Report of a Survey of Sexual Health Advisers

Undertaken on behalf of the RCP/BASHH
Working Party on Alcohol and Sexual Health of Young People

Introduction

The working party members asked the authors to contact the Society of Sexual Health Advisers (SSHA) membership to establish whether initiatives about taking an alcohol history as part of a holistic sexual and lifestyle history were being undertaken by Sexual Health Advisers (SHA). This paper will report on the findings of this survey.

Method

A letter was emailed (appendix Doc 09.04) to all SHAs whose email address was obtained by one of the authors. SHAs were asked to answer 6 questions relating to:

1. Alcohol use assessment
2. Referral of patients/clients who have harmful, hazardous or dependent alcohol use
3. Undertaking brief interventions as a form of risk reduction
4. Training received
5. The SHAs views about transferable skills to extend their role
6. Whether the SHAs think this a role they wish to be involved with

SHAs were asked to email their responses to one of the authors by the 22nd May 2009. Document 09.04 was emailed to 53 SHAs. Analysis was undertaken using a calculator.

Results

Responses were received from 16 SHAs a 30% (16/53) response rate, one response was discarded because the questions were not answered.

Question 1 - Do you formally assess alcohol consumption as a part of your routine clinical practice?

13/15 (86.6%) said yes, 2/15 (13.4%) no. The following comments were made

- For young people under 18 yes, for others, it's dependent on our discussion about their risk taking.
- All young people under 18 are asked about their alcohol, drugs and cigarette use when using a young person's proforma. (These can vary from service to service) Specific quantities and frequency of alcohol are asked about. With older patients alcohol consumption is only asked about if it seems to play a part in assault or risky sexual behaviour

Question 2 - If yes, where do you refer patients/clients who have hazardous, harmful, or dependent alcohol use?

13/15 (86.6%) referred patients to local alcohol services directly, 2/15 (13.4%) referred to the patient/clients general Practitioner for onward referral. The following comments were made

- If an >16 yr old discussed with patient and further advice sought from Trust child protection officer/team
- If they were MSM and alcohol was affecting their sexual health we would refer to one of the gay men's project/GMFA's programmes.

Question 3 – Do you perform brief interventions as a form of risk reduction strategy with clients?
6/15 (40%) said yes they did perform brief risk reduction interventions; 7/15 (46.6%) said no they did not perform brief interventions, 1/15 (6.6%) sometimes and 1/15 (6.6%) was not applicable because they did not assess alcohol use as part of their routine clinical practice.
A selection of the comments made by respondents:

- Yes if alcohol use is contributing to sexual risk taking
- Sometimes, but more often not.
- If having an affect on risk behaviour/ risk management we would include alcohol intervention as part of this but we would not carry out any specific alcohol work

Question 4 – If the answer to question 3 is yes could you tell me the types of training you have received and where you have received your training.

- Motivational interviewing – several respondents
- Trained as a nurse in mental health and have worked in substance misuse
- Ongoing team supervision by the clinical psychologist
- On the job training!

Question 5 – Do you think Sexual Health Advisers have transferable skills to extend their role in this direction?
14/15 (93.3%) said yes, 1/15 (6.6%) no, the following comments were made.

- Yes if competent at using MI, or other model of behaviour change shown to be effective with reducing alcohol use but may require additional training
- Yes because there is often a link between sexual risk taking and alcohol
- Especially with motivational interview training
- Worried about time to undertake another aspect to the role
- Yes if it is within the context of risk management, although a more specialised alcohol specific training would be useful, in particular if we were going to be doing more addiction work (although skills are transferable there would need to be training and guidance on doing this work)

Question 6 – Is this something that Health Advisers want to be involved in?
13/15 (86.6%) said yes, 1/15 (6.6%) no, 1/15 (6.6%) was not sure whether she/he wished to be involved. The respondents made the following comments.

- I would say yes but speaking to one of the other health advisers I agree that I think it would depend on the level. If in a sexual health context then yes, it would seem strange not to include it in sexual health work, particularly with young people. However if it was more specific alcohol addiction intervention work, then it may not be feasible due to due to interest and/or staff capacity
- Absolutely with appropriate training and support
- Want to be maybe need to be
- Everyone who is involved in the patients care in a sexual health setting should be able to offer brief interventions
- SHA's may need to address alcohol use in the context of sexual risk reduction so need to have appropriate competencies. Do not think role should be extended to include alcohol counselling while there is so much pressure on HA time for core aspects of our role and specialist alcohol services are available.
- It's something I would be interested in training for.

Discussion and recommendations:
Overall the majority (86.6%) of respondents undertook an alcohol assessment as part of their routine clinical practice and referred to local alcohol services where there was harmful, hazardous or dependent alcohol use was identified which is a positive outcome in relation to the work of the working party. A minority (40%) performed brief interventions to reduce alcohol consumption but 93.3% thought SHA's had transferable skills which would enable them to undertake this work. And 86.6% thought they wished to be involved with this work in the future providing that the patient/clients alcohol use was associated with taking sexual risk.

The limitations of this survey are

1. It did not include all sexual health advisers working in the UK with young people; apparently the SSHA does not have a complete email list for all clinics.
2. In some clinics other practitioners undertake the sexual health adviser role and this survey did not include them.
3. There was a 30% response rate and therefore insufficient numbers to gain anything other than a snap shot of views.
4. Three people responded on behalf of their team.

Recommendation – If the working party seeks to establish whether taking an alcohol history is part of routine clinical practice in sexual health clinics in the UK then the authors recommend that a survey of clinics is undertaken including community settings providing STI screening and Chlamydia screening programmes.

1st June 2009, Authors Richard Betournay and Linda J Tucker