Sex and wellbeing
Evaluation report

swanswell

Executive summary

Swanswell was asked to design and develop a cost-effective service model that identifies and treats sexual dysfunction. The brief was to do so via screening and simple brief intervention where possible, and provide pathways to psychosexual therapy where needed.

Swanswell's clients were initially felt to be a good testing ground for a model like this, as people with drug and alcohol problems can be prone to associated sex problems (Bang-Ping, J, 2008)[1]. However, it's important to note that one of the main objectives of this project was to develop a model which could be used within the course of other treatments **already** being accessed by clients across **a range of healthcare services**. We developed an escalating pathway of treatment that:

- deals with clients' problem(s) at the earliest possible point in the pathway
- is easily embedded into a range of frontline primary care services (e.g. drug/alcohol services, practice nursing, sexual health/family planning clinics)
- gives people space to talk about previous or continuing trauma, which can be followed up via established safeguarding procedures

The project, commissioned by the Birmingham Sexual Health Joint Commissioning Group (BSHJCG)[2] is made up of four stages:

Stage 1:	Development of prototype screening, assessment, brief intervention and pathway
Stage 2:	Initial pilot to test prototypes within drug and alcohol services in a shared care setting
Stage 3:	Review and adjustment of prototypes following the initial pilot, and subsequent development of the training programme and materials
Stage 4:	Larger-scale pilot within the Birmingham area involving generic workers in primary healthcare teams and Swanswell workers in shared care settings

Stages 1 - 3 are complete. The initial pilot (involving one Swanswell worker and a small sample of 24 existing clients) showed us that the screening method was useful in helping people acknowledge and talk about any problems. It demonstrated that there's a need for services like this and that brief interventions can help.

Of the people screened:

- **54%** had current concerns regarding their sexual wellbeing
- **38%** received a Swanswell brief intervention of some form

Stage 4 is ongoing, involving training of 31 more Swanswell workers and a number of generic workers in primary healthcare (in the Birmingham East and North Primary Care Trust area). Between them, these workers are piloting the service on a larger scale - and we're very much looking forward to seeing the results in September 2011.

This programme is very exciting as a model for screening and early intervention for people with sexual dysfunctions. Integrating this process into front-line services and primary care settings such as doctors' surgeries will provide people with quick and easy access to brief interventions or referral to sex therapy when needed.

Report

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We knew that Swanswell clients would likely be a suitable sample of people to test our screening and intervention model. Sexual dysfunction is common among people with substance misuse problems. We know, for example, that **59 - 84%** of males who are dependent on alcohol also experience sexual dysfunctions of one form or another. The story is similar for regular heroin users, with the **majority** of them reporting low sex drives, and **39 - 48%** of them experiencing erectile dysfunction (Bang-Ping, J, 2008)[1].

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This report summarises stages 1 - 3 of the project, including the small-scale pilot involving one Swanswell worker trained for this purpose and 24 existing clients.

Background on sexual dysfunction

While there are no universally accepted categories for sexual dysfunction, Masters and Johnson (Masters, W.H. and Johnson, V.E., 1970)[3] are widely regarded as being responsible for the development of a modern theory of sex therapy, which has evolved into the general categories listed below.

Category	Dysfunction
For women	
Sexual desire	Impaired sexual desire
Arousal	Impaired sexual arousal
Orgasm	Orgasmic dysfunction (unable to orgasm despite arousal)
Others	• Vaginismus (muscles in the vagina tighten, making penetration impossible, extremely difficult or painful) • Dyspareunia (pain during sex) • Vestibulodynia (chronic unexplained pain in the vulva) • Sexual phobias
For men	
Sexual desire	Impaired sexual desire
Arousal	Erectile dysfunction (unable to have an erection that's firm enough for penetration)
Orgasm	Premature ejaculation (typically within 2 minutes after penetration or before) Retarded ejaculation (unable to ejaculate despite a firm erection and high levels of arousal) Ejaculatory pain
Others	• Dyspareunia • Sexual phobias

This description is by no means comprehensive, and further definitions on recognised sexual disorders can be found in The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, usually known as 'DSM-IV' (*DSM-IV-TR,* 1994)[4].

In general, the causes of sexual problems can be physical (e.g. illness, surgery), psychological, or a combination of both (e.g. anxiety following heart surgery).

Among the physical causes, we know that sex problems are more common in people who have alcohol and/or drug problems (Medlineplus online, 2010)[5] (Bang-Ping, J., 2008)[1] (Bang-Ping, J., 2009)[6], and also in those on substitute medications to treat drug addictions (Hallinan, R., et al, 2008)[7].

In addition, sexual dysfunction can also be caused by prior or continuing trauma, so giving the client space to talk about sexual function provides opportunities to disclose and resolve these issues, via existing safeguarding procedures.

In the UK, the White Paper 'Healthy Lives, Healthy People: Our Strategy for Public Health in England' (Department of Health, 2010)[8] seeks to work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services. Our programme fits in well with these principles.

The model and training – Swanswell's approach

We previously identified that our clients were not being assessed for any sexual dysfunction concerns, despite evidence to show that external factors such as illness, prescribed medication, life stresses, sexual trauma, illicit drugs, alcohol and nicotine may have an impact.

We wanted to develop a service to give people (in a variety of primary care settings) easy and quick access to therapy in a way which doesn't cause them any worry, with the minimum amount of professional intervention.

So we designed and tested a prototype programme for them, consisting of four stages.

- In **stage 1**, working alongside an expert in psychosexual therapy, we did some desk-based research and produced our prototype model of care, and associated documentation
- In **stage 2** we carried out an initial small-scale pilot of our intervention and pathway with selected clients, which gave encouraging results
- In **stage 3** we reviewed and revised our prototypes, and developed training material
- In **stage 4** (the larger-scale roll-out) we trained 31 Swanswell workers in shared care settings so they could take part in a larger pilot.

We based our brief intervention on the **PLISSIT** model (Annon, J., 1976)[9], which enables 'non-sex therapist' health workers to recognise and introduce an escalating series of treatment options for sexual problems. **PLISSIT** stands for:

Permission	We invite the client to think about sex problems and talk openly about them
Limited **I**nformation	Includes reassuring and educating clients on their concerns
Specific **S**uggestions	Implementing strategies to solve the problem – e.g. advice on sexual techniques, couple communication, relaxation, and signposting to appropriate services
Intensive **T**herapy	Psychosexual therapy or other specialist services

Throughout the process, workers need to be aware that the presenting symptoms may indicate underlying conditions which require medical attention. So we trained them to identify these risks and to refer to other professionals, particularly general practitioners (GPs), when appropriate.

The initial pilot – testing the prototype

Having designed the intervention, we trialled the service on a small number of Swanswell clients. We worked with 24 people in total – 21 men and 3 women.

All of them were screened, assessed, and given brief interventions and/or referrals for further treatment where needed.

As usual with our programmes, all data was collected using our HALO database system. This allowed for quantitative data to be recorded and used as a benchmark for future work.

The training

Having trialled the prototype with a small number of clients, we adjusted and developed the training material, which includes the following themes:

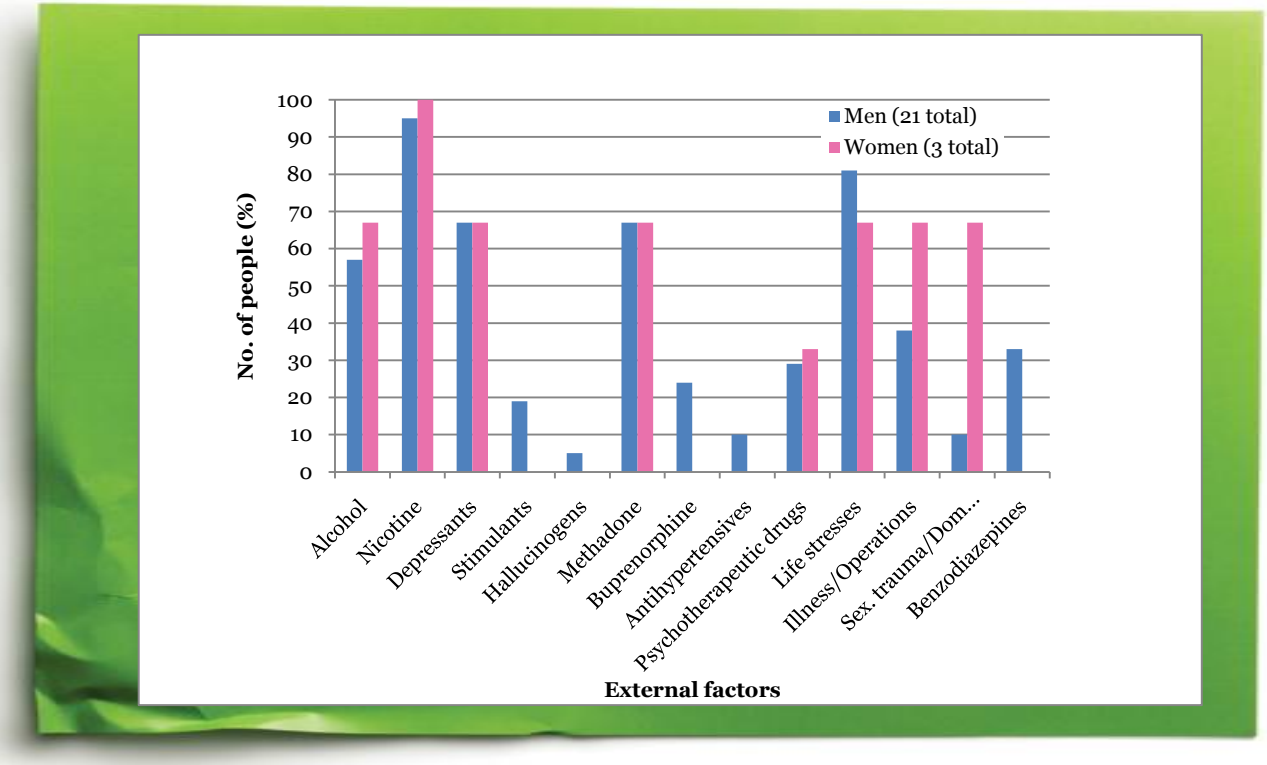
Session	Themes
1	Introduction
2	Talking about sex – taking the embarrassment out of using sex terms and defining sexual dysfunction
3	Safeguarding and sex and wellbeing interventions – ethical issues, e.g. ensuring we don't encourage clients to have good sex with abusive partners
4	Our brief interventions – based on the **PLISSIT** model (see below), and covered in our Sex and Wellbeing guide, which is issued to trainees
5	Intervention in practice – case study role plays
6	Summary and evaluation

All of our trainees were issued with our sex and wellbeing guide, which enables them to deliver brief interventions. As well as screening and assessment tools, and a referral pathway, the guide contains information about different brief interventions. The material also includes clear factsheets covering a number of sex problems (including symptoms, causes, and treatment), which can be discussed with the client.

Results of the small-scale pilot

The screening process was successful in identifying external factors likely to affect sex and wellbeing in both the men and the women. These included alcohol, nicotine, heroin, cannabis, cocaine, stimulants, Methadone, psychotherapeutic drugs, sexual traumas, asthma, and life stresses (see figure 1).

Figure 1: External factors affecting sexual health - screening results for 21 men and 3 women



The screening also helped people to identify current and past concerns, as shown in figures 2 and 3.

Figure 2: 100% of the women identified one or more concerns

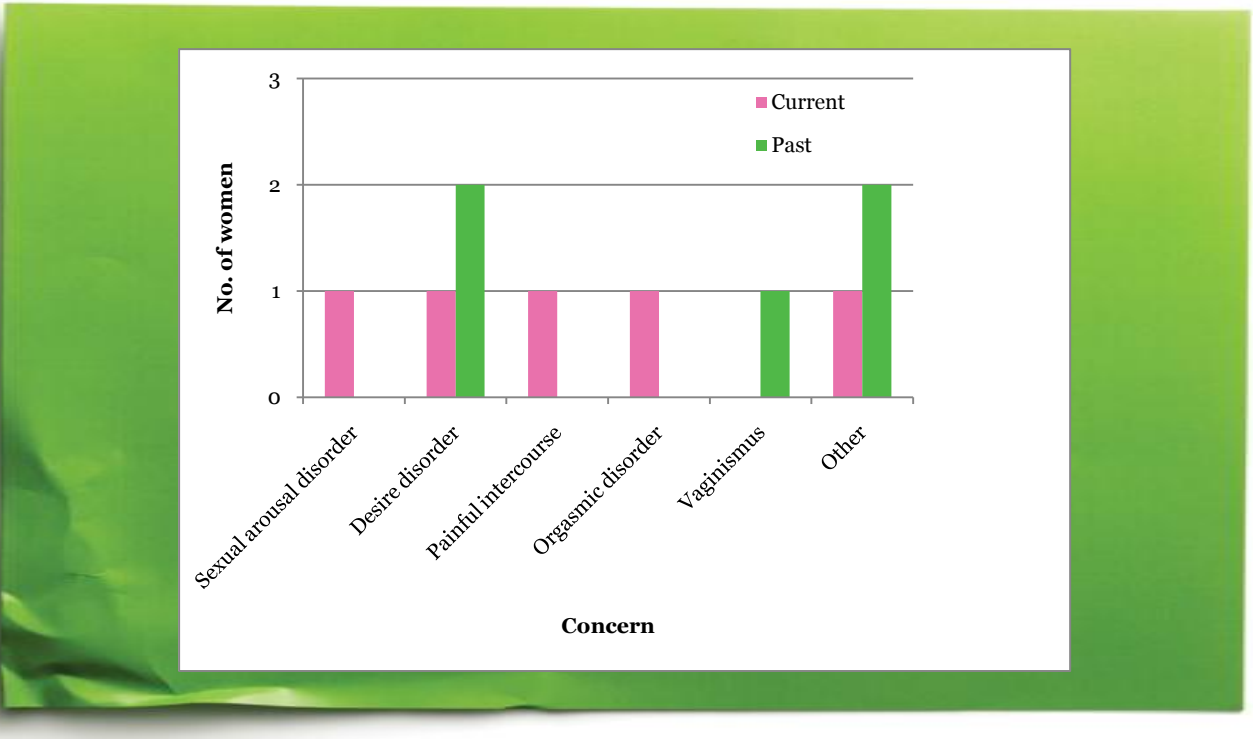
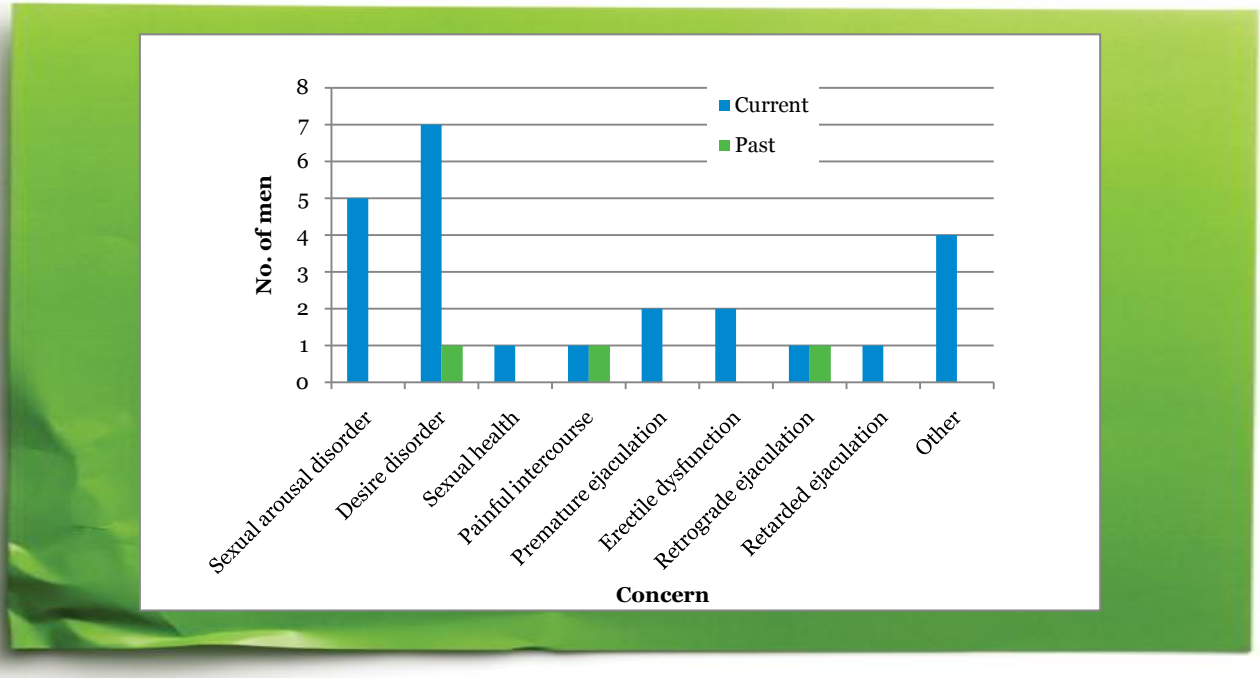


Figure 3: 50% of the men identified one or more concerns



Outcomes

Of the 24 people screened in our small-scale pilot:

- **54%** had current concerns regarding their sexual wellbeing
- **33%** of the women received brief interventions
- **38%** of the men received brief interventions

In the cases where the brief interventions were not appropriate to solve clients' problems, our worker referred them further to other professionals (which is, in itself, a brief intervention).

For the women:

- one was referred to a doctor for physical examinations
- two were recommended for sex trauma counselling
- one was referred on for psychosexual therapy

For the men:

- two were referred to a doctor for physical examinations
- two were recommended for sex trauma counselling
- three were referred on for psychosexual therapy

The three referrals to GPs for physical examinations were acted upon, but only one of the referrals for psychosexual therapy was taken up by a client (a male). All four people referred for counselling to deal with previous sex traumas declined the appointments offered to them.

On the whole, clients' opinions on the screening process were very positive. All of them said that they felt safe and comfortable during all stages of the process:

- *'I was always too embarrassed to speak to anyone about my problems in the past, but my Swanswell worker gave me the space and confidence to talk about them and get them sorted'*
- *'I would never have approached my GP, but this programme made it easier for me to discuss my concerns'*
- *'I did have concerns that past sexual abuse had left lasting damage, but being referred to the GP put my mind at rest'*

Sammy's and Mary's stories came to light as a result of the initial pilot, and are used as case studies within the training sessions for healthcare workers.

Sammy's story

Sammy is a 45-year-old man who injects heroin, smokes crack twice a week and is currently on a prescription for Methadone to stabilise his heroin use. He's being treated for schizophrenia and is taking anti-depressants for anxiety. He has no family living near him.

He says he was abused whilst in a children's home, but never spoke of it to anyone else. He also says he has a lump under his foreskin (which has grown), which he'd seen a female doctor about, but walked out when she made a flippant remark about it. Since then he hadn't seen anyone about the problem.

Sammy has only had one sexual relationship. He wore a condom which hid the lump and nothing was mentioned. He's not had any relationships since then because of embarrassment and the pain.

He says he has a low sex drive since using heroin and is unable to ejaculate. In the past, while withdrawing from drugs, he says he could achieve an erection and ejaculate when masturbating.

As a result of Swanswell's programme, Sammy was given access to sex trauma counselling (which, so far, he has declined). The police were informed of the alleged abuse in his past and the investigation is ongoing.

He was also encouraged to see a doctor again (this time a male one), who diagnosed the lump on his penis as an easily-removable varicose vein. Sammy has been offered an operation for this, but has so far declined. While Sammy is still not in a relationship yet, he feels much better about the lump, and says the diagnosis has 'put his mind at rest'.

Sammy's issues are complex; he continues to see a Swanswell worker, who manages his care plan. He can revisit any of these issues with his worker when he's ready.

Mary's story

Mary is 22 and a mother to a toddler and a baby. She's been with her partner, who she met whilst using heroin, for five years. She's now off heroin and receiving aftercare, while her partner is on a prescription for Methadone to stabilise his heroin use. She sometimes smokes cannabis.

While growing up, Mary's home life was very unstable. Her parents regularly used drugs and both of them had mental health problems. At the age of seven, she was abused by her brothers and uncle. She experienced domestic violence and at age 14 was thrown out of her house and subsequently raped. Before speaking to our Swanswell worker, she hadn't had any counselling for this.

Her relationship with her partner is volatile. He has anger issues and regularly verbally abuses her and pushes her about.

Mary has very low self-esteem, mostly relating to her body image. She doesn't like her partner watching porn as she compares herself to the women in the films. During sex she feels very low and says her mind is elsewhere. She complains of pelvic pain afterwards and says she doesn't orgasm (although she pretends to). Her partner complains about Mary's low sex drive.

She says that in the past, when using illicit drugs she had no interest in sex. It was drug-induced and she switched off and just '*went through the motions*', even though it was painful due to tightening of her vaginal muscles.

Again, Mary's case is complex and brings up the need for support on a number of levels. Of paramount importance was the need to address the domestic violence and abuse issues, and this was included in her care plan.

As part of Swanswell's intervention, Mary was able to open up and discuss these problems. She was referred for psychosexual therapy and counselling for sex trauma and domestic violence (although she did not take this up). Her care plan also included steps to raise her self-esteem, which has helped her to deal with her body image issues.

Mary successfully completed her drug treatment.

The way forward

We achieved our objective of designing and developing a service model that identifies and treats sexual dysfunction through screening and simple brief intervention, where possible, and provides pathways to psychosexual therapy if it's needed.

The results of the mini-pilot suggest that a need exists for this type of intervention amongst our clients and that brief interventions can be delivered easily and cost-effectively within a background of other treatment currently being accessed.

Sammy and Mary's stories illustrate the complexities of individual cases. They reinforce the need for a model such as this which allows people space to discuss problems in their own time, in familiar surroundings and address them via an internal or external treatment pathway covered by appropriate safeguarding processes.

While time will tell whether the brief interventions have resulted in improved sexual functioning for those who received them, feedback so far has shown that a significant number of clients have welcomed the opportunity to discuss and address their problems in familiar surroundings.

Importantly, the output and outcomes from the mini-pilot prototype have informed revision of the training and documentation for the workers involved in the larger-scale pilot. This larger pilot will give us access to a much larger data sample, and strengthen the validity of the statistics.

In view of the low uptake of further referrals for sex trauma counselling, we'll be looking carefully at the larger-scale pilot to see if those results are mirrored in greater numbers. If this is the case we may, in future, consider whether there's a need to adapt our brief interventions to include treatment on sex trauma too.

This programme is very exciting as a model for screening and early intervention to promote sexual wellbeing. We look forward to integrating this process into front-line services and primary care settings such as doctors' surgeries and family planning clinics to provide people with quick and easy access to brief interventions and, if necessary, sex therapy.

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