DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. The summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

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Drug Use in Street Sex worKers (DUSSK) study: results of a mixed methods feasibility study of a complex intervention to reduce illicit drug use in drug dependent female sex workers.

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Study of combined trauma and substance use intervention confirms high level of unmet need among female street-based sex workers, but encounters major difficulties recruiting and retaining participants.

SUMMARY Most female street-based sex workers in the UK are dependent on heroin and/or crack cocaine (1 2 3), and sell sex to fund their drug use – keeping them entrenched in what has been described as a 'work–score–use' cycle (1 2). Previous substance use interventions for this population have used educational (1 2), psychological, and substitute prescribing approaches, but none have robustly demonstrated a positive effect in reducing drug use.

In collaboration with street-based sex workers and service providers, and informed by existing research (1 2), the featured study tested the feasibility of a novel intervention designed to simultaneously address the unique and complex combination of drug use and post-traumatic stress disorder (PTSD) in female drug-dependent street-based sex workers.

The featured paper reports the results of the Drug Use in Street Sex worKers (DUSSK) feasibility study, which aimed to (1) evaluate the recruitment and retention of street-based sex workers to the intervention; (2) examine the experience and acceptability of the intervention for participants and service providers; and (3) explore costs to service providers associated with the intervention.

The intervention proposed an integrated care pathway for street-based sex workers, with participants supported to access treatment for their trauma in parallel with drug treatment. All elements of the intervention were delivered by female staff through a collaboration between three service providers: National Health Service (NHS) trauma services; a street-based sex worker charity; and a drug treatment charity.

Key points
From summary and commentary

Female street-based sex workers who used heroin and/or crack cocaine at least once a week in the past month were invited to participate in a women-only, combined trauma and substance use intervention.

The Drug Use in Street Sex worKers (DUSSK) feasibility study found that it was an acceptable approach for reducing the drug use of street-based sex workers, but would not be an easy intervention to implement more widely.

The severity of trauma disclosed by street-based sex workers proved very challenging for service providers, and furthermore, the intervention costs were driven up by poor participant attendance.

The intervention was delivered in the following order:

1. **Getting started.** Participants were invited to attend a weekly drug treatment group to reduce fear and anxiety about engaging in a group setting and get used to the format and level of disclosure expected.
2. **Preparation for recovery.** Participants then progressed to another drug treatment group, the aim of which was to enable participants to achieve a level of life/drug use stability, such as demonstrating engagement and functioning in the group, positive interaction with group facilitators, and regular receipt of opioid substitution therapy. This group focused on barriers to change, the pros and cons of drug use, and exploring triggers for using drugs.
3. **Stabilisation.** When group facilitators judged participants to have reached a level of drug use stability *and* participants had attended three sessions consecutively, they were offered screening for PTSD symptoms by a female clinical psychologist. Those experiencing PTSD symptoms were invited to attend five PTSD group sessions, facilitated by the same clinical psychologist.
4. **Therapy.** Once all stabilisation group sessions had been completed, the clinical psychologist assessed participants' readiness for one-to-one eye movement desensitisation and reprocessing (EMDR) therapy, which the American Psychological Association describes as "a structured therapy that encourages the patient to briefly focus on the trauma memory while a therapist directs your eye movements, which is associated with a reduction in the vividness and emotion associated with the trauma memories". If eligible, participants were able to begin a course of 12 sessions with the clinical psychologist delivered on a weekly or fortnightly basis.

Participants were recruited through flyers, posters, and drop-in sessions at the charity for street-based sex workers. Of 125 contacts made with women:
• 41 women were screened for the eligibility to take part in the study, and among these 11 were eligible and consented to participate and three were eligible but unable to give consent (two were too distressed and one had health issues preventing participation).
• 84 women declined screening, for example because they were too busy (13 women), not interested (11 women), or they were not currently engaged in street-based sex working (10 women).

A total of six participants were interviewed and four received all components of the intervention, providing a small sample on which to evaluate the experience and acceptability of the intervention from the perspective of participants. Attendance at drug treatment groups varied throughout the study, with participants sometimes arriving late or leaving early. The five most frequent attenders were invited to PTSD screening of which four attended and all were found to have symptoms of PTSD.

Ten interviews were conducted with representatives from the drug treatment service (four participants), the trauma service (two participants), and street-based sex worker charity (four participants).

Main findings

Barriers and facilitators to attendance

The unsettled nature of participants' lives – underpinned by drug use problems, poor adherence to opioid substitution therapy, sex work, tiredness, and poor mental health – was perceived to be a significant barrier to attendance. Arguments between participants, a lack of readiness to confront issues with drugs and trauma, and an absence of social support were also described as making attendance difficult, while delays in being referred for screening and trauma treatment specifically had a negative impact on participants' motivation to attend.

> *"My mental problems, my drug use, everything, just my life, it gets in the way [of attendance]." (Service user)*

> *"They're so low resourced, they just don't have the distress tolerance to be able to cope with any more distress, they're already facing so much. Even things like their housing and threats of eviction." (Service provider)*

> *"My home life was getting a bit chaotic. My depression was getting really bad as well. So, yeah, and I was waiting for my antidepressants to work but they took a while. Yeah, it was just my depression, that's all. My anxiety." (Service user)*

> *"If I've been working the night before there's no way I could have attended because I'm too tired, because you work all night." (Service user)*

> *"It took a little bit of a while and also for them to access their stabilisation groups then their one to ones. I think we may have lost some of the interest." (Service provider)*

Service providers across all partner agencies sent reminders to participants, which were appreciated and described as helpful by participants. The sex worker charity played a vital role in encouraging attendance through reminding participants to attend, arranging transport (taxi, bus or driving participants to sessions) and helping participants prepare for the intervention. Provision of sandwich lunches before the groups was seen by service providers and participants as helpful for encouraging attendance, facilitating a relaxed start to groups, and supporting concentration. Vouchers in the amount of £10 per session were also viewed as encouraging attendance by participants and service providers.

> *"So just keeping that contact going if they were coming in, in our drop-in service I would see them and then sort of give them reminders, did they want little welfare calls, that type of thing." (Service provider)*

> *"I was turning up and I was like sort of god like hanging out for (…) that lunch. It was like, not the reason I was turning up but the main reason why I could (…). There is light at the end of the tunnel, you know you're gonna be nourished and fed.' You're gonna be able to concentrate as well." (Service user)*

Comments from service providers indicated that the inclusion criteria could be widened to make the intervention available to more women:

> *"I think from a clinical point of view if you remove that criteria (sex work at least once a week in the last calendar month) and then of course there's more chance of getting people through to the finish line to be able to be ready for treatment at the end." (Service provider)*

> *"Actively drug using? Yes, that makes sense (…). If they've been able to bring that down themselves maybe another service would be better. Like, what this offered, it's specialistic in this. So if you was able to manage to a level yourself, maybe you don't need [the intervention]… I'm not sure, I think that would be an interesting conversation because if they could bring it down themselves, they'd probably be a lot more stable and a lot more reliable to actually get to the EMDR." (Service provider)*

> *"So I think if you were to extend the period of time and say 'Oh actually do you know if you've used within the last three months you can participate in the study and then someone who's three months abstinent or reducing from their street heroin use or their crack use is then exposed to somebody who's going no no no man I'm using up like a party every night'. There'd be that ethical thing within it but it would be nice to see the study opened up to a wider cohort." (Service provider)*

Acceptability of the intervention

All service users perceived the intervention to be valuable, representing an opportunity to bring about positive change in their lives, including gaining some stability, and an opportunity to combine treatment or therapy for their mental health *and* substance use problems.

Service users described generally positive intervention experiences. They described forming meaningful relationships with the drug group facilitators and clinical psychologist. They liked that the groups were female and sex worker only, they knew other participants already and could speak openly about, and relate to, one another's experience of trauma, drug use and street sex work. Participants also valued that the intervention was delivered at the premises of the sex worker charity, which was liked for its familiarity, safety, comfort, convenience and freedom from judgement and shame. The day of the week, time and frequency of sessions, drug group session length and group size were also acceptable to most participants and service providers. These factors overcame some of the barriers participants highlighted to attending mainstream drug services.

Service providers viewed the intervention as a novel opportunity for street-based sex workers to receive mental health treatment while continuing to use drugs, and to address the barriers to mainstream drug treatment. The group facilitators described enjoying delivering the groups and building good relationships with participants. However, they described some drug sessions as intense and difficult to manage due to participants' distress, accounts of trauma, and chaotic behaviour. The need for appropriate support and supervision of facilitators was highlighted as a requirement to manage these challenges. Service providers also proposed extending the stabilisation work to develop the effectiveness of the trauma treatment and recommended the intervention offer alternatives to EMDR to suit individual participants' needs.

Service providers said working in partnership with other specialist services to deliver the intervention was valuable, and there was mutual respect and good communication between staff. It was suggested it would have been useful to have collaborative, regular case-review meetings between the services to assess the progress and needs of the participants and enhance the communication channels.

Strengths of the intervention

The intervention helped participants to reflect on their need to address their trauma and drug use. Some acknowledged that they were not ready to address their trauma but aspired to this in future, having had positive experiences of therapy during the intervention. Participants attributed improved wellbeing, coping strategies and perceptions of self-worth to the intervention. One participant was seen less on the street-based sex worker outreach van (an indicator of sex working) and significantly, stopped using her working name, signifying 'taking back ownership of who she is'.

One group facilitator felt that the flexibility of the intervention was able to accommodate participants' unstable lives and levels of trauma, which would have prevented them from complying with the rules of conduct in mainstream drug services and thus prevented them from receiving treatment to address their needs. Another positive feature of the intervention was that participants felt able to discuss their sex work due to the membership of the groups (all were female and street-based sex workers).

Cost

The total cost of the intervention was £11,710. The most expensive component was the 'getting started' sessions, which totalled £6,842. The stabilisation groups had the highest cost per session (£203), but had the second to lowest cost across the intervention (£1,014). Although the one-to-one sessions had the lowest cost per session held (£103), the larger number of sessions at this point resulted in this section having the highest cost per eligible participant (£724). Trauma screening had the lowest cost per eligible participant (£191).

The authors' conclusions

The Drug Use in Street Sex worKers (DUSSK) study sought to explore the feasibility of delivering a novel, complex intervention to a population with high levels of unmet need. Three service providers worked together effectively despite setbacks such as changing contracts and service pressures, and those receiving the intervention deemed it to be an acceptable approach for reducing drug use. However, it would not be an easy intervention to implement more widely.

The severity of trauma disclosed by street-based sex workers proved very challenging for service providers. Furthermore, intervention costs were driven up by poor participant attendance, although staff pressures and the re-tendering process did also increase the length (and cost) of the intervention period. Staff suggested that delivery could be improved by providing further support to staff for managing trauma disclosure, extending stabilisation sessions, and closer working.

FINDINGS COMMENTARY Female street-based sex workers tend to have a high level of need and poor drug treatment outcomes. Speaking to the need for a service of the kind evaluated in the featured study, a qualitative study with 24 women in Bristol (UK) found that feeling unable to discuss their sex work in drug treatment groups was one of the factors that undermined their engagement in the treatment process. Women outlined how disclosure of sex work resulted in stigma from male and female service users as well as adverse interactions with male service users. Choosing *not* to disclose wasn't desirable either, as non-disclosure meant they could not discuss the full context of their lives, including unresolved trauma, which emerged or increased when they reduced their drug use.

However, even in the context of an intervention specifically for female street-based sex workers, the featured study showed that there are many situational, environmental and relational factors that can work against this population of women becoming and staying engaged with treatment for their substance use problems. Some of these factors were the very problems that the featured intervention sought to respond to, for example drug use problems and poor adherence to opioid substitution therapy. Others were factors that services would need to address to avoid losing participants, such as delays referring women for screening and trauma treatment. Additional factors may reflect the novel and unfamiliar aspects of the intervention among this population, for example a lack of readiness to confront issues with drugs and trauma, and arguments between participants.

The intervention was delivered in collaboration between National Health Service (NHS) trauma services, a street-based sex worker charity, and a drug treatment charity, which collectively provided the necessary expertise to deliver an integrated care pathway for street-based sex workers. Among drug treatment staff, there was evidence to suggest a training, knowledge or experience gap, which left some overwhelmed at the level of trauma that was disclosed and the level of distress that was displayed in the group sessions.

There was a perception among both staff and service users that the unsettled nature of participants' lives prevented them from fully engaging. In contrast, when 14 practitioners from a range of clinical disciplines and service delivery models in England were asked about how they respond to the needs of women with substance use problems, histories of abuse, and symptoms of post-traumatic stress disorder, some resisted the suggestion that non-attendance or compliance with treatment reflected a woman's lack of readiness for change or commitment. Instead the problem was redefined by practitioners around *services* not being set up to address the challenges women face in accessing treatment. Regardless of their professional backgrounds, all practitioners in this other study eschewed the traditional medical model focused on women's deficits and pathology in favour of a strengths-based and relationship-based approach. Several spoke explicitly about the importance of reframing mental health symptoms and substance use as understandable responses to traumatic experiences, and focusing on women's internal resources and resilience to manage the impacts of abuse.

'Trauma-informed' and 'trauma-specific' care

UK substance use treatment guidelines promote 'trauma-informed' practice as core business (see ▸ side panel). This represents an organisational approach,

Principles for trauma-informed care

Adapted from guidelines for UK clinicians providing treatment for

based around five core principles: (1) trauma awareness; (2) safety; (3) trustworthiness; (4) choice and collaboration; and (5) building strengths and skills (free version of paper available). Within the context of substance use treatment, trauma-informed practice provides practitioners with a framework to avoid re-traumatisation, promote physical safety, and use strengths-based interventions (eg, motivational interviewing).

The next level up from this is 'trauma-specific' practice, which is focused on treating trauma and substance use in an integrated manner through therapeutic interventions involving practitioners who have received specialist training in post-traumatic stress disorder and substance use. Experts agree (1 2 3) that the gold standard for delivering such work is the staged treatment model:

1. safety and stabilisation (eg, building therapeutic relationships and education around substance use, interpersonal abuse, post-traumatic stress disorder, coping skills, and physical safety);
2. memory processing (eg, addressing traumatic memories);
3. reconnection and establishing future identity.

people with substance use problems.

• Recognise the high rates of trauma exposure in the population.
• Promote awareness and understanding of trauma among patients and the workforce.
• Recognise trauma symptoms and behaviours as the individual's best attempts to adapt to and manage their experiences.
• Provide a treatment environment that promotes physical and emotional safety.
• Avoid inadvertently re-traumatising clients and patients.
• Prioritise trauma recovery as part of treatment goals.
• Support patients to make choices and take control of treatment decisions.
• Undertake routine screening for trauma experience and reactions.
• Explain the principles of trauma-informed care to patients, for example, by explaining why trauma-related questions are asked during the assessment.

Post-traumatic stress disorder is a type of anxiety disorder that can develop after someone experiences a traumatic situation (ie, something that is harmful or life-threatening). *Complex* post-traumatic stress disorder comes with additional symptoms and can develop among adults or children who have experienced repeated or prolonged traumatic events, such as violence, neglect or abuse. This tends to be more severe if the traumatic events happened early in life, the trauma was caused by a parent or carer, the person experienced the trauma for a long time, the person was alone during the trauma, or there is still contact with the person responsible for the trauma. Until December 2018, guidance on post-traumatic stress disorder promoted a sequential model where substance use disorders were to be addressed first, while clinical guidance now advises against excluding patients with substance use problems.

Substance use problems and post-traumatic stress disorder can overlap in a number of ways and for a number of reasons (1 2), including:
• trauma initiating the development of post-traumatic stress disorder and substance use problems;
• destructive or risky behaviour (such as drinking and drug use) stemming from post-traumatic stress disorder;
• drinking and drug-taking as a way to cope with trauma and symptoms of post-traumatic stress disorder;
• substance use making people vulnerable to, exposing them to, or increasing the likelihood of them experiencing further traumatic events.

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