying it was important and all of that. So having someone at me, telling me how important it was"

Nicola specifically visited Chloe to ensure she would attend pre-arranged hospital appointments. It appeared that this 'double pronged' tactic encouraged Chloe to act, not only for her own benefit but also to show she did not want to 'let down' Nicola.

"And I'm the kind of person, if she turns up for me, I can't just ignore her. She came all the way up the other week to take me to hospital, I spoke to her on the phone…she turned up (at the house) and I didn't want to ignore her. But I couldn't be bothered. So I said 'I can't be arsed' (attending the appointment). But then I got ready and went"

This is an example of the Health Advocacy and Support Worker acting as a 'reason' for Chloe to attend her appointment.

As is a common characteristic of many individuals involved in the street sex working, Chloe's personal life is chaotic and she has been diagnosed with Bi-Polar disorder which contributes to this chaos. In many ways, she finds it 'all too easy' to forgo appointments, due to either inconvenience or simply just not feeling able to emotionally address the health related problems. Therefore, certainly in Chloe's situation, there is an absolute requirement that there is a key trusted person who can effectively act as a catalyst for action. Chloe admitted that she wouldn't have bothered to addresse the severe dental issues had Ms Pickup not pushed her to address them;

"And I got my teeth sorted out. I might have my dentures by Christmas. And I wouldn't have done that if she hadn't kicked me up the backside"

Ms Pickup was present not only to accompany Chloe to appointments, but was also on hand to make appointments in the first place, something which Chloe admitted she did not have the initiative to facilitate herself. She also made sure she was able to take Chloe directly to hospital and GP appointments with the use of her vehicle. This combination of practical and emotional support resulted in a positive outcome for this particular service user.

Chloe's situation is compounded by the isolation which characterises her life, certainly in relation to health matters, as she notes that she has no one else to discuss these health issues with. Furthermore, she keeps her involvement in the sex industry private from all medical professionals she interacts with. This means it is especially important that focussed support is provided from a trusted person who is aware of this involvement. This is particularly important due to the relationship women's lifestyle and work can have on their personal help. Furthermore, having a trusted person on hand to accompany a service user to appointments appeared to be important from a psychological viewpoint, given that women are not able to be open to others about their work due to perceived stigmatising attitudes.

Chloe's interaction with other support workers in various agencies has been difficult, therefore she considers a challenge to find a support worker who is non-judgemental and personable. This is particularly important when one considers the sensitivity of the health

problems Chloe presents with. This means that the personality and ethos of the individual who is employed in such positions is paramount. Chloe argued that;

"I have been spoken to like shit by certain workers…I don't even go there anymore"

This means when Chloe comes into contact with an individual who she perceives to be unpleasant, she is highly likely to divorce her interaction not only that particular worker, but also with the entire organisation as a whole - separating her from a service which may be able to provide her with assistance via another avenue within that organisation.

As well as the direct health benefits, there are also social and education benefits which will be reaped from a successful interaction with healthcare services. Chloe's wish is to enrol on a college course, however did not feel able to due to feeling self conscious regarding the cosmetic state of her mouth, feeling that people would assume she was a drug user;

"People judge as soon as they see your mouth. Oh, she's a crackhead or a smack-head"

She hopes that, when her new dentures are fitted, she will be able to have some confidence around the people she will meet at college. In time, Chloe hopes to enter the employment market - attending college and having the confidence to do so would be a positive move towards this goal. This example shows how attention to health related concerns can also positively affect a person's negotiation into a less chaotic lifestyle.

Chloe's story highlights a number of issues which impacted upon her lack of action with regards to her health problems. Of particular note are the issues around stigma and trust. Her case highlights the problems that can arise when service users are shifted across various staff members - not only must trust be negotiated, but the service user must again open up their personal circumstances to yet another individual;

"Nicky knows my situation, she knows my partner, she's there for me. Me family issues. She knows everything. This is the main issue you have with support agencies, you get to know someone, they know everything about you, and then they swap you for someone else and then you have to do it all again"

Chloe found this tiring and spoke of her hope that Ms Pickup would remain at Basis Yorkshire, so she would not have to intimately 'get to know' and put trust in another project worker, saying that ***"she wouldn't be bothered about her (health) appointments if she (Ms Pickup) wasn't around"***. Indeed, Chloe presented as quite emotionally tied to the project as a whole, and emphasised that even when she left sex work, which is her plan, she still wants to remain in contact with both her health and support worker and Basis Yorkshire as she believes that issues will always present themselves, and she would always need someone to turn to. Tellingly, she also reported that she would never be able to talk about her sex working in a past tense to anyone else due to the stigma involvement in the sex industry elicits from the general public.

The above quote also alludes to Chloe's willingness to confide in Ms Pickup with regards to issues outside the health and support worker remit. However, she is able to, which Chloe's permission, pass on relevant information to other Basis Yorkshire staff who are in a greater position to assist, meaning that other problems Chloe may have in her life can also be addressed as well as health related ones.

Since the interview with Chloe took place, as of January 2017 she has continued to engage with health professionals, having attended her appointment for impressions for new dentures. Previously to her interaction with the health support worker, Chloe was afraid about visiting the dentist however now appears to be on track to reaping the social and health related benefits of good oral health. She has also remained free of drug use and got engaged in December 2016. Therefore, Chloe's interaction with Ms Pickup appears to have helped her to make significant changes to her lifestyle, in particular with regards to accessing essential health care services.

Service User: Amy

At time of interview, Amy was thirty-eight years of age and was not working in the sex industry at the time, however may or may not return at any time, depending upon financial need. Prior to becoming one of Ms Pickup's cases, Amy was working with a benefits support worker who was at the time employed by Basis Yorkshire. Ms Pickup has brought Amy a food parcel in the course of her previous voluntary work with Basis Yorkshire - this formed their first interaction. This opportunity was used by Ms Pickup to tell Amy about the service that she was able to offer as a result of acquiring the Health and Support worker post. Upon receiving this information, Amy decided to explore what was on offer and was referred to the support from a health needs assessment.

Critically, Amy has no other support from any other organisation aside from Basis Yorkshire. There is no family support, and no mental health provision despite long standing issues around access to Amy's children who are currently in Local Authority care.

The quote below illustrates the impact being told directly about the service;

"Nicky told me about her role to do with health and hospitals and dentist and I was like 'oh I need a dentist for my teeth. And my health, and I was saying to her how bad it had got you know what I mean, I mean I'm so flipping lazy I go to the chemist everyday (for methadone) and there's a doctor beside it but I never went"

It would appear being told about the service gave Amy the push she needed to consider the severity of her health problems. Prior to this, she lacked the initiative to take matters into her own hands despite being in close proximity to a doctors surgery. Upon becoming one of Ms Pickup's cases, Amy was registered with a dentist and doctor - prior to this she wasn't registered with either. This illustrates Amy's requirement to, certainly at the moment, to have someone take action on her behalf, with her permission;

"Nicky got me a doctor and a dentist. She made me an appointment"

Amy presents with a number of health problems including Chronic obstructive pulmonary disease (COPD). This cannot be cured but requires management from a health care professional. Unfortunately Amy has a fear of medical staff due to an unpleasant hospital admission for septicaemia where she was hospitalised long term, for a number of months. This experience obviously helps to explain her prior lack of involvement and indicates that her unwillingness to go to the doctor was a result of more than just 'laziness'.

"When I go to the doctor, I always think they will send me to hospital which they had done the last few times and I don't like hospitals"

As was the case with Chloe, the decision to go to hospital was related to Ms Pickup - in particular, Ms Pickup's willingness to accompany and wait while Amy attended appointments was key.

INTERVIEWER: "What made you go to the hospital?"

"A lot of it was to do with Nicky, you know what I mean, like I've gone down and Nicky's come with me"

Since working with Ms Pickup, Amy has attended hospital 8-9 times, with 3 occasions requiring visits to accident and emergency. Considering she was not registered with a G.P. prior to becoming a case, this shows support for the need for a health and support worker in Chloe's life, certainly for the time being.

Amy's case required a great amount of time and on two occasions she spoke of occasions where Ms Pickup has remained with her long after her allocated hours of work. For example, her first admission to accident and emergency involved a four hour wait. On a separate occasion, another hospital visit lasted for thirteen hours. On both occasions Ms Pickup stayed with Amy, after her contracted hours of work so that Amy would definitely attend the appointment. Therefore, it would appear that Ms Pickup often takes on work outside of her remit. Because there is no family to support Amy, Ms Pickup offered to collect some clothes for Amy from her home so she could get changed at the hospital. In this case, the hospital themselves had refused to provide Amy with any pyjama bottoms or trousers due to the state of an abscess.

Despite Amy's reliance on Ms Pickup, a break through was observed when Amy declared she has taken the initiative and went to the hospital on her own. For this particular service user, this should be considered a huge achievement given the fact that previously she was incapable of registering with the local G.P. and her fear of hospitals. To be able to go without the support of Ms Pickup is indicative of her adopting new attitudes to health and the responsibility she has to herself and her own wellbeing long term. However, Ms Pickup still influenced the visit partially, as she was keen to let her know she was managing to deal with the stress of attending an appointment alone. Amy also appears to show an interest in addressing other health problems she has which were of lesser immediate importance than what was getting dealt with at the time however this indicates that she is finally starting to think about her own health and addressing it;

"I want to ask about my back cause I'm walking really bad now"

Amy had low expectations of healthcare providers, not only because of her long term stay in hospital due to septicaemia but also due to an unpleasant dentist appointment in which the dentist was considered to treat her like a 'butcher'. Despite this, she went back after being referred to the dental hospital rather than forgo additional treatment. Compounding misgivings around accessing these services in general, Amy is particularly vulnerable to do lack of support outside of Basis Yorkshire. She considered her social worker to be 'useless'. This individual had been assigned to provide emotional support to people who are estranged from family members, however she failed to contact Amy, who described her as being a bit 'docile' during their first and only encounter. Amy never heard from her again.

Amy has long term medical needs which will require medication for the rest of her life. She did comment towards the end of interview that she would probably not continue to address this long term issues without the help of a Health and Support Worker;

INTERVIEWER: Will you keep addressing the problems you have that are ongoing without Nicky?

"No. That's what I say to her, she gives me a kick up the arse. I didn't like going out before. At one point I wouldn't even go to the chemist….I'm taking steps now though, I used to get really paranoid about going out and everyone's looking at me and all of that stuff you know"

It would appear that in Ms Pickup's work with Amy around health related issues, it seems that other mental health issues, such as problems leaving the house, were also being partly addressed by simply having a regular and reliable source of support. However, despite the one occasion when Amy went to hospital herself, it would seem she is still reliant on Ms Pickup's support. Therefore, further work should be done to reduce dependency in time, so that Amy can learn to help herself, but it is without doubt that at the moment, the role of Health and Support Worker is crucial is ensuring these immediate health concerns are met. There appeared to be a definite change in attitude however, which is encompassed in the following quote;

"Without her, it goes to show, I wouldn't have bothered with the doctor's again. I could have and I didn't and not I look back and think 'why didn't I do that?' …. I'm just waiting to see about getting seen by the vascular doctor now"

When asked about the future, Amy hoped she would continue to work with Ms Pickup. As with Chloe, part of this appears to be attributed to Ms Pickup's ability to form a trusting relationship with service users, something which appears to be lacking within outside provision;

INTERVIEWER: How do you see yourself addressing your health problems in the future?

"Hopefully with Nicky like. There's me health but she is a good listener and patient and other things I would get embarrassed about. Like I need an implant out and I don't want to talk to anyone about that"

Since the interview took place, Amy was hospitalized for three weeks with an infected leg ulcer. She also has had tests done on her heart and spine and was checked for gall stones. The very fact she is addressing these health issues which have manifested over a long period of time indicates a willingness to engage with health care professionals, something which was avoided at all costs previously.

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APPENDIX 2

Quantitative data

Figures for final report – Health Support & Advocacy Worker - 3 Jan 2016 – 19 Dec 2016

Time invested per case:

AW:

Housing x 1 = 1hr

Prison visit x1 = 2hrs

Drop in x 2 = 1 hr 20 mins

Visits x 1 =20 mins

CP:

Visits x 3 = 5hrs

GP x 1 = 5hrs

Mental health interventions x 2 = 2hrs 55 mins

No show x 1 = 55 mins

CD:

Medical assessment x 1 = 1hr 30 mins

Dental x 1 = 1hr

No show x 2 = 1hr 35 mins

CB:

No show x 2 = 1 hr 15 mins

Visit x 1 = 5 mins

DG:

Dental x 1 = 25 mins

DS:

Visit x 1 = 30 mins

JC:

Visit x 11 = 11 hrs 30 mins

GP x 18 = 15 hrs 35 mins

Dental x 6 = 7 hrs 55 mins

Hospital appointments/in-patient visits x 10 = 14 hrs 50 mins

No show x 2 = 1hr 30 mins

LSH x 2 = 2 hrs

A&E x 5 = 34 hrs

Medical assessment x 1 = 1hr 50 mins

Methadone x 35 approx figure

JH:

Dental x 6 = 6 hrs 5 mins

Opticians x 2 = 2 hrs 15 mins

Visit x 2 = 55 mins

Drop in x 2 = 3 hrs 50 mins

KJ:

Visit x 1 = 1hr

No show x 1 = 1 hr

KI:

Visit x 9 = 13 hrs 50 mins

Dental x 5 = 12 hrs 30 mins

GP x 4 = 4 hrs 25 mins

No show x 1 = 50 mins

Hospital appointments x 1 = 2 hrs

Drop in x 1 = 2hrs 45 mins

KM:

GP x 9 = 5 hrs 20 mins

A&E x 2 = 19 hrs 20 mins

No show x 10 = 5 hrs 35 mins

Drug/Alcohol services x 8 = 9 hrs 15 mins

Dental x 1 = 45 mins

Opticians x 1 = 1hr 20 mins

Visit x 11 = 13 hrs 10 mins

Hospital appointments x 1 = 2 hrs 30 mins

Housing x 4 = 8 hrs 45 mins

Job centre x 1 = 1 hr 30 mins

LE:

Visit x 1 = 1 hr 45 mins

LR:

Dental x 5 = 5 hrs

Housing x 2 = 3 hrs 5 mins

Visit x 1 = 2 hr 30 mins

GP x 1 = 2 hrs

No show x 1 = 50 mins

LN:

Visit x 2 = 2 hrs 45 mins

Drug/Alcohol services x1 = 2 hrs

No show x 1 = 1 hr 30 mins

Maria:

Visit x 2 = 40 mins

No show x 2 = 1 hr 20 mins

GP x 1 = 1 hr 30 mins

SB:

Visit x 3 = 1 hr 30 mins

SA:

Visit x 41 = 50 hrs 55 mins

Hospital x 11 = 12 hrs 10 mins

Drug/Alcohol services x8 = 23 hrs 50 mins

GP x 2 = 3 hrs 30 mins

Housing x 2 = 4 hrs

No show x 2 = 1 hr 50 mins

Professionals meetings x 7 = 12 hrs 45 mins

ADDITIONAL ENGAGEMENT ACTIVITIES

Outreach interventions – x 404

Drop in interventions – x 27

Sauna interventions – x 17

Prison visits – x 2

APPENDIX 4

Additional information

Nicola Pickup was runner up for 'Unsung Hero' at the Yorkshire Evening Post 'Best of Health' Awards 2016.

Basis Yorkshire have won the national Glaxo Smith Kline's Impact Awards for 2017, beating 400 other charities to be a winner in the top 10 charities in the UK delivering health impact in the community (PLEASE NOTE THIS IS STRICTLY EMBARGOED BY THE FUNDER UNTIL 28.02.17).

Partner testimonial:

Dear Nicky,

I just wanted to say thank you for all your work as Health and Advocacy Worker at Basis. Your work has made a great difference to the women. I am especially thinking of your outreach work with our GP and mental health nurse, the allocation of a pre-booked appointment system at York Street Health Practice for the women and also the work to develop a flu vaccination outreach. The health needs assessment you developed will inform our work. Your approach is so positive, caring and supportive that you make partnership working both easy and effective - so thank you! Best wishes, John

John Walsh

Practice Manager

York Street Health Practice

68 York Street

Leeds

LS9 8AA

APPENDIX 5

Case studies

Case Study – Kay – 4 November 2016

I started working with Kay in January. Kay is a 41 year old white British woman who has three children, who no longer live with her. She is on a methadone script, and smokes crack on a daily basis. She has a regular partner who she has an on/off relationship with and has been sex working, mainly to fund her drug addiction since her early twenties. A few years previously Kay was present during a violent house robbery, and has since suffered with anxiety and panic attacks.

At the time Kay's mental health wasn't good, she suffers from bi-polar and was off her medication, and at times said she had felt suicidal. Other health issues included a large growth on her gum, which she had had an emergency referral for to the dental hospital over two years ago, but never went. She had also had a smear test which showed abnormal cells. An urgent follow up appointment was made to perform a colposcopy, but again due to Kay's chaotic lifestyle, she never made the appointment.

Along with her health issues above Kay was behind with her rent due to the bedroom tax and was at risk of eviction. She accessed food parcels from us on a regular basis, and when things got really tough she would start sex working again in the managed area in Holbeck, which all had an impact on her mental health, especially her self-esteem. During the periods that she had to go back out sex working she used to say how much she hated this and was always fearful that her children would find out and never speak to her again.

We first looked at getting her back on her medication to try stabilising her mental health. As well as offering periods of emotional support when needed with her relationships with her partner, and her two adult children, that she still has contact with.

Kay's goals were that she wanted to have a home she could feel proud of, where her elder children could come and visit. She wanted to either go college or to try finding a part time job where she could feel like a normal person, and feel valued. She was really conscious of the growth on her gum and the fact that she had hardly any teeth, as this changed the shape of her jawline and she felt people judged her as a smack head. This was one of the reasons that prevented her going to college or looking for employment. So we re-registered her with a dentist who made the referral straight away.

I also got her to see the nurse at her GP surgery who phoned straight through to the colposcopy department to try fast track Kay through. It took two attempts to get her to the colposcopy appointment as in-between the referral and the appointment, Kay's mental health was not good again. She had moved property to a one bedroom flat in a new area and had not registered with a new GP yet so was off her medication. Her relationship had broken down again, and she was sex working again. During the next couple of weeks we prioritised Kay's needs again and managed to get her back on her medication, and feeling more settled in her property. We eventually got her to her colposcopy appointment and thankfully she received her results 6 weeks later which were fine. They are going to keep regular 12 months checks on her in case anything changes.

A few weeks ago Kay had her growth removed and has a follow up appointment to have the rest of her teeth removed. She is then booked in to her dentist following this to have some new dentures fitted, which will hopefully give her the confidence to make positive changes in her life. Kay and her partner stopped using crack seven days ago as she has had enough of

drugs, and wants to do it so her sons feel proud of her, and so she can feel part of a family again. She knows it is going to be really hard, but feels this is the right time for her to be able to do this.

Case Study – SA – 25/11/16

SA was referred to Basis Sex Work Project in March 2015, she is a 37 year old woman who at the time was sex working in Holbeck in the managed area.

I started working with SA in January 2016 where I was asked to support her around her substance misuse. At this time SA was drinking around one litre of vodka a day and was on a daily script for her methadone. She had moved in to Carr Beck (wet hostel) a few weeks before to get help in trying to reduce her alcohol intake in the hope of getting a detox.

SA talked a lot about her past, including her childhood and the relationship with her dad, who was a drinker and used to belittle her and knock her confidence and self-esteem. This led to SA developing an eating disorder. One of her brothers died from alcohol at the age of 30, and SA was convinced the same was going to happen to her. She has a good relationship with her mum, who also looks after SA's two older children, aged 18 and 12, due to SA's problem with alcohol she can no longer stay at her mums. SA also has two younger children aged around 4 and 2 who were taken in to care due to SA's substance misuse and domestic violence with her ex partner. This had a serious impact on SA, and at the time she was not offered any form of counselling or support to try come to terms with what had happened. This in turn led to an increase in SA's alcohol use. She had previously been raped, assaulted and held against her will whilst sex working

SA's main aim was to get in to detox and rehab. She has previously had three rehabs, managing 9 months, 6 months and 3 months. Due to her drinking increasing to around one and a half litres of vodka a day and her health deteriorating quite rapidly over a short period of time SA was pinning all her hopes on this, as she used to say on a daily basis to me "I don't want to die". Leading up to her assessment for a detox, the police liaison officer, Carr Beck and I supported SA on a daily basis to ensure she picked her script up from the local pharmacist, attended all her Forward Leeds appointments, as this was part of the agreement to plan for her detox. As well as supporting her around her motivation for trying to keep on track, especially for her children. During the assessment SA became frustrated and disheartened when told there was a three week waiting list, and that's if she was accepted for the detox. Because of this and the assessment questions that followed, SA became agitated and seemed to of given up hope. She became frustrated that the worker didn't understand her, and her needs. I explained how SA was really motivated, and had attended all her appointments, and that she was struggling to reduce her alcohol intake, as this was making her sick. She couldn't attend any group sessions prior to the detox, as she had started suffering from panic attacks. She was willing to work with her key worker at Forward Leeds on a 1-1 basis, and then attend group sessions during and after detox. At SA's next Forward Leeds appointment SA was told St Anne's had refused her detox at present due to her lack of motivation, and that she would have to attend AA meetings (group sessions), work more with Forward Leeds and reduce her daily alcohol intake, they would then reconsider her for detox.

From this point on SA became very low, her mental health deteriorated causing memory loss, and panic attacks became more frequent. She was sick on a daily basis, sometimes three or four times. She had damaged the nerves in her foot, due to falling asleep whilst

intoxicated knelt down, this caused problems with her ability to walk, which led to falls. Her skin started to become more discoloured and her face and stomach started to swell.

A care planning and a multi-agency meeting were held to look at ways of helping SA and especially around her physical and mental health. The issues around this were actually getting SA to appointments. She did not sleep during the night so then struggled to get up to attend GP appointments, which could only be booked on the day at 8.30am. Forward Leeds appointment were at Kirkgate, which again was a problem, as it could take over an hour to get SA up, ready and in to a car to then get her there and back could take up to another two hours. Carr Beck didn't always have the staff capacity or transport to do this. Then there was ensuring there was someone available on a daily basis to take her for her methadone, as by this time she was not capable of going alone. Without all this support SA would definitely not of been capable of attending any appointments, meetings or looking after her many complex health needs.

A few weeks later SA became so ill that she admitted herself to hospital, where she spent three weeks. During this time she managed to detox for her alcohol, had physio on her foot to help improve her balance and walking, and her skin colour and swelling improved. She was told that she could never drink alcohol ever again as the damage to her liver was so bad, and that if she did she would likely die. She was discharged from hospital to Carr Beck, whilst Forward Leeds were looking in to rehab for her and alternative accommodation. SA's mum, Carr Beck and I stated we didn't want SA to return to Carr Beck as a wet hostel is not ideal for a recovering alcoholic, but when asked, Sarah said she would return to Carr Beck as she thought she would be able to get a flat quicker from there.

Since returning to Carr Beck SA relapsed. Her violent ex partner re-appeared and she started using heroin, and was drinking vodka in large quantities again, one and a half litres a day. In order to fund this SA started sex working again. As she was so intoxicated constantly she was putting not only her health at risk, but also her personal safety, on a daily basis. She didn't understand the implications around this concerning her safety, and was often found wandering around dressed inappropriately in just her dressing gown, with no underwear. We spoke at length about the risks involved whilst she was sex working, such as violent or sexual attacks, and the type of men that she would likely attract, due to her inability to assess situations or the ability to defend herself. SA said she had to keep sex working in order to pay for her alcohol, otherwise she would die. She was picked up by the police on occasions, not realising where she was, what day, or time it was. SA was allocated a new key worker from Forward Leeds who was based in a GP surgery nearer to Carr Beck, in order to try making it easier to engage with SA. She was also offered her own accommodation from Housing Options, but at this point SA was in no position to be able to live independently. SA realised she had made a mistake at this point by coming back to the hostel and started staying away from there more often. She complained of feeling isolated and lonely and we talked about trying to engage her in other services so she could socialise and occupy her mind. Around this time SA was starting to disengage further from workers, was drinking even more and was even more difficult to work with. She was constantly getting arrested for breach of the peace, drunk and disorderly, and Carr Beck discussed serving notice on her tenancy. She had been assaulted, fallen over and had cuts and bruising and a chesty cough. Her foot was getting worse as she had missed the hospital appointment for it and had stopped caring even more about her health. She was missing appointments with her alcohol worker, and there were concerns over carrying on with her script due to risk of overdosing.

After discussions at a care planning meeting it was decided that I would make a referral to Adult Social Care as I was so concerned about SA's health, along with her safety, especially whilst she was out sex working. She was also neglecting herself and her memory was getting worse, making this more difficult to work with her.

Two months after SA's first hospital stay she was admitted again by ambulance as she was complaining of stomach pain and had cuts and bruising all over from constantly falling over. During this stay of just over two weeks SA again completed a detox. After 4 days I asked where SA would be discharged to, as the staff nurse said she thought it would be in the next couple of days. I stated that I didn't want her going back to Carr Beck like last time, otherwise she would relapse again and be back in hospital within a few weeks and pointed out the cost and time implications to the NHS and other services. A hospital social worker was allocated and worked closely with SA to assess her needs and what she would like to happen. At this time she was offered a place in Kirkstall Court, which is a brain injury residential unit catering for people with alcohol related, as well as people suffering from dementia and physical disabilities.

After five weeks SA relapsed again and left Kirkstall Court. Her ex-partner had once again managed to get in touch with her, she complained that Kirkstall Court wasn't right for her as she had no one to speak with apart from the staff and felt isolated and lonely again. This left SA homeless again at short notice. I liaised with ASC and temporary provisions were put in place to try ensuring SA had somewhere to sleep and was safe. Further multi agency plans were arranged to look at steps moving forward. At this point SA stopped engaging altogether. She was sleeping rough as she didn't feel safe going to the Crypt as it was mixed occupants. She was now off script, and although appointments had been made for her to attend Forward Leeds it was impossible to find SA to take her there as she had no fixed abode or no phone to contact her on. Her behaviour become even more chaotic, her drinking increased, which meant she had to sex work more in order to fund this, and she was arrested numerous times as members of the public and business owners were ringing the police to report her passed out on the street. ASC needed to assess SA's capacity, but again this was hard to do as she had no fixed abode and was constantly intoxicated.

Within two weeks of leaving Kirkstall Court SA was admitted once again to St James after having a seizure and a chest infection. Again she was given Librium and antibiotics for her chest infection. Whilst she was in hospital I arranged with ASC for them to come and do an assessment on her. They did and she was found to have capacity. At this point SA was asked what she would like now to look at moving forward. She wanted to go to rehab, but until that could happen she wanted to go somewhere like Carr Beck where she could continue drinking, rather than somewhere where she couldn't, and then risk getting evicted again. The following day SA discharged herself from hospital as she wasn't happy with the doctors as they just wanted to treat her chest infection.

Another professionals meeting was held and it was arranged that SA would be offered a place at Oakdale House, which she accepted. We looked at registering her at a nearby GP and I contacted Forward Leeds to invite them to the next meeting to look at rehab possibilities. At this point SA had no key worker there and I was told they would speak to a manger about this. SA was having problems settling at Oakdale and her drinking was increasing and she wasn't engaging with workers there. Five days after moving in SA was evicted due to anti social behaviour.

A referral was made to WYFI to offer SA more support, and a worker was assigned to work with her in a couple of week's time. Again provisions were made to ensure SA had a bed available at the Crypt as a temporary measure, but she never went. I made appointments at

Forward Leeds and registered SA at York Street. SA had managed to reduce her alcohol intake but had started using heroin, and started sex working again, putting her in an extremely vulnerable position.

SA and her mum were invited along to a professionals meeting the following day so that they could have an input in to SA's care plan. She was offered a place at Bracken Court, again as a temporary measure until something more suitable for her could be offered. I had booked a GP appointment the following morning but when I went to collect SA she had been assaulted the previous night at the hostel by two females and a male. She refused to report it when the police were called as well as refusing to go with the ambulance. SA didn't feel well enough to go with me to her GP appointment and just wanted to have a drink and sleep, against my advice. A few days later SA started engaging again and appointments were made with a GP, followed with an assessment with their alcohol worker, as York Street had offered to work closely with SA to try and provide all her care under one roof, to make it easier for her. As we work closely with staff at York Street and particularly with one of the GP's there, they had also offered to come out and do a visit at the hostel as I was so concerned about her health issues. SA started missing appointments that I had made for her, as she had started staying away from Bracken Court as she felt vulnerable there, and had stopped engaging with her key worker there, so again it was difficult to know where to find her to take to her to any appointments. Her memory was also getting worse, and she would not remember what day of the week it was or when you had arranged to pick her up.

Her health started deteriorating again and she had swelling in her calves, but refused to let me take her to A&E or the GP's. She went herself a couple of days later to A&E, but walked out after several hours.

Bracken Court were finding it difficult to cope with SA and were concerned for other residents and staff members around the risk of Hepatitis C, as SA was having accidents in the communal bathroom. They also didn't think this was the right place for her as he needed supported living, but agreed she could stay until further housing was sorted. She was threatened again by one of the residents, and refused to go back and started staying on the sofa at a vulnerable males house who she had just met.

Her worker at WYFI had made referrals for supported housing, and was now on waiting lists. SA was engaging well again with her and started attending appointments, in the hope she would get in to rehab.

Another professionals meeting was held. Her social worker had managed to do another assessment on her to see if she had capacity, and it was stated that she had capacity. Myself and her WYFI worker disagreed with this, especially as she is intoxicated the majority of the time, her memory is not what it should be and there is self neglect. It was decided to take SA out of Bracken Court and placed in an ASC bedsit until rehab was in place, or a property with supported living became available.

SA stared feeling more settled, hopeful and was making good progress. Her ex partner again managed to find where she was and started visiting the flat, along with another male. SA was reported on two separate occasions for anti social behaviour, due to noise, and for her own safety and that of the landlord, was evicted again. A bed has been made available again in the Crypt, but she will not stay there, so is sofa surfing or sleeping rough. This has had an impact on her progress and she feels let down again by services.

We have just arranged for an assessment to be done on SA by our new Housing First worker. This is a new model in Leeds where a different approach is taken in the support plan of some of the most chaotic women. Housing is provided first, and then once the chaos

of homelessness is eliminated from a person's life, clinical and social stabilisation can hopefully occur faster. SA has also just had her rehab assessment and is hoping for a date in 6-8 weeks, so hopefully her future can be more stable.