

The Manual for Sexual Health Advisers

Society of Sexual Health Advisers (SSHA)
www.ssha.info

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| TABLE OF CONTENTS | PAGE |
|---|------|
| Foreword | 5 |
| Background and acknowledgments | 7 |
| Contributors | 8 |
| Society of Sexual Health Advisers (SSHA) | 10 |
| Introduction | 11 |
| Grading scheme | 14 |
| Section A: Partner Notification | |
| 1. Introduction | 16 |
| 2. Interviews | 23 |
| 3. Provider referrals | 41 |
| 4. HIV | 47 |
| 5. Ethics | 51 |
| 6. Audit | 55 |
| 7. Further research | 61 |
| Section B: Managing Sexual Infections | |
| 8. Sexually transmitted infections | 67 |
| 9. Patient recall | 83 |
| 10. Ethical issues in patient recall | 93 |
| 11. Triage | 96 |
| 12. Ethical issues in triage | 100 |
| Section C: Counselling in Sexual Health Adviser Practice | |
| 13. Counselling | 104 |
| 14. HIV testing and management | 125 |
| 15. Ethical issues in pre and post HIV test discussion | 141 |
| 16. Working with the 'worried well' | 144 |
| 17. Hepatitis C testing and management | 148 |
| 18. Psychosexual counselling | 155 |
| 19. Pregnancy options | 163 |

| | |
|---|-----|
| 20. Rape and sexual assault | 176 |
| Section D: Legal and Professional Framework | |
| 21. History of sexual health advising | 188 |
| 22. Law and the sexual health adviser | 194 |
| 23. Ethical issues in sexual health advising | 208 |
| 24. Code of professional conduct | 221 |
| 25. Leading a team of sexual health advisers | 226 |
| Section E: Community Settings | |
| 26. Community health advising | 245 |
| 27. Outreach work | 251 |
| 28. Ethical issues in outreach work | 264 |
| 29. Working in prisons | 267 |
| Section F: Sexual Health Promotion | |
| 30. Theories and principles | 277 |
| 31. Standards and guidelines | 287 |
| Section G: Working with Specific Groups | |
| 32. Working with African people | 310 |
| 33. Working with young people | 314 |
| 34. Working with gay men | 326 |
| 35. Working with lesbians | 339 |
| 36. Working with interpreters | 343 |
| Tables | |
| 2.1 Motivating the patient | 30 |
| 2.2 Contact slips | 31 |
| 2.3 Required contact data | 36 |
| 3.1 Provider referral methods | 43 |
| 6.1 Standards for good practice in partner notification | 58 |
| 8.1 Major groups of sexually transmitted infections | 68 |
| 8.2 Gonorrhoea - Signs & Symptoms | 69 |

| | |
|--|-----|
| 8.3 Chlamydia - Signs & Symptoms | 70 |
| 8.4 Syphilis - Signs & Symptoms | 72 |
| 8.5 Trichomonas - Signs & Symptoms | 73 |
| 8.6 Partner notification – Look back periods | 80 |
| 9.1 Recall - Recommended actions | 90 |
| 11.1 Triage - Recommended maximum waiting times | 98 |
| 23.1 Respect for autonomy | 212 |
| 23.2 Beneficence/non-maleficence | 213 |
| 23.3 Justice | 216 |
| 23.4 Management of confidentiality | 217 |
| 23.5 Guidelines for managing an ethical dilemma | 219 |
| Appendices | |
| Ch.2 Partner notification – patient leaflet | 39 |
| Ch.9 Patient recall - sample letters | 92 |
| Ch.18 Psychosexual assessment | 162 |
| Ch.19 Integrated care pathway for discussing pregnancy options | 170 |
| Ch.19 Pregnancy testing protocol | 174 |
| Ch.20 Sexual assault sample information sheet for patients | 184 |
| Ch.20 Rape trauma syndrome | 185 |
| Ch.22 Sex laws at a glance | 205 |
| Ch.22 NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Dir. 2000 | 205 |
| Ch.25 Measuring health adviser activity | 241 |
| Ch.25 Health adviser questionnaire/ interview tool | 242 |
| Ch.25 Health adviser annual objectives | 243 |
| Ch.31 Sample condom distribution protocol | 306 |
| Ch.33 Under 16's - example proforma | 322 |
| Ch.33 Under 16's - suggested proforma for health advisers | 324 |

Foreword

PROFESSOR MICHAEL ADLER

Sexual health advisers are central to the control of sexually transmitted infections and HIV. This was recognised by the Sexual Health and HIV Strategy, which identified the need for the development of this group. Those fulfilling the role of Health Advisers come from a range of backgrounds, all of which over the years have added greatly to the richness and diversity of this group. All professions within the health service are increasingly, and rightly, challenged to produce good practice guidelines based on evidence. This manual is both a good practice guideline and a theoretical text for sexual health advisers. The strategy indicated that the Department of Health wished to identify a process of defining roles and responsibilities of health advisers, and the manual goes a long way towards this.

□

The strategy is ambitious and health advisers are central to its successful implementation. One of the fundamental planks of the strategy was to involve primary care in the delivery of good sexual health services. The increasing role of health advisers working within the community and at a primary care level will help to deliver this aim. However, given the increasing breadth of tasks under taken by Health Advisers and the different localities in which they will working, it is more essential than ever that they have a tool which enables them to work in all of these environments using good practice guidelines. The manual does exactly this and is another step in the increasing recognition of the major contribution made by this group of professionals.

Background and acknowledgments

It has been 23 years since the publication of the 'Handbook on Contact Tracing in Sexually Transmitted Diseases'. * A need existed to have a working document that aims to better equip practitioners seeking to respond to the challenges of sexually transmitted infections in the 21st century.

The 'Manual for Sexual Health Advisers' has been written primarily for sexual health advisers working in genitourinary medicine. However it will also have relevance and value to other professionals working in sexual health. This will include practitioners in community settings of primary care as well as managers and commissioners of services.

The Steering group would like to thank the many people who have been actively involved in it being published. Individuals who have contributed to specific material are acknowledged at the end of the relevant chapters.

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The Society of Sexual Health Advisers

Sexual health advisers work in Departments of Genitourinary Medicine (GUM clinics) in the UK and Ireland

The ***Society of Sexual Health Advisers*** (SSHA) is a U.K. national organisation with approximately 300 members out of an estimated 350 sexual health advisers in the country. It provides an opportunity for members to meet and work towards further professional development.

The role of the sexual health adviser varies enormously from clinic to clinic. It involves working with individuals and groups affected by issues related to sexual health in general and sexually transmitted infections (including HIV) in particular. Their role will commonly embrace the following features:

- Partner notification/ contact tracing
- Sexual health promotion
- Teaching / training
- Counselling
- Research and audit

There is as yet no core qualification for health advising. Training courses are run by various educational establishments to better equip them in their role. Sexual health advisers come from a variety of professional backgrounds including nursing, health visiting and social work.

Local groups meet regularly and an annual conference is held each Spring.

A Council of elected officers and regional representatives meets 6 times a year. It sets standards, produces statements and addresses specific issues by setting up working groups.

SSHA is part of the Amicus/MSF union. Members benefit from expert help in raising and resolving problems encountered at the workplace.

<http://www.ssha.info>

Introduction

HEATHER WILSON

This manual has been commissioned by the Department of Health (DH) as part of the implementation of the National strategy for sexual health and HIV. The main references to health advisers in the strategy are:

- The Department will ensure the role of sexual health advisers is developed and numbers increased
- The Department will identify a process of defining roles and responsibilities of health advisers
- Improvements in partner notification within clinics and the community
- The Department will identify a process for developing a health adviser qualification by 2005.¹

If the health adviser role is to develop and we are to become a state registered profession, a basic text that can be used by all health advisers and their colleagues is essential. This text begins the process of defining roles and responsibilities and will contribute to improvements in practice, as national recommendations for best practice are implemented.

The construction of a theoretical practice base requires the construction of a body of knowledge. Health advising is a profession which is multi disciplinary and draws from a melting pot of other disciplines, including nursing, medicine, psychology, counselling and social work. The knowledge and skills needed for health advising have been developed and discussed over the years at conferences and study days. These have been primarily organised by the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD), the professional body for health advisers, now the Society of Sexual Health Advisers (SSHA). We have been fortunate enough to have the resources of the MSF/Amicus trade union to support us.

Contact tracing (partner notification) has been the subject of international research and publication though only a small proportion of this pertains to health adviser activity in the UK. There is a paucity of research or theoretical debate dealing specifically with other aspects of the health adviser role, such as sexual health promotion, counselling and community work. This manual draws upon existing theory and research evidence to offer guidelines for good practice in all aspects of the health adviser's role, including partner notification, counselling and health promotion. It is hoped that these recommendations will be strengthened and refined by future research and audit.

In the two decades since the last publication about health advisers from the DH, the role of the health adviser has developed and expanded. Health advisers came from a tradition of social work and counselling as well as contact tracing, and these skills were required in abundance with the emergence of HIV and AIDS during the 1980's. The large proportion of time was spent on HIV pre test counselling and long term support and counselling of HIV. The Monks Report in 1988 acknowledged the increased burden and recommended that at

least one health adviser be employed per clinic.² In 1993 Hogg and Allen found that an average of 50% of health adviser time was being spent counselling.³ The HIV work attracted recruits to health advising from a counselling background, with 55% of health advisers having a counselling qualification.⁴ This new perspective has enriched the profession, adding new disciplines and theories to the melting pot. Like the almoners in the 1920's, health advisers were devoting a substantial part of their workload to the social, financial and relationship problems of their patients. Hogg and Allen found that this was often to the detriment of contact tracing, health education and outreach work. They argued for a refocusing onto partner notification and prevention initiatives, including outreach work.⁵ The 1990's saw an increase in the bacterial sexually transmitted infections, such as gonorrhoea, syphilis and chlamydia, and, consequently, health advisers increased the proportion of their time spent on partner notification.

Counselling, particularly one off or very short term interventions, and HIV work continue to be an important part of the health adviser role, these are both discussed in depth in this manual. A national survey of health advisers in 2001 found that health advisers viewed counselling skills as the most important.⁶ As Leach demonstrates in his chapter, one-off counselling sessions are of great value to patients^{*} and, while health advisers are too busy to offer long term counselling, the course of their regular work involves very valuable counselling interventions.

Health advisers have also responded to the growing demand for outreach and community work. Most health advisers have input into schools and young people's work⁷ and sex workers projects.⁸ Several community health advisers have been appointed both for research, as in the Wirral and Glasgow, and in community projects, such as the sexual health outreach worker project (SHOW) in Birmingham. Community work methods are also being used in partner notification.^{9 10} This is an exciting and expanding area of health advising and this manual contains recommendations for good practice in both outreach and community work.

The practice of health advising is a potential ethical minefield. The health adviser represents both the public health and the interest of the individual patient and regularly deals with those who have been sexually abused or assaulted and the legal and confidentiality problems that arise. We have placed considerable importance on the ethical considerations of all aspects of our work and these are discussed throughout the manual.

The guidelines and recommendations in this manual are not intended to be set in stone. They are designed to be updated and expanded on as necessary. The theoretical and ethical debates are a starting point for establishing an ongoing discourse of sexual health advising that is unique to this profession.

^{*} The term patient has been used throughout to refer to a recipient of health adviser care within a health care setting. The term client is used to describe those who have been seen elsewhere: for example, during outreach work.

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Grading scheme

A grading scheme and hierarchy of evidence has been used in some of the partner notification chapters of this manual. * The definitions of the types of evidence and the grading of recommendations to be used are set out as follows.

STATEMENTS OF EVIDENCE

- Ia* Evidence obtained from meta-analysis of randomised controlled trials.
- Ib* Evidence obtained from at least one randomised controlled trial.
- IIa* Evidence obtained from at least one well-designed controlled study without randomisation.
- IIb* Evidence obtained from at least one other type of well-designed quasi-experimental study.
- III* Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
- IV* Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

GRADES OF RECOMMENDATIONS

- A Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation. (*Evidence levels Ia, Ib*)
- B Requires the availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation. (*Evidence levels IIa, IIb, III*)
- C Requires evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. Indicates an absence of directly applicable clinical studies of good quality. (*Evidence level IV*)

GOOD PRACTICE POINTS

The manual makes frequent statements about recommended best practice. Unless otherwise stated these are at a level C. This includes the experience of the 'sexual health adviser manual steering group' and other chapter authors, taking into consideration the views expressed by other professionals during the formal consultation period.

Much of health advising work has been based on custom and practice over the years. This is not something to be apologetic about. It is merely a fact and a feature of emerging professions striving to consolidate their research base. Recommendations for good practice capture some of wisdom gleaned over the years, even if empirical evidence still needs to be gathered.

* Agency for Health Care Research and Policy. <http://www.ahcpr.gov/> (accessed 4th Feb 2003)

Section A

Partner notification

Chapter 1 - Introduction

Chapter 2 - Interviews

Chapter 3 - Provider referrals

Chapter 4 - HIV

Chapter 5 - Ethical issues

Chapter 6 - Audit

Chapter 7 - Further research

Partner notification: an introduction

CHRIS FALDON

Tracing and notifying people who may have had contact with a sexually transmitted infection (STI) is a complex and skilful activity. It is a vitally important strategy in the control of infection. Clinics with inadequate sexual health adviser resources will struggle to do it well.

“I think the person should always be contacted and if the person who has the infection does not want to do it then they should be contacted by the clinic. It is not right someone being in danger of having a disease and have it themselves and spread it onto other people unknown that they might have it. It’s a domino effect isn’t it? It can spread really quickly.” (sexual contact traced by a sexual health adviser)¹

INTRODUCTION

Once a person is diagnosed with a sexually transmitted infection there are many questions posed and answers sought.

“How could I have got this infection?” “Who gave it to me?” “Have I infected someone?”

The task of establishing a strategy to inform sexual partners is not an easy one, but of vital importance as there are compelling reasons and good evidence for the epidemiological value of this intervention.^{2 3 4} There is often much at stake and this is where health advisers can step in and make a difference as to how the process is managed. Discussions about partners and subsequent actions to secure their attendance demand a high level of skill and yet are crucial if the chain of transmission is to be broken.⁵ For patients to use sexual health services confidently in the future it is vital that they experience a personal and professional approach to the complex issue of ‘partner notification’. As a core role of health advisers, the act of tracing and notifying sexual contacts generates a concern within the profession to be better equipped to do the job more effectively.

Partner notification has been defined as:

“...the process of contacting the sexual partners of an individual with a sexually transmitted infection including HIV, and advising them that they have been exposed to infection. By this means, people who are at high risk of STI/HIV, many of whom are unaware that they have been exposed, are contacted and encouraged to attend for counselling, testing and other prevention and treatment services.”⁶

Partner notification has been an important component of controlling sexually transmitted infections since the 1940s.^{7 8} Custom and practice have to a greater extent guided its methods. As a researched activity, momentum has gathered since the advent of HIV. Asymptomatic cases of infection are frequently detected through contact tracing but the societal benefits, and relative cost effectiveness of different strategies are poorly understood.⁹ Much of the work done on evaluating the effectiveness of partner notification strategies comes from the USA.

The theoretical rationale for contacting sexual partners of a person with a bacterial STI is that individuals with asymptomatic infection are identified and treated, thereby reducing morbidity and duration of infectiousness. The net effect is the breaking of the chain of infection.

There is a deeper level of partner notification to consider. It is vital that partner notification strategies pay attention to more than individual case finding approaches since some individuals intentionally or unintentionally withhold information about sexual contacts. These missing individuals may be playing a key role in maintaining levels of infection.¹⁰ Other methods of reaching such individuals need to be employed.

A more sophisticated approach acknowledges that the distribution of an STI within a community is only partly dependent on the sexual behaviour of individuals within that community. Rates of partner change and barrier contraceptive usage are obvious variables that influence the spread of infection. The efficiency of transmission and the duration of infectiousness of the STI also play a part. It would be wrong however to focus solely on individual behaviour. To do so would miss the broader picture, which takes into account the influence mixing of high and low risk populations has on STI distribution.^{11 12} Traditional methods of individual case finding approaches need to be supplemented by more sophisticated methodologies to seek out foci of infection.^{13 14} Professionals require a greater understanding and appreciation of the social contextual determinants of sexual health status. All too often their focus is on individual risk factors.¹⁵

Patterns of infection can be studied by an approach known as ‘social network analysis’. This originally set out to evaluate models of disease dynamics and resource issues but has been used successfully in partner notification. It is achieved through identifying infection clusters by data gathered from attending patients and traditional partner notification methods. This can enable the tracer to get closer to establishing where the influential core groups and key individuals are in any given community that maintain endemic STI transmission. As such it can amplify partner notification outcomes.¹⁶

Genitourinary medicine (GUM) clinics in the UK at the turn 21st century have struggled to keep up with the demand for their services due to the increasing burden of sexual morbidity in the population.¹⁷ Sexual health advisers need to embrace a contemporary view of partner notification that facilitates targeted primary prevention initiatives.^{18 19 20} This is achieved by better understanding the forces at work that facilitate the spread of infection. Effectiveness measures can therefore move beyond recording the ratio of contacts seen to index patients*.

21

* The term index patient refers to a patient with an STI whose partners need to be notified

Little work has been done on measuring the direct effect partner notification has on the incidence and prevalence of infections in any given community.²² Several factors can thwart partner notification outcome measurement. These include:

- The sensitive subject area
- Limited national morbidity data sets
- Absence until 2002 of a National Sexual Health Strategy²³ leading to a fragmented picture of service provision

By way of an example a contact may choose to attend a different GUM clinic to the index patient. Different work practices may mean that this event is not conveyed to the clinic where the contact tracing was initiated. Another possible scenario is that a sexual contact visits the general practitioner for treatment. It is highly unlikely that this will be relayed back to the health adviser, as no statutory duty exists to pass on such information.

Even across clinics substantial differences of approach to partner notification have been recorded.²⁴ There was an excellent attempt in 1980 to produce comprehensive guidelines for contact tracing in the UK.²⁵ Over a decade later the professional organisation for Health Advisers working in GUM (SHASTD) produced 'Partner Notification Guidelines'²⁶ though these were not wholly informed by research findings. A culture of 'evidenced based medicine' emerged at the close of the 20th century and more research into partner notification has been encouraged.²⁷

A survey of partner notification practices at GUM clinics in the UK revealed that the most popular method used was patient referral (*Evidence III*).²⁸ This is where patients choose to contact partners themselves. It was discovered that 99% of clinics preferred this approach to be their first choice. Similar findings are reported in Scotland,²⁹ Holland,^{30 31} Sweden,³² and the USA.³³

The less popular practice of provider referral involves a health care worker taking sufficient details in order to telephone, write or visit a contact. In the UK it is '*health advisers*' formerly known as '*contact tracers*' that largely perform this duty. '*Disease Intervention Specialists*' take the lead in partner notification in the USA.

Most work done in researching attitudes to partner notification is with professionals engaged in the process. Differing beliefs and attitudes are reported which will account for the wide variation in which contact tracing policies and practices are adopted. The UK Policy Studies Institute examined the views of professionals working in GUM clinics. Doctors and nurses favoured provider referral partner notification more than health advisers. The latter group raised objections such as fears of breaching confidentiality, contravening the law, driving people away from testing, creating anxiety, or overstressing resources (*Evidence III*).³⁴ Regional variations in attitudes existed, with health advisers in the Thames regions more sceptical about the desirability of partner notification programmes. Similar findings were reported elsewhere.³⁵ National guidelines were recommended to clarify the prevalent confusion surrounding the issue. These later emerged for HIV partner notification, stressing that contact tracing should not be an isolated activity but was an essential part of a comprehensive, coordinated HIV and STI prevention, care and support programme.³⁶

Five years on from this guidance it was discovered that only 18% of a survey sample of 57 clinics in England had developed their own local policies for HIV partner notification

(*Evidence III*).³⁷ On the macro level there are a number of calls for national guidelines and audits of partner notification to better instruct health professionals in their duties.^{38 39}

The most comprehensive guide to contact tracing in the UK pre-dates HIV.⁴⁰ It is supremely important to attend to the minutiae of partner notification. Guidance documents exist to instruct professionals about the primacy of partner notification in infection control.^{41 42} Procedural details were somewhat lacking, and this document sets out to redress the balance.

Guidelines have limited value if inadequate resources are allocated to implement them. The 'National strategy for sexual health and HIV' acknowledges that the health adviser role needs to be strengthened and their numbers increased. Studies of partner notification for gonorrhoea have associated health adviser resources with outcomes. A contact is less likely to attend when the index case had been diagnosed in a clinic reporting inadequate health adviser time (*Evidence III*).⁴³ Clinics with poorer partner notification outcomes may be as a result of greater workloads, fewer interview rooms or desk spaces, and less health adviser experience (*Evidence III*).⁴⁴

These current guidelines emanate from a clear mandate by the Department of Health through the publication of the National Strategy for HIV and Sexual Health to recommend the adoption of national standards of care and service provision. They are drawn from relevant research findings and expert opinion and as such make recommendations for best practice in this crucially important field. More research and better resources will encourage health advisers to reflect on practice and make appropriate adjustments as their work is seen to be not only valuable but also valued.

TERMINOLOGY

The literature describes different partner notification terms, many of which have similar or identical meaning.^{45 46}

Partner notification and contact tracing

These terms will be used interchangeably and are largely accepted to convey identical meaning. This is despite the fact that 'partner' can imply a degree of commitment to a relationship and 'contact' does not. The latter was the first to appear in the literature. There is however a deeper issue of semantics worthy of mention.

Socio-economic and political pressures, that began in the 1970s and continued through to the advent of HIV era in the 1980s, fostered a growing ambivalence in some quarters to the practice of contact tracing as a method of STI control.⁴⁷ Its labour intensive and intrusive features were challenged when confronted with escalating trends in diagnosed gonorrhoea within a generally under resourced medical discipline. The lack of a cure for the ever-increasing numbers of people presenting with the viral conditions of herpes, warts, hepatitis B and latterly HIV also played a part. This was against a background of an increasing emphasis on the civil rights of individuals as opposed to those of the wider community. As HIV began to dominate the picture within genitourinary medicine, with large numbers of positive gay men reporting many anonymous and untraceable sexual partners, there was a fear that the practice of contact tracing would be ineffective, and held the potential to discriminate and alienate some.⁴⁸

By the end of the 1980s the public health care establishment responded to the political pressure of activists by dropping the out of favour term 'contact tracing' and replacing it with

‘partner notification’. It was felt that this took the emphasis away from the investigative nature of the practice and implied a more personal approach. There remained however a view that the one-dimensional activity of ‘notifying’ individuals of a potential exposure to infection undersold what is in reality a far more complex activity.⁴⁹ This has been somewhat rekindled in the new millennium with the reclaimed interest in sexually transmitted infections and the public health agenda.⁵⁰

At its very best partner notification is a tool that holds potential to control infection, fulfil an ethical duty to warn the unsuspecting and indicate not only where infection is but also importantly where it is not.⁵¹ A reawakened concern for the social context of STI by examining concepts of transmission networks favours the old nomenclature of ‘contact tracing’ because of its implied epidemiological and ethnographic approach.⁵² When attempting to describe the activity of seeking partners of STI, the use of the term ‘partner notification’ can be pictorially viewed as the shell of the context but ‘contact tracing’ the soul.⁵³

Patient, partner, passive or self-referral

Denotes when the index patient with the infection informs sexual partners. They are encouraged to notify partner(s) of their possible infection without the direct involvement of a health adviser. The patient may:

- Provide the partner with information
- Accompany the partner to the clinic
- Hand over a contact slip

The health adviser may help a patient to establish the information to be passed on to a partner and the methods of providing it.

Provider or active referral

A health care worker notifies a patient’s partner(s). In the UK health advisers in GUM clinics almost exclusively perform this. The index patient provides information on partner(s) to a health adviser, who then confidentially traces and notifies the partner(s) directly.

Conditional, contract or negotiated referral

A hybrid approach may be employed where an initial patient referral is followed up by a provider referral after an agreed period of time, if the contact has not attended.

Partner management

This term is beginning to be seen in the literature and has the appeal of inferring a more strategic and holistic approach to the process of engaging with partners.⁵⁴ It may resonate more with those anxious to reclaim ground relinquished to the more laissez-faire term of ‘partner notification’ and yet reluctant to re-embrace ‘contact tracing’ with its associated negative connotations.

CONCLUSION

UK morbidity data on sexual infections is only available through statistical returns to the Department of Health from GUM attendances. STIs are diagnosed in other settings but it is difficult to estimate their number because of the lack of surveillance data. The Public Health Laboratory Service reported that as little as 10% of all cases of chlamydia are seen in GUM

clinics.⁵⁵ The challenge is therefore great as to how to respond to the vast need for effective partner notification in patients diagnosed in Primary Care. Whilst these guidelines are written primarily for those working in a GUM setting it is hoped that they will be of interest and value to colleagues placed elsewhere.

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Partner notification: interviews

GILL BELL

The success of partner notification depends upon the patient's willingness to co-operate. This chapter describes how health advisers use interview structure and techniques to minimise resistance and encourage participation.

OBJECTIVES

The objective of partner notification interviews are:

- To ensure that, whenever possible, contacts of sexually transmitted infections (STIs) are informed, either by the index patient or by a health adviser
- To ensure the patient understands the infection and is able to comply with treatment and follow-up arrangements
- To explore ways of helping the individual to reduce future risk of acquiring or transmitting a sexually transmitted infection
- To identify the need for additional support and/or onward referral
- To gain insights into the sexual networks hosting transmission, which can guide complementary control strategies

WHO TO INTERVIEW

All patients with an STI that could cause significant morbidity in an untreated partner may be referred to a health adviser. The range of infections typically includes:

- Gonorrhoea
- Chlamydia
- Syphilis

- Pelvic inflammatory disease
- Epididymitis
- HIV
- Hepatitis B/C
- Non-specific urethritis (NSU)

For recommended look-back periods, see Ch.8: Sexually transmitted infections

SECURING THE INTERVIEW

Patients are more likely to agree to an interview if their experience of the service as a whole has been positive. It is important that all members of the multidisciplinary team are supportive of partner notification, and that an efficient internal referral system is in place. The health adviser therefore has a role in ensuring that:

- All staff understand which patients are to be seen by the health adviser
- All staff understand the rationale, process and importance of partner notification
- All staff understand their particular role in facilitating the interview
- Referrals are worded positively (“It will be helpful for you to see the health adviser” is better than “I’m afraid you’ve got to see the health adviser.”)
- The health adviser is informed if a patient needs to be seen quickly
- Waiting times are minimal
- Patients are managed appropriately
- Patients are treated with warmth and respect
- The clinic environment is pleasant, comfortable, and child friendly

WHEN TO INTERVIEW

Interviews are normally scheduled to follow discussion of diagnosis and treatment, allowing the health adviser to clarify understanding of all aspects of care. However, if the patient is unlikely to wait after treatment has been given, it may be useful to offer the interview beforehand. Medication can be given at the same time, to streamline care, if the health adviser is approved to dispense.

Some index patients are informed of their diagnosis over the telephone when being recalled for treatment. The need to inform partners may be raised at the same time, to minimise delay. Arranging for the patient and the regular partner to attend on the same day could reduce the risk of re-infection.

Patients attending as **contacts of infection** may also benefit from partner discussion on the day of presentation, even though the diagnosis is not yet available. The patient can be advised of the need to avoid exposure to untreated partners whilst being reassured that they do not need to notify anybody at this stage. Preliminary discussion about who may need to be notified if an infection were found can be a useful preparation for the patient, and can yield valuable information for the health adviser. It is worth remembering that the patient may not return, particularly if he or she has already received medication. In this situation it is much easier to follow-up partner notification issues by telephone when preliminary face-to-face discussions have already taken place.

PREPARING FOR THE INTERVIEW

Before greeting the patient it is important to be familiar with the background, including:

- Reason for attendance (routine check; symptomatic; referred by partner, health adviser or other agency)
- Symptoms – type and duration
- Sexual history
- Results and treatment given
- Concerns or issues raised
- Details of known contacts (name, diagnosis, date attended/treated, sexual history)

As a result, the interview can be personalised and tailored appropriately.

THE INTERVIEW ROOM

The success of the interview may be influenced by the quality of the environment. A suitable room would be:

- Accessible to patients with disabilities or children in pushchairs
- Soundproofed and shielded from the view of passers by, to protect confidentiality
- Free from interruption by telephones or other staff
- Equipped with necessary materials, including: contact slips; GUM Clinic directory; information leaflets and diagrams; condoms and lubricants; condom demonstrator and tissues; play materials for children
- Free from hazards to adults or small children
- Pleasantly appointed with comfortable chairs
- Equipped with an alarm for emergency use
- Free from records containing confidential information about others

BEGINNING THE INTERVIEW

The interview is more likely to be successful if the patient feels relaxed, safe, supported and in control from the outset. To generate the necessary confidence and trust, the health adviser would:

- Greet the patient warmly from the waiting area, with an open friendly manner to dispel potential fears of being interrogated or judged
- Tactfully exclude third parties who may inhibit partner discussion, such as a parent, current partner or older children, unless the index patient requests their presence
- Include third parties who may be helpful: young attendees in particular may value the support of a friend, care worker or parent, who may in turn assist with partner notification by prompting recall, supplying information or encouraging the index patient to co-operate. Interpreters may also be necessary if there are language difficulties (see Ch 36: Working with Interpreters.)
- Introduce him/herself and explain the purpose of the interview in a manner that conveys warmth, respect, support and professionalism
- Avoid creating anxiety or resistance by apologising
- Identify and address presenting concerns without delay, particularly if the patient looks upset, angry, worried or in a hurry. Prioritising the patient's needs at this early stage is a duty of care. It is also an opportunity to build the trust, goodwill and rapport necessary for co-operation with partner notification.

UNDERSTANDING THE INFECTION

An STI diagnosis may provoke a range of strong emotions, including shame, guilt, fear and anger. This could make it difficult for the individual to absorb information given by the doctor or nurse at the time.

It is important to clarify the patient's understanding early in the interview because subsequent misconceptions may lead to unnecessary anxieties or reduce compliance with treatment. Furthermore, awareness of routes of transmission and incubation periods is necessary to help identify contacts at risk and prevent re-infection. Knowing the serious consequences of untreated infection may encourage co-operation with partner notification.

Questioning style

The patient's level of understanding can be assessed most effectively by using open questions that encourage the sharing of details, such as: "What has already been explained about..." This is more productive than closed questions that invite one-word answers, such as "Has your infection been explained to you?"

The patient's answer provides insight into his or her cognitive level and preferred language. This enables the health adviser to pitch further information and discussion at an appropriate level, without mystifying or patronising the patient. Communication is most effective if words are familiar and sentences short.

Patients may feel more able to ask questions if these are openly invited. Information tailored to the specific needs of the individual is more likely to be taken on board.

It is essential to build rapport at this early stage by personalising the discussion and encouraging dialogue: if the health adviser is doing all the talking, and information is given in standardised form, the patient may disengage; this could make it more difficult to involve the patient in discussion about partners.

It is also important to avoid overloading a person with more information than is needed, or can be absorbed, at an emotionally stressful time.

COMPLIANCE WITH TREATMENT

Clarify that the patient is able to comply with the treatment regime and follow-up arrangements. If difficulties are identified, discuss with the doctor and/or make alternative arrangements. Document in the notes.

ENGAGING CO-OPERATION WITH PARTNER NOTIFICATION

The success of partner notification in the UK largely depends upon the patient's willingness to co-operate, since there is no statutory obligation to identify or notify contacts.¹ Motivating the patient to take part is therefore the central challenge of the interview. The following techniques may be useful:

Establishing rapport

The patient will be more likely to discuss partners if s/he can talk to the health adviser easily. Building good rapport depends upon an ability to show interest, empathy and respect; to listen effectively; to encourage dialogue; to identify shared values and to express approval of positive behaviours or intentions. Negative signals such as boredom, irritation, shock and distaste will inhibit rapport.

Ensuring the patient feels in control

Fear of what partner notification might entail could discourage some people from discussing partners. This barrier may be overcome by emphasising choice and offering early reassurance that the person will not be forced to do anything against his or her will. It would be unethical to coerce, bully, threaten or blackmail a patient into giving names or notifying partners.

Testing resistance

The health adviser needs to make an early assessment of the patient's willingness to discuss partners in order to structure and pace the interview appropriately. A useful approach is to ask open questions that allow the patient to say as much or as little, as s/he wishes. Examples might be: "How long do you think you may have had this?"; "Where do you think it came from?" Some patients will share their thoughts easily and volunteer names, while others will be more reticent. These questions allow the index patient to withhold information s/he is not ready to give, without seeming rude. As a result, the patient develops a sense of being in control and the health adviser gains insight into the patient's level of resistance without having created conflict.

Inviting the patient to set the scene

It may be helpful to discuss partners in general terms initially, without pressing for identifying details prematurely. At this stage, most people will be willing to give a first name and describe the type of relationship (regular, ex, casual). Questions about where and how they met (if recent) are usually non-threatening, and can help to develop a relaxed rapport while giving insight into the patient's "social and sexual milieu".² This is useful: understanding the values, attitudes, language and behaviours associated with transmission networks allows the interviewer to select the right words, questions and motivators.^{3 4} Sensitive information about the contact, such as involvement in prostitution, sex clubs or drugs, may be more readily shared before the contact's full name has been given.

Using the social context

Identifying connections between people can suggest ways of tracing a contact. (For example, "You said she works with your friend.... Could you ask him her name?... Could she be contacted at work?). Learning where people met may uncover key locations that are functional to transmission⁵ such as certain pubs, clubs, saunas or drug houses. These can then be targeted by additional control efforts, including health promotion^{6 7} and on-site screening.^{8 9 10 11 12} (See Ch 27: Outreach work)

Encouraging disclosure

Patients may hesitate to reveal all sexual partners in case this is met with shock or disapproval. Reassurance can be offered by using open questions (such as "Who else may be involved?") that suggest the health adviser expects and accepts there could be others. Closed questions, (such as "Is there anybody else?") may inhibit disclosure by giving the impression that interviewer wants to move on, or would disapprove. Questions or comments that imply blame or judgement (such as "Who might you have given this to?") would be avoided. Open question prompts may be repeated until the patient indicates the list is complete.

Using memory prompts

Memory prompts may help patients with multiple partners to recall forgotten individuals. A range of such cues have been described and evaluated by Brewer & Garrett,¹³ including role relationship, location, personal timeline, network and alphabetic cues:

- **Role cues**
Focus on types of relationship mentioned by the patient, such as regular, casual, ex, one-night stand, client, dealer, sex-worker. The interviewee is asked to consider who else s/he has had each type of relationship with during the look-back period.
- **Location cues**
Require the patient to remember where they met each named contact, then consider who else they have met at each of the places mentioned.
- **Personal timeline cues**
Involve identifying key events during the look-back period, such as vacations, business trips, time in jail or the end of a relationship. The patient is asked to think about sexual contacts associated with each event.

- **Network cues**

Focus on the partners already identified. The interviewee is asked to consider whether they have had sex with anyone else known to each named contact.

- **Alphabetic cues**

Involve asking the patient to recall all recent sexual partners whose names begin with...each letter of the alphabet.

Brewer & Garrett ¹⁴ found that each cue in isolation was moderately effective, particularly alphabetic and location cues, which increased the number of sexual partners recalled by 10% and 12% respectively. When all cues were used together, the impact was much greater, increasing the number of sexual partners recalled by 40% (*Evidence 1b*).

Taking a thorough sexual history

Taking a systematic sexual history may reveal some contacts that have not been mentioned because the patient believes they have not been at risk. Specific, exhaustive questioning is recommended, such as “Apart from X, Y and Z, who else have you had sexual contact with in the past x months?”

Challenging assumptions about the source may be necessary; for example: “You may not have caught it from X. The symptoms can sometimes take a while to develop, so you could have caught it earlier. Y could also be involved.”

Explicit discussion of the types of sexual contact that may have transmitted infection is advisable. Exclusive use of ambiguous words, such as ‘sex’, which denotes vaginal or anal penetration for some people, may result in oro-genital, oro-anal or genital-genital contacts being overlooked.

The patient may omit to mention partners with whom condoms have been used, in the mistaken belief that there has been no risk of transmission.¹⁵ It is therefore advisable to ask specifically whether there are other partners with whom condoms were always used, but who may have been at risk from unprotected genital contact.

Protecting contacts from blame

The health adviser may protect the contact from blame by stressing the difficulty of knowing how long an infection has been present and the possibility that the source may have been unaware of the infection. Blame is unhelpful because it may put the contact at risk, or be a justification for not notifying that person.

Motivating the patient

If the patient has reservations about partner notification, it is helpful to:

- Emphasise the risk of re-infection from untreated partners
- Stress that the contact may not have symptoms and will not be aware of the infection unless he or she is informed
- Indicate the long-term damage the contact may suffer if not notified
- Reassure the patient that all information given is confidential, and that the contact will not be informed of their diagnosis or other partners
- Emphasise that the patient is in control and has a choice of approaches (patient or provider referral)
- Avoid suggesting or sanctioning the possibility of doing nothing, unless circumstances are exceptional (for example, the contact is terminally ill, or there is a serious, unavoidable risk of violence)
- Consider the contact's right to know
- Offer a leaflet on the importance and procedures of partner notification (example in appendix)

NEGOTIATING THE METHOD OF PARTNER NOTIFICATION

The patient has the choice of informing partners themselves (patient referral), or allowing a health adviser to notify them, without the patient's name being mentioned (provider referral). Sometimes conditional referral is agreed, whereby provider referral is initiated if the partner has not attended by an agreed time.

For patient referral

Good practice would include:

- **Preparing the patient**
It might be helpful to discuss how, when and where the contact might be informed. Potential embarrassment or conflict may be minimised by selecting the most appropriate place, time and words.

The best approach will depend on individual circumstances. Typical choices are between: informing face to face, by phone or by post; using a private or a public place; informing immediately by phone or deferring until face to face discussion is possible; disclosing the exact diagnosis or referring vaguely to "an infection" in the hope that the contact tests negative, and will therefore never know the infection was sexually transmitted.

Patients would normally be discouraged from jeopardising the confidentiality of the contact by passing explicit messages through a third party: provider referral may be more appropriate if the patient is unable or unwilling to contact the partner directly.

- **Clarifying the boundaries of confidentiality**

The patient needs to understand that the contact will not be informed of the patient's diagnosis or other partners, but that the contact is entitled to know his or her own diagnosis, which will also be confidential.

- **Offering a contact slip for each partner**

The health adviser would offer a contact slip, explaining how and why these are used (see table 2). The name of the infection may be entered, if the patient agrees: a UK study found that more contacts attended when the infection (chlamydia) was named on the contact slip.¹⁶

Table 2.2

| <i>Contact slips</i> | |
|---|--|
| These are issued by all GUM services to patients wishing to notify their own contacts. | |
| Purpose | |
| <ul style="list-style-type: none"> ▪ To give the contact sufficient information to book an appointment and find the service ▪ To enable the contact to be managed appropriately ▪ To inform the issuing clinic of the contact's attendance | |
| Content | |
| <ul style="list-style-type: none"> ▪ Clinic name, address, telephone number, opening times and location ▪ Index patient number, diagnosis or diagnostic code * and date of diagnosis ▪ Contact details following presentation, including number, diagnosis, date of diagnosis and the name of the clinic | |
| Use | |
| <ul style="list-style-type: none"> ▪ All patients should be offered a contact slip for patient referrals ▪ All contact slips should be returned to the health adviser at the issuing clinic once completed (unless the information has been given by phone) ▪ If the contact lives in another area, details of nearest GUM service would be provided | |
| * A national coding system for diagnoses is used by GUM to protect confidentiality | |

- **Using a look-out system**

Contact slips are not always used, particularly if the partner is informed by telephone. A system is therefore needed to ensure that medical staff managing the contact will have enough information to give appropriate care.

If the contact has attended the clinic before, details can be entered into his or her medical notes. If not, a lookout system is useful to ensure the contact is identified. This requires keeping a record of all contacts expected to attend the clinic, together with the index patient details. The names of all new attendees should be checked for matches. For easy reference, the information can be stored on cards and filed alphabetically, or retrieved through a computer database, such as iSoft CDS/Telecare system.

The need for these contingency measures arises because contacts do not always disclose that they have been asked to attend, and they may leave the service falsely reassured without having had the necessary tests and/or epidemiological treatment. This system is less likely to be useful in cities where the contact has a choice of clinics.

- **Negotiating a back-up plan**

Contingency measures are useful in case the contact fails to attend: studies have reported that only 11-32% of initial patient referral agreements result in contact attendance.^{17 18} (evidence level 3). Obstacles include the difficulties of locating the person; raising the issue; or convincing the contact that they need to seek care. Since the index patient may not return to the clinic, it is important to negotiate a back-up plan during the first interview, if possible (for example, “If he’s not been within x days/weeks should I contact him directly, or speak to you again?... Is it ok to ring you?...”) Patients may be more motivated to notify contacts promptly if they realise that progress will be monitored.

- **Re-interviewing the patient**

A follow-up interview may be necessary if there is no record of the contact having attended. The purpose of this is to check progress, gather any additional data and repeat the offer of provider referral if the index patient is having difficulty. There is evidence that many patients who initially opt to inform their own partners subsequently agree to provider referral at follow-up interviews.¹⁹ These can be conducted face-to-face when the patient returns for follow-up, or over the phone- preferably by prior arrangement.

For provider referral

Good practice would include:

- **Select appropriate method of notifying the contact**

The contact may be approached by post, telephone or personal visit, although the choice may be restricted if only limited information is available, such as a telephone number. Guidance may be sought from the patient, who is likely to know the contact’s individual circumstances, and can alert the health adviser to potential pitfalls (For example: “Ring him on his mobile, he works away” “Don’t send anything through the post in case her husband sees it-

ring her during the day” “Send her a hospital letter so she knows its not a wind-up”).

- **Negotiating a back-up plan**

An alternative approach might be agreed, in case the first choice fails. It may be necessary to arrange to speak to the index patient again, should more information be needed.

- **Clarifying the boundaries of confidentiality**

The patient would be reassured that the contact would not be given any information that could expose his or her identity: this includes name, gender, area of residence, date of exposure and type of relationship. The patient would also be aware that the contact’s subsequent diagnosis is also confidential. However, if the health adviser fails to find the contact, the patient may be informed so s/he can reconsider patient referral and/or avoid re-exposure.

- **Preparing the index patient to manage the possible consequences**

Consideration would normally be given to the likelihood that the contact might guess the index patient’s identity. Provider referral is a hazardous choice for current regular partners, who may feel betrayed and humiliated to be informed by a third party. It is important to ensure the patient has considered the consequences, and is equipped to manage any resulting difficulties.

The index patient may be confronted subsequently by a contact claiming to ‘know’ they instigated provider referral. The patient can avoid being tricked into confession if s/he is prepared for this, and is confident in the confidentiality of the service.

Equally, a contact may notify the index patient in future, unaware that they have already attended: preparing the patient for this possibility may help them to maintain composure and respond appropriately.

MANAGING RESISTANCE TO PARTNER NOTIFICATION

This section considers ways of managing different forms of resistance:

- **The patient believes they do not have sufficient information**

It is important to make it clear that any information can be useful. Most people will be able to give a first name, estimated age, physical description and say where they met; others may even know the area where they live, or occupation. Even if this is not enough to trace the contact, it may allow the person to be recognised and managed appropriately if they attend spontaneously. (The potential for this is greater in small clinics, where a health adviser is more likely to be aware of the majority of attendees).

Incomplete data can also be useful if several index patients give different pieces of identifying or locating information for the same contact: eventually the person may be traced on aggregated data.

Sometimes patients have substantial details about the contact, including full name and/or date of birth, but believe they need to provide a full address

before action can be taken: the health adviser may explain this can be obtained from other medical records. Where details are insufficient, the patient may be willing to seek more information from mutual acquaintances.

- **The patient believes the contact is not involved**

The patient may have a fixed view on who is the likely source of infection and be unwilling to notify previous contacts within the look-back period. The danger of infected contacts being overlooked may be avoided by emphasising the difficulty of being certain about the duration of the infection. The risk of exposure despite condom use, due to unprotected genital contact, would also be outlined. If the patient cannot be persuaded to inform a regular partner, it is worth advising repeat tests if unprotected sexual contact is resumed.

- **The patient is afraid of the consequences**

Partner notification is not without risk for the index patient, who may fear loss of relationship, verbal abuse, a damaged reputation or even physical violence.^{20 21} The health adviser may help to reduce risks or fears by providing a supportive environment where anxieties can be explored: this may enable the patient to reassess fears and manage risks effectively. Some fears - that the contact will know who gave their name; be angry; end the relationship or tell others - can be examined and possibly challenged: for example, confidence may be enhanced by reassurances about confidentiality, or by considering the possibility that the contact may be more grateful than angry.

The patient may be able to reduce the risk of angry confrontation by selecting an appropriate time and place, speaking calmly, resisting blame or guilt and focusing on the need for medical care rather than speculating about the source.

Sometimes there are fears that the patient or a regular partner may come face to face with another contact, thereby compromising confidentiality and risking confrontation. The healthy adviser may be able to prevent this by booking appointments personally, at 'safe' intervals.

Where there is risk of violence, delaying provider referral until the patient is in a place of safety, or the contact is in prison, may be acceptable.

The negative consequences of not notifying partners should be emphasised. For example, the index patient may become re-infected, or may eventually be confronted by a contact who has realised s/he could have been notified earlier, thus preventing complications and further transmission.

- **The patient is hostile towards the contact**

Unwillingness to inform a contact may be rooted in anger or resentment, particularly if the infection has brought an infidelity to light. If the patient is given the opportunity to ventilate and explore these feelings with the support and understanding of the health adviser, anger may eventually dissipate sufficiently for the patient to reconsider.

Stressing the frequent absence of STI symptoms can challenge false beliefs that may be fuelling resentments, such as the assumption that the partner has knowingly passed on an infection. Equally, the patient may assume the

infection has been recently acquired, and that therefore a partner has been unfaithful.

Emphasis upon the serious consequences of untreated infection may stir enough concern or conscience to override anger. If the patient is still not ready to co-operate, further discussion may be postponed.

- **The patient is uninterested in the contact's welfare**

Indifference is often a barrier, particularly towards casual partners where there is insufficient familiarity or sense of connection to provoke empathy, concern or obligation.

There are several techniques that may help here. The first is to build some sense of familiarity by 're-visiting' the contact and making that person as real and three dimensional as possible. This may be done by asking a series of questions that move from the superficial (age, appearance) towards some speculation of circumstances, personality, values and aspirations.

The second technique is to encourage a sense of relationship by focussing on the interactions between them (how they met, what attracted them to each other, how they got on, how they parted).

A third approach involves strengthening a sense of connectedness by identifying social connections through mutual acquaintances. Finally, empathy can be encouraged asking the patient to imagine how they would feel if the situation were reversed and the contact failed to let them know.

However, these types of enquiry may feel threatening and intrusive; they require great skill and can be time consuming. For these reasons they are only recommended when there is a good rapport with the patient, and the contact is believed to be both traceable and at high risk of a serious infection, such as syphilis.

- **The patient believes the contact will not attend anyway**

Patients who have previously failed to persuade a partner to attend may see no point in trying again. Exploring the reasons why the contact is unwilling to attend may suggest solutions: for example, a chlamydia contact who is afraid of swabs or blood tests may agree to a urine test only; a contact who does not believe s/he has been at risk may be persuaded by a hospital letter; a contact wanting to avoid acquaintances who work at the clinic may be willing to visit the GP.

- **The patient believes the contact must be aware already**

It is important to challenge the assumption that the contact will be symptomatic, or will have been screened during pregnancy or at the time of cytology.

IF THE INDEX PATIENT REFUSES TO CO-OPERATE

If the index patient refuses to co-operate with partner notification, despite being fully informed of the consequences, the following actions may be taken:

- The index patient could be informed that, if another patient names the same individual and gives permission provider referral, the contact will be notified.
- The case for notifying a contact without patient consent would be discussed with colleagues, including a consultant (See Ch.5: Partner notification - ethical issues). The index patient would be informed of any proposed action.

CONTACT DATA RECORDING

Data are sought and recorded to allow:

- The contact to be managed appropriately, in the absence of a contact slip
- The index patient to be managed appropriately, through cross-referencing of results
- Provider referral to take place
- Contact attendance to be verified
- Effectiveness to be evaluated

The health adviser would record enough contact information to confirm attendance, or facilitate provider referral if the need arises. The full name, address and phone number are ideal. A date of birth is useful if the address has to be sought from the Patient Administration System (PAS), the Family Health Services Authority (FHSA) or the GP.

Insight into the contact's home circumstances is valuable if phone calls or visits are to be made. Incomplete details and descriptors can also be useful because they may allow an untraceable contact to be recognised, managed appropriately and cross-referenced if they attend the clinic spontaneously. Network information such as where people met, or how they met, should also be documented.

Table 2.3

| <i>Data required for all contacts</i> | <i>Additional data potentially required for provider referral</i> |
|---|---|
| <ul style="list-style-type: none"> ▪ Full name/first name/nickname ▪ Date of birth/age ▪ Address/street/area/city ▪ Dates of first and last sexual contact ▪ Type of contact- oral, vaginal, anal ▪ History of condom use ▪ Type of relationship- regular, casual, ex, commercial ▪ Where met if casual or commercial | <ul style="list-style-type: none"> ▪ Telephone numbers- home, work, mobile ▪ Email address ▪ Occupation ▪ Place of work ▪ Physical description ▪ Home circumstances (who lives with) ▪ History of violence ▪ Current drug use, if any |

THE PATIENT IS RELUCTANT TO GIVE DETAILS

Patients who plan to inform partners themselves may be reluctant to give identifying information: either because they don't appreciate why it is needed, or have anxieties about who may have access to it and how it may be used. Clarifying the following points may encourage disclosure:

- Contact details are recorded confidentially to ensure the contact can be identified and managed appropriately in the absence of a contact slip
- The index patient may also benefit if results can be cross-referenced because the contact may have an additional infection for which the patient needs epidemiological treatment, such as trichomoniasis
- The need to re-treat the index patient following re-exposure prior to contact treatment can be identified
- Contact data will only be available to clinic staff involved in their care
- The contact will not know their name has been given
- Contacts will not be able to find out about each other
- Information will not be used to notify the contact without further discussion

Some patients may not be willing to give details until they have the partner's permission, but will agree to provide them in future if the contact consents. In this situation ensure the patient is aware of the pitfalls and the importance of using a contact slip (explained above).

RISK - REDUCTION

The following interventions may help the patient reduce future risk of acquiring or transmitting STI:

- Ensuring the patient is aware of transmission routes, including unprotected oral, anal vaginal and genital contact. Clarify the limited protection offered by condoms ²²
- Personalising risk, with reference to local/national epidemiology. For example, if the patient were a local teenage girl, more emphasis would normally be placed on the risk of chlamydia than HIV. The opposite would be true for a gay man
- Identifying acceptable ways of reducing risk, such as condom use, minimising the number of partners, restricting types of sexual contact, ensuring partners have been screened/treated
- Reinforcing attempts made to reduce risk
- Identifying factors that may encourage risk, such as relationship issues,^{23 24} or drug/alcohol use. ²⁵ Explore ways these might be managed more safely
- Arranging for hepatitis B vaccination, if indicated

- Discussing the need for referral to other agencies. Supply information and/or arrange referral if appropriate

A FLEXIBLE APPROACH

The above format is for guidance only. The style, order and content of each interview would be tailored to suit individual needs, attitudes and time available. If time were limited, priority would be given to discussion of partners and how they could be notified. If the patient had refused to name partners in the past, it may be worth offering contact slips on a first-name only basis.

If the patient has had the infection several times before, s/he may need more time to discuss risk reduction, and less for information. On the other hand, it may be counter-productive to place heavy emphasis on risk reduction: there is some evidence that repetition of health promotion messages may alienate some individuals and contribute to increased risk taking as a result of “safe-sex fatigue”.²⁶

DOCUMENTING AGREEMENTS, ACTIONS & OUTCOMES

Contact data is usually recorded on a pro-forma sheet and stored in the patient’s notes * For each contact, the following information would also be recorded, signed and dated:

- The agreement reached, for example: ‘patient to inform’, ‘health adviser to inform’, ‘untraceable’, ‘patient to seek more details’, ‘patient refuses’, ‘not involved’
- Actions taken, for example: ‘Contact slip issued’ ‘Telephoned contact. Informed. Appointment booked for dd/mm/yy’
- The final outcome, for example: ‘attended’, ‘untraceable’ ‘notified, but failed to attend’
- The contact’s clinic number, diagnosis and dates of diagnosis and treatment
- Unverified reports that the contact has been treated by a GP, or outside the UK

CONCLUSION

Partner notification interviews employ a range of techniques to encourage patients to inform sexual partners themselves or provide information for the health adviser to notify them. Successful negotiation resulting in contact attendance may protect the patient from re-exposure, the contact from the complications of un-treated infection and the community from onward transmission.

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* For example see www.ssha.info

What about partners?

Leaflet developed by Newcastle GUM clinic health advisers

Coming to a GUM clinic can be a difficult journey to make. Going through an examination of your private parts, have blood taken and talking to complete strangers about the intimate details of your sex life can be very hard.

The staff are well aware of how embarrassing it can feel to come to the department. We are specially trained to give you care and attention of the highest quality. It is vital that you are treated with dignity and respect. Your individual needs should be met with great sensitivity.

We follow strict guidelines of confidentiality set down by Parliament. You therefore should be able to confidently approach us with any concern safe in the knowledge that we will work hard to protect your interests.



A GUM clinic plays a vital part in controlling the spread of sexually transmitted infections. Not everyone who uses our service will have such a condition but many do. Unfortunately some infections can be present without any obvious signs or symptoms. It is quite common for someone to have an infection and not know anything about it. Without treatment a few of these infections (though not all) can lead to more serious health problems. By this stage it can be very difficult to sort out complications that might have occurred. It is for this reason that you may be asked about current or previous sexual partners.

The more people who are given the opportunity to have a check-up the less chance there will be of picking up an infection in the first place. It is also of little value in having tests and treatment if your regular partner is not assessed at the same time. This may only lead to you becoming re-infected and the problem returns and possibly worsens.

The *health advisers* are present to help you talk in detail about your situation. Not only can they help you to better understand what has been going on with your treatment and care but also they can assist you to work out the best way to approach sexual partners. It is crucial that you feel in control of any decisions taken and that the best solution is found. We do not want you to feel under pressure to give information against your will.

So how can partners be encouraged to attend a clinic?

We will help you to work out which partners should be seen. This will vary according to the condition you have and your own individual circumstances. It may be helpful to practice with us how to phrase things or introduce the topic into the conversation. You may be given a printed piece of paper called a '**contact slip**' to pass on to a partner. This should be taken to their local clinic and will help them to get the correct tests and possibly treatment.

The health adviser may ask you if you would be prepared to give any details of partners. This can be as much as you know or are prepared to reveal at this stage. Talking to partners, past and present, about infection risks can be extremely hard. We understand when some choose not to

do it. This is where we can help. Partners can be contacted discreetly by us or from another GUM clinic without giving away your details. You may not have full information about them but we can often find out more.

Summary.

- Sexually transmitted infections can often be treated easily and effectively if they are quickly dealt with.
- Many people with infections will not realise they have a problem.
- GUM clinics treat individuals with tact and sensitivity.
- The health advisers can help to see that partners are invited to attend. This may help to protect their sexual health. It also could help you to lower the risk of coming across infections in the future.

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Partner notification: provider referral

CHRIS FALDON

Sexual health advisers reduce levels of sexually transmitted infections (STIs) by actively tracing a sexual contact. Not offering an effective provider referral service will result in many people not being contacted and warned of the risk to their sexual health. Difficult decisions based on legal and ethical considerations are sometimes needed.

INTRODUCTION

The active process of a health professional tracing a sexual contact is known as a 'provider referral' (see Ch.1: Partner notification - introduction) and is to be encouraged. Surveys conducted in the early 1990s however have indicated that this approach has suffered from a declining popularity.^{1 2} Legal and ethical pitfalls abound (see Ch. 5: Partner notification: ethical issues, Ch. 22: Law and the sexual health adviser) and it is important that health advisers have a knowledge and understanding of the key principles involved in seeking out sexual partners. This chapter covers the practical aspects of tracing contacts through provider referral methods.

Commitment to provider referrals has been reported to be weaker in metropolitan clinics (*Evidence III*), where health advisers were burdened with a greater HIV workload,³ contacts were harder to find⁴ and effectiveness more difficult to measure.⁵ The move away from provider referral in the UK pre-dates HIV and was first recorded in a provincial setting. The proportion of screened contacts notified by a contact tracer in Newcastle in 1970 was 23%, compared with 62% in 1946.⁶ The recorded decline of syphilis and gonorrhoea in the 1980s has been cited as a reason for changing partner notification practices.⁷ Patient referral was increasingly encouraged in preference to provider referral for these infections.

Health advisers surveyed from a random selection of twenty UK clinics report favouring active partner notification for bacterial STI. Nearly a quarter thought it was entirely up to the index patient. The reluctance to violate privacy and a belief that responsibility should lie with the index patient are common misgivings with the practice (*Evidence III*).⁸ The same survey found that 55% of health advisers believed that provider referral should and had to be done

for STIs but only 5% for HIV. It was the firm opinion that it held no value in controlling the HIV epidemic. Concerns were raised about confidentiality, deterring people from testing, creating anxiety and over-stretching resources. The right of a contact not to know of their exposure to HIV was also held to be important.⁹

Contacts are more likely to attend for assessment as a result of a 'provider' and 'contract' referral rather than by 'patient' referral (for definitions see Ch.1: Partner notification - introduction). Moderately strong evidence exists, following a systematic review of partner notification strategies, to support this (*Evidence Ia*).¹⁰ Eleven randomised controlled trials comparing two or more strategies with over 8,000 participants were included. None of the studies were conducted within the UK. A study conducted in England concluded that provider referral was an effective means of securing the attendance of contacts that might not otherwise have been informed (*Evidence III*).¹¹

As with all forms of partner notification the confidentiality of the index patient is to be protected, although it is important that possible loss of confidentiality is discussed with the index patient before any provider referral is commenced. A health adviser never confirms the identity of the index patient without their consent. If the contact has only one sexual partner, confidentiality may be compromised.

It is often necessary for the health adviser to seek the assistance of colleagues in other clinics in order to carry out provider referral. The clinic closest to the contact would normally be asked to do the provider referral. There are differences in practice and approach to provider referral between clinics. Nationally applied standards will help overcome this problem along with a recognised training programme for all sexual health advisers. Some clinics may struggle with insufficient resources to carry out provider referrals effectively. There is however a professional obligation for health advisers to co-operate and communicate with one another. A real effort is needed to make further enquiries and take appropriate action when another clinic seeks assistance with provider referrals.

It is considered good practice that health advisers seeing those patients with syphilis, gonorrhoea, chlamydia, PID, chancroid and HIV offer a provider referral service (*Grade A*). Several clinics will also consider it for NSU and trichomonas. To enable the health adviser to carry out provider referral the index patient is to be encouraged to give as much accurate and relevant information regarding the contact(s) sought as possible. (See Ch.2: Partner notification - interviews)

AMPLIFYING INCOMPLETE INFORMATION

All too often provider referral can stumble at the first hurdle because there is insufficient data to easily locate the contact. However, with adequate resources and a determination to proceed, the health adviser can often move beyond this. The use of the following resources may prove valuable:

- Telephone directory, patient databases (GP and hospital systems) and electoral rolls. It is important not to divulge any information that may compromise confidentiality
- Colleges and universities often co-operate with health advisers who discreetly enquire about students at their institutions. Many will agree to forward on a sealed letter without having to divulge addresses. The same can often be said for large employers

- Internet resources such as www.192.com and www.bt.com. Health adviser teams can operate more effectively when they have their own dedicated access to the internet and have an email account
- Software packages are commercially available that can give personal information on contacts with relative ease. For example, the names of residents of a particular street can be pulled out when the index patient was not sure of the house number. Similarly it is sometimes possible to locate the address of two adults living together in a particular area – Mary Jones living with Fred Bloggs in Gateshead

SPECIFIC METHODS OF PARTNER NOTIFICATION

The most appropriate method to use for provider referral will have been agreed during the contact-tracing interview (see also Ch.2- PN Interviews & Ch.9- Recall) A hierarchy of methods is impractical since individual circumstances will vary. There are clear resource issues to address that are linked to each method. These may affect choice. The following table may assist in the decision making process.

Table 3.1

| Method | Advantages | Disadvantages |
|---------------|---|---|
| Letter | Cheap. Easy to employ with standard computer generated templates. Reduces the risk of having to engage with other household members. Enables contact to respond in their own time. | Easier for contact to ignore them and thus not become fully informed. Anxiety provoking for contact if clinic not open when responding. Address searches can be time consuming. Awaiting a response can delay effective management. Unsure if contact receives it unless sent by recorded delivery. |
| Telephone | Easy to employ with skilled health advisers. Swift to enact. Opportunity to establish the correct identity of contact and gather more information. Ability to give information and negotiate action. | More expensive than a letter in most cases where mobiles are used. Inquisitive non-contacts pose a threat to confidentiality and need careful handling. Drawn into giving too much information away. |
| Text Message | Cheap. No cost to recipient. | Limited amount of information. Mobile numbers change frequently. |
| Visit | Able to impart quality information to contact. Can provoke a response where other methods have failed. | Resource intensive. Safety vulnerabilities. Potential to disrupt domestic/work situation. Intrusive. Difficulty managing confidentiality if others are within earshot. |

For each of the following methods of provider referral activity, several actions are recommended (*Grade C*).

Letter

The task of sending a letter from the clinic can be complex and fraught with difficulties. The following needs to be considered:

- It is good practice to ensure that there is nothing specific in a letter to a contact to suggest an STI although research into this area would be useful
- The envelope is not identifiable as being sent from a hospital. It is to be clearly marked with either “Confidential”, “Private” or “For Addressee Only”. Arguably this may actually draw more attention to the letter than is desirable. Once again research evidence is lacking on this point
- Use stamps in preference to a hospital-franking machine to generate less suspicion. The full name and address provided is used
- A direct line telephone number for easy access to the health advisers is to be included in the letter in order to encourage swift resolution of partner notification
- Send letters by first class post to reduce the risk of it arriving at the weekend. This may cause undue distress by leaving the recipient unable to contact the clinic. Part time clinics may need to consider setting up alternative arrangements for contacts receiving a letter on days the clinic is not operating
- Have an efficient system in place to respond swiftly to contacts that call the clinic
- Wait one week before further action, if necessary

Telephone

Many health advisers do productive partner notification work over the telephone. This demands a high level of skill and training. The following guidelines should assist:

- A basic tool for health advisers is to have their own dedicated telephone line that can make long distance calls without having to go through the hospital switchboard
- Ensure the right person has been reached before giving any information. Issues taken into account include: convenient time for discussion of a personal nature and the possible need for verification of the authenticity of the call. Checking correct identity over the phone is difficult. If in doubt disclose as little as possible and encourage a face-to-face interview
- Offer to call back at a more convenient time, if necessary
- Set up the facility to withhold the telephone number from a third party should an unsuccessful attempt be made to call a contact
- Take care to answer in-coming calls discreetly so as not to immediately identify the clinic to the caller until the correct identity of the contact has been established

- Telephone answer machine messages that identify the department can inadvertently undo attempts to remain discreet. It may be best to leave a first name of health adviser(s) and an option to have someone call them back
- Persuading some people to attend demands good telephone interviewing skills especially when a person is asymptomatic. The potential for long-term damage from untreated infections needs emphasising. Also provide the option to just treat epidemiologically (if appropriate) if screening tests (swabs and needles) will inhibit attendance
- Where possible make an appointment there and then. Assure them that they will be seen quickly and given priority attention if a triage system is operational (See Ch.11: Triage).
- Text messages may be used if the contact continually has their mobile switched off. They can be preferable to leaving an answer machine message that may cost the caller to collect

E-mail

The use of email holds potential to trace contacts. Care is needed as follows:

- Ascertain from the index patient if it is a private mailbox before sending any messages
- Check to see if there is a trust policy on sending emails to patients/contacts since there may be legal implications. In the absence of a specific policy it would be wise to wait until one was in place. A confidentiality statement is recommended to be included in all electronic transmissions

Visit

Health advisers have undertaken visits to the home, workplace and social settings for many years.¹² The need to visit is generally seen as a last resort but all health advisers need to retain the capacity to undertake this activity when necessary. This is something to be clearly identified in the job description of all health advisers. The advantages and disadvantages of each individual visit needs careful consideration. Substantial pitfalls exist and it is extremely resource intensive. This option should not be withdrawn from the health adviser. The following need careful attention:

- Visits risk causing upset to the partner/contact if other family members/friends/colleagues or partners are present. They do, however, allow for the contact to be informed of their potential exposure and to be reassured
- As with all domiciliary visits the safety of staff is of paramount importance. The health adviser ought to inform colleagues of visit locations and carry a mobile phone. Visits with another colleague are the ideal
- It is advised that, in most circumstances, the health adviser does not enter the house/flat for safety reasons and does only what is felt comfortable
- Leave behind a clinic brochure or telephone numbers with a traced contact. It may help to make an appointment for them to attend before leaving

- Often the person is not present and therefore a prepared letter can be left. The hand delivered nature of this letter can provoke a response where other methods have failed
- A visit can reveal clues as to a person's whereabouts through discreet enquiries of neighbours and other household members

CONCLUSION

Conducting provider referrals demands that attention is paid to detail. It is as much an art form as a science and can take a great deal of time and training to develop the professional skills required. More testing for sexually transmitted infection is performed in community settings. Health advisers are ideally placed to occupy a key role in training and supporting other staff outside specialist centres. These will almost certainly have had little or no experience in contact tracing. It is important that health advisers alone perform provider referrals and referral pathways to them are established by other services set up to detect STIs (Grade C). Only in exceptional circumstances will another professional undertake to do a provider referral. Where this takes place, a full discussion with the health adviser will be necessary.

Actively seeking contacts can be a professionally daunting task but possesses a value that cannot be easily ignored. The experience of one sexual contact traced through a provider referral method has been captured in a qualitative research study. His reflection has much to commend the practice of provider referrals. It meets individuals at a time of real vulnerability and as such requires great sensitivity, tact and skill.

*"It needed that professional touch (provider referral). I would not have taken it as seriously. I would not have digested it as quick or what have you. It was a lot more professional this way than somebody (a sexual partner) coming up and speaking to me... Yes I think it is much easier for yourselves to do what I would have found too hard to do."*¹³

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Partner notification: HIV

DORINDA THIRLBY AND SANDRA JARRETT

People diagnosed HIV antibody positive often react in a very responsible and caring way towards their current and previous sexual and/or needle sharing contact(s). The first issue for them to deal with in regard to their status is setting out to inform their partners themselves and practise safer sex.

INTRODUCTION

This chapter is based on the document 'Guidelines For Piloting And Audit of HIV Partner Notification Management In Chelsea And Westminster Health Care Trust: HIV/ Genitourinary Medicine Services'.¹ Partner notification for HIV has been hotly contested over the years as opposing views pitched public health concerns against the right of individuals to know or not know their HIV status. As yet there is still no cure available and no early intervention that will render an infected individual non-infectious to others, other than a permanent change in their sexual behaviour.

Studies suggest that anti-retrovirals decrease levels of HIV in other parts of the body, including vaginal secretions and seminal fluids. However, there is good evidence that people taking anti-retrovirals can still pass on HIV to other people – even if their viral load has been reduced to 'undetectable' levels.² Now there are more effective treatments, a stronger argument exists to justify notifying people who are potentially infected with HIV but may be unaware of their risk.

HIV PARTNER NOTIFICATION AIMS

Partner notification for HIV aims to:

- Provide a public health control measure to prevent the spread of HIV infection
- Be a benefit to infected individuals through the provision of early treatment and intervention that may delay progression to symptomatic disease³

- Provide the opportunity for individuals notified to make informed decisions about significant life events, for example, reduction of vertical transmission in pregnancy, particularly those who previously had no awareness of their risk and are found to be HIV antibody positive
- Increase awareness of how to prevent infection in individuals notified who previously had no awareness of their risk and are found to be HIV antibody negative

KEY PRINCIPLES OF HIV PARTNER NOTIFICATION

Much of the principles and practice of partner notification outlined above can be applied in the context of HIV infection. However there are some issues pertinent to contact tracing for HIV that merit closer inspection:⁴

The principal of voluntary co-operation with partner notification for STIs applies equally to the management of HIV contacts. The primary ethical obligation to notify a sexual or needle sharing contact rests with the infected individual. However, if the patient does not raise the issue of partner notification then it is the responsibility of the health adviser or doctor involved to do so. It is important that patients are not coerced into revealing names of partners for the purpose of contact tracing.

It is important to note that some potential patients may feel wary about using services and seeking HIV testing where HIV partner notification is being practised in such a way that it may undermine the confidentiality of patients and their contacts. This may discourage testing and potentially stop some patients from accessing the service.

The Department of Health Guidelines on Partner Notification for HIV infection state that:

"Clinic attendees have a right to expect to be treated sensitively and not to be put under undue pressure to notify partners or to agree to provider referral. There is also the danger that if there is a perception that patients are put under pressure to reveal names of partners then those at risk might be deterred from coming forward."

5

It is recommended every newly diagnosed HIV antibody positive patient tested in a clinic be referred to the health advisers. It is good practice also to offer referral to the health adviser to patients known to be HIV antibody positive transferring their care from other clinics. The health adviser needs to record in the patient's notes that the issue of partner notification has been raised and the outcome of the discussion (See chapter 14: HIV testing and management).

If the patient declines to see the health adviser, it is recommended the doctor raise the issue of partner notification with the patient and record this in the notes.

It is considered good practice to address partner notification in the post-test session following an HIV antibody positive result. Most patients will themselves raise partner notification at this point but may need time to consider how to inform current or past contacts. In the initial post-test discussion the priority is to respond to the patient's immediate concerns and if partner notification is not raised in this session, the health adviser needs to ensure partner notification is addressed in subsequent sessions.

Where patients are under ongoing HIV care, it is important to regularly discuss partner notification, as there may be additional partner(s)/ contact(s) identified over time.

The patient is usually the best person to notify his or her sexual and/or needle sharing contact(s) and the health adviser needs to support and assist the patient in informing his or her contact(s) in practical terms, such as rehearsing discussions, working out possible strategies and using role play to enable the patient to feel more at ease in talking to their contact(s). A thorough discussion will take place with the index patient about possible negative implications for themselves and contact(s) if a third party were to be involved in notification.

When the patient feels unable to inform his or her contact(s) the health adviser can offer the facilities of provider referral. This may be carried out by:

- The health adviser offering to inform the contact(s) in the presence of the index patient, or to be available within the clinic when the index patient informs the contact
- The health adviser informing the contact(s), ensuring the index patient's identity remains confidential

If the health adviser carries out the partner notification, it is essential the privacy and confidentiality of the index patient is ensured at all times. The index patient's identity and sexuality will not be revealed to the contact(s) being notified unless the index patient requests the contact be told their identity. Confidentiality is first raised in HIV pre-test discussion and is reiterated at the time of post-test counselling. Likewise, the outcome and result of the contact(s) notification cannot be revealed to the index patient.

Where the index patient already has an established relationship with one health adviser or doctor it may be more appropriate for another health care worker to carry out provider referral. To avoid the risk of the index patient meeting a contact in the GUM clinic, it may be more appropriate in some cases for the contact to be seen in another GUM clinic. It is important to point out to the index patient who requests or accepts the offer of provider referral that their contact(s) may be able to deduce their identity, and that they may also feel frustrated and anguished in not knowing the outcome of the provider referral.

At all stages of provider referral, a senior health adviser and consultant are to be involved. If there are concerns about offering or carrying out provider referral, it is essential to discuss each case on its own merit to decide whether provider referral is appropriate, for example if there may be significant harm to the index patient and/ or their contact(s). Any decisions taken would be clearly documented in the index patient's notes.

Once the contact of provider referral attends the clinic and is seen by a health adviser, it is recommended they be informed they may have been in contact with HIV infection. Some clinics have avoided doing this explicitly out of desire to safeguard the confidentiality of the index patient. It is however crucial that the contact is given sufficient information to make an informed decision to test or not. Explanation is required that the index patient's identity and sexuality cannot be divulged - unless the index patient has given consent.

It is good practice for the health adviser to offer pre-test HIV discussion for all such contacts as well as full sexual health screening.

It is important HIV partner management be monitored and evaluated and therefore subject to periodic review.

If the patient definitely does not wish to inform their own contacts or not use the system of provider referral they will continue to be treated and cared for without prejudice.

Where there is an ongoing risk of HIV transmission to a contact, and the contact is unaware of the patient's HIV positive status, there may be different legal and ethical considerations, for example current case law on wilful HIV transmission where the risk to an individual may outweigh the confidentiality of the index patient. It is essential the health adviser discuss such cases with their senior/ manager and the consultant who will decide an appropriate course of action including taking specific General Medical Council medical professional guidance on how to manage the patient. The General Medical Council on giving information to close contacts states that:

“you may disclose information about a patient, whether living or dead, in order to protect a person from risk of death or serious harm. For example, you may disclose information of a known sexual contact of a patient with HIV where you have reason to think that the patient has not informed that person, and cannot be persuaded to do so. In such circumstances you should tell the patient before you make the disclosure, and you must be prepared to justify a decision to disclose information.”⁶

HIV partner notification can bring up difficult socio-legal and ethical dilemmas, which this chapter has tried to address. It is important to remember that patients receiving an HIV positive diagnosis may have many issues to consider, including the initial shock and adjustment. Therefore partner notification needs to be dealt with in a non-threatening and sensitive manner, which may take more time over several sessions. Please refer to Ch 14 on HIV testing and management, Ch. 5 on Partner Notification: Ethics and Ch. 23 Ethical Issues for further guidance.

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Partner notification: ethical issues

GILL BELL

The potential conflict of interests between patients and contacts can make partner notification ethically challenging. This section considers some of the ethical choices that may have to be made.

INTRODUCTION

The dilemmas health advisers face in balancing simultaneous duties (to the individual patient, to the contact of infection and to the wider community) are felt most keenly in relation to partner notification. The conflict of interest between parties makes it difficult to a) respect the autonomy of all individuals, b) do good for everyone concerned, c) avoid harming anybody and d) treat all fairly. The issues covered here are not exhaustive, but are representative of the range of concerns to be addressed.

Guidelines for the management of ethical issues can be found in chapter 23: Ethics, where concepts such as *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* are discussed in more detail.

SHOULD PRESSURE BE APPLIED TO THE INDEX PATIENT?

The principle of voluntary co-operation with partner notification enshrines a commitment to patient autonomy.¹ Unless the patient is willing to inform a contact, or allow the health adviser to do so, the contact may not be made aware of his or her risk. Yet it could be argued that, ethically, the contact has a right to know, and the health adviser has a professional duty to ensure s/he is informed.

So should pressure be applied to the index patient? If so, how much? Is 'encouragement' acceptable? What about 'persuasion' or 'strenuous advice'?

Obviously it would be unacceptable to bully, threaten or blackmail patients. However, there is often a fine line between encouragement and coercion. Arguments against applying pressure would be that it violates autonomy and breaches the tacit contract of voluntary participation. It may also be counter-productive from a public health point of view because people who have felt coerced into giving names or permission to notify may avoid health advisers in

future, or give false information. They may even advise friends to do the same! The control of sexually transmitted infections (STI) depends upon having accessible and acceptable services, so any actions that alienate potential users may be counter-productive in the long-term.

An argument for applying pressure might be that there is a duty to protect the interests of the contact, who may be at risk of significant harm. There is also a duty to protect the community from possible further transmission. From this perspective the health adviser may have a duty to negotiate strenuously on behalf of others.

The degree of anticipated harm may influence the amount of pressure that could be justified: for example, there would be a greater duty to advocate on behalf of a pregnant syphilis contact than a contact of trichomoniasis.

CAN HEALTH ADVISERS LIE?

The need to tell the truth is upheld by most ethical codes, either because it is an absolute moral principle in its own right, or because it is a condition of autonomy upon which moral value rests, or because it is a social convention that is likely to maximise benefits over harm.

Trust in health professionals depends partly upon public confidence that practitioners will tell the truth, or at least avoid telling lies. Jeopardising patient trust by telling a lie may have far reaching consequences because all aspects of health care depend upon trust between patient and practitioner.

However, there are situations where telling a lie may protect the patient or contact from harm. For example, when undertaking provider referral there is always the risk of encountering a third party, such as a parent or regular partner. Most health advisers will try to avoid arousing suspicion by, for example, adopting a telephone manner that assimilates the way a friend, or a business contact, might sound. However, there are occasions where actually telling a lie, (claiming to be a customer, a friend, a work colleague, a school nurse) might protect the contact better.

A justification for such lies might be that they honour an overriding duty to protect the person's confidentiality, without really harming anybody. Confidentiality is a fundamental principle of sexual health care: it makes services safe to use, and subsequently contains community levels of STIs.

Patients would not agree to provider referral unless they were confident that this would be done discreetly. Contacts may be less willing to attend clinic if being notified caused them difficulties. The overriding need to protect participants may justify a lie that appears to do much more good than harm.

On the other hand there is the danger of being 'caught out' with an implausible lie, which sometimes may cause greater problems. Other objections to lying may be that it is unprofessional, or against the health adviser's personal principles.

SHOULD HEALTH ADVISERS COLLUDE WITH LIES TOLD BY OTHERS?

Suppose an HIV positive man, diagnosed some months earlier, promises to bring his partner for testing providing the health adviser colludes with his story that he is also being tested for the first time on the same day. He agrees that he will then tell the partner his result, regardless

of the partner's HIV status. A refusal to collude would jeopardise the partner's access to health care if positive, or ability to avoid future risk if negative. However, agreeing to collude involves the health adviser in a serious deceit: if the truth were to emerge in the future, the trust between the partner and the service could be damaged. Public confidence in health professionals might be undermined.

SHOULD CONTACTS WHO FAIL TO ATTEND BE REMINDED?

If a notified contact fails to attend clinic as agreed, should the health adviser approach the person again? Arguments against might be that the clinic has fulfilled its duty to inform, and the individual is now responsible for him/herself. Further reminders could be perceived as harassment, and may alienate people from using the service or co-operating with partner notification in future.

Others would be in favour of follow-up to establish the reason for non-attendance in an attempt to make the service more accessible to that individual. Contacts may need a second chance, or more information about the tests, or reassurances about confidentiality. There is also a duty to the community to minimise the incidence of infection. There is evidence that contacts who attend following a reminder have higher rates of infection than contacts who were informed only once (69% v 49%).²

SHOULD CONTACTS BE NOTIFIED WITHOUT PATIENT CONSENT?

Should the health adviser inform a contact against the index patient's wishes, if the identity of the contact is known?

Arguments against would emphasise the risks of breaching trust and jeopardising confidentiality in situations where the contact's only recent partner was the index patient. The patient may be placed in danger of reprisals, and the damage to the relationship between the patient and the clinic might compromise future care. The long-term damage to public health if services were mistrusted would also be a factor.

Arguments in favour would cite the contact's right to know, and the health adviser's duty to warn. The degree of duty to contacts is controversial: some health advisers have expressed the view that it is the patient, not the clinic, who has the ultimate duty to warn the contact.^{3 4}

There is also a view that there is a greater duty to warn contacts that are also registered as patients of the service, because a direct contractual duty of care is then invoked. However, it could be regarded as inequitable for some contacts to have more rights than others to the same health warning. Failure to notify might itself be seen as a breach of public trust: it would not be unreasonable for a citizen to assume that health advisers would inform them directly of known specific avoidable health risks.

Other reasons for notifying the contact would be to limit the damage caused by untreated infection, and to protect the community from onward transmission.

SHOULD CONTACTS BE INFORMED OF FUTURE RISK?

Sometimes the contact is unaware of his or her ongoing risk of acquiring an incurable infection, such as HIV, from a regular partner. To warn the contact would inevitably breach

the index patient's confidentiality, and damage the trust required for optimal care. Such a policy may undermine public health by discouraging HIV positive individuals from using the service, or acknowledging the existence of uninformed partners. On the other hand there is a pressing duty to inform known individuals of a serious avoidable health risk, and prevent further transmission.

CONCLUSION

There are complex ethical issues that need to be considered during partner notification. It is good practice to discuss difficult choices with colleagues, and document the reasons for the decisions made.

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Partner notification: audit

GILL BELL

Audit provides insight into what works well and what needs to change. This section considers how partner notification might be audited.

INTRODUCTION

Audit involves the systematic evaluation of resources, practices and outcomes against agreed standards, with a view to improving the quality of service. As a central requirement of Clinical Governance, audit must receive priority.¹

BENEFITS OF AUDIT

Audit can help health advisers to optimise partner notification outcomes by revealing the following:

- **The effectiveness and efficiency of different procedures at local level**
Tasks will be performed with greater confidence and commitment if there is objective evidence that they are worthwhile. The best use can be made of existing resources by prioritising the most effective activities.
- **The need for additional resources**
Audit findings can provide the evidence base for a case of need.
- **The need for better liaison**
Audit may draw attention to difficulties within the multidisciplinary team, or between clinics.
- **Achievement**
The feedback provided by an outcome audit may increase motivation, morale and job satisfaction.

AVOIDING THE PITFALLS

Good design and analysis are essential to ensure that the audit process does not mislead or demotivate. Support and guidance may be available from the local audit department, or medical colleagues. Difficulties may be minimised if health advisers are directly involved in all stages of partner notification audit.

GENERAL GUIDELINES FOR AUDIT

The following considerations may be useful:

- **Topic selection**

Priority would be given to aspects of the process where there are concerns about effectiveness, efficiency or acceptability.

- **Design**

Beginning with clear, precise questions will help to identify the types of data needed. (For example: ‘What proportion of patients with x infection are seen by the health adviser?’ ‘What proportion were referred?’ ‘What were the reasons for non-referral?’ ‘What proportion refused?’ ‘What proportion failed to wait?’). The methodology selected would be able to produce reliable and valid information: retrospective case-note review is only appropriate if all required information is likely to have been documented in all cases; prospective studies, on the other hand, may mislead because staff behaviour can be influenced by the monitoring process. The data collected would be able to identify need for change.

- **Data collection**

Piloting the audit tool will check that there is a place to record all findings. A “not known” option is useful to indicate missing data. The person(s) recording the data needs to be adequately prepared. There may be a risk of bias if the recorder has a vested interest in a particular outcome.

- **Data analysis**

The process and outcome standards recommended below are measured using simple mathematics, and are manageable by health advisers. The local audit department or medical colleagues may be able to help if more complex analysis is required for locally designed audits.

- **Data interpretation**

To avoid the risk of bias and/or subsequent conflict, a representative of all affected staff groups would be involved in discussion.

- **Recommendations**

These would reinforce practices that are working well and identify areas where change may bring improvements.

- **Action**

Findings would be fed back to all concerned and recommendations acted upon.

- **Re-audit**

Further audit would be required to assess whether the implemented changes have been effective.

Inadequate resources may adversely affect partner notification outcomes. ²

The Society for Sexual Health Advisers (SSHA) recommends the following levels of provision:

- **Staffing levels**

The Health Adviser's Working Party for the DH ³ recommends that:

- All GUM clinics should have health advisers
- There should be no single-handed health adviser posts
- There should be at least one health adviser per consultant

- **Staff training**

The need for systematic health adviser training has been recognised by The national strategy for sexual health and HIV ^{4 15} and is currently under review. Members of SSHA have access to an annual conference and regional study days.

- **Staff support**

Access to regular management and clinical supervision is recommended. Opportunities to discuss difficult aspects of their work with other health advisers and a consultant physician may also be beneficial.

- **Interview rooms**

A minimum of 0.5 suitable rooms per health adviser is recommended to minimise patient waiting times.

- **Office accommodation**

At least one designated health adviser office is required for administration and storage.

- **Telephones**

An ex-directory line is needed to safeguard confidentiality. In addition to this, at least 0.5 telephones per health adviser are required to liaise with colleagues and respond to requests for information, advice or urgent appointments. A cordless phone is useful to permit movement between quiet areas for sensitive discussion and a computer terminal for booking appointments. A mobile phone is required for safety during home visits.

- **Answer machine**

An answer machine on the ex-directory health adviser line will reduce the number of missed calls from patients, contacts or other clinics.

- **Desk spaces**

To ensure adequate record keeping and organisation, each health adviser needs their own desk space.

- **Computerised population data and health records**
Databases may provide addresses and telephone numbers to facilitate provider referral. Access to a terminal is recommended.
- **Internet and email facilities**
An internet facility provides access to relevant data; email assists communication with colleagues, patients and contacts. Access is recommended for all health advisers.

PROCESS AUDIT FOR PARTNER NOTIFICATION

Examining and evaluating the partner notification process may indicate ways of improving efficiency and outcomes. It is essential to be sure that the best use is made of resources, that the methods used are locally effective and that time is not being wasted on unproductive activities.

The following standards for good practice offer suitable criteria for auditing the partner notification process:

Table 6.1

Standards for good practice in partner notification

- Patients with gonorrhoea, chlamydia, syphilis, hepatitis or HIV are referred to a health adviser to discuss partner notification on the day of diagnosis
- Reasons for non-referral or patient refusal are documented
- Patients referred to a health adviser to discuss partner notification are interviewed within 15 minutes
- Provider referral is offered to all patients who may have difficulty notifying partners themselves
- Provider referral agreements are acted upon without delay
- Assistance with provider referral is requested of the nearest clinic, if the contact lives outside the area
- Provider referral is performed at the request of another service, if the contact lives in the locality
- Patients who elect to notify their own partners are followed up to monitor progress. The offer of provider referral is repeated if difficulties are experienced
- The index patient's clinic is informed of contact attendance as soon as possible, by phone or return of the contact slip
- Documentation is accurate and complete
- Verification of contact attendance is sought where possible
- The partner notification process is acceptable to index patients
- The partner notification process is acceptable to contacts of infection

OUTCOME AUDIT FOR PARTNER NOTIFICATION

Partner notification outcomes give some insight into the effectiveness of the strategy at local level. However, outcomes can not be taken as a proxy measure of health adviser performance:

variable local factors, including population demographics and mobility, sexual mixing patterns and local service provision all influence the success of partner notification.⁵

Outcomes measures alone do not indicate whether, or how, performance can be improved. These insights are provided by process audits.

RECOMMENDED STANDARD FOR PARTNER NOTIFICATION OUTCOMES FOR GONORRHOEA AND CHLAMYDIA

This standard has been selected in conjunction with the MSSVD/AGUM Clinical Effectiveness Group. It is based on aggregate findings from recent UK partner notification studies.⁶ There is insufficient evidence to recommend a specific standard for partner notification outcomes for syphilis, hepatitis or HIV. Annual outcome audits are recommended.

Standard: At least 0.5 contacts per case of gonorrhoea or chlamydia will be verified as having attended within 90 days of the first health adviser interview

Definitions

'Case'

Includes cases diagnosed elsewhere but referred to GUM for partner notification and/or post treatment review. Includes cases that initially presented as contacts. Positive results at test of cure are counted as additional cases unless treatment failure is suspected.

'Contact'

A person who has had sexual contact with an infected partner during the recommended look-back period. Contacts named by more than one case will be counted more than once.

'Verified attended'

Attendance is noted from in-house records, or confirmed by a health care worker from another service.

Achievability

The standard of 0.5 contacts per case is achievable for the vast majority of services, although local allowance will need to be made for clinics that serve very mobile populations with a high rate of partner change. Clinics serving stable populations might expect to exceed this target by at least 50%

Time span

The time span of 90 days is deliberately generous to allow all successes to be counted. In practice there will be an emphasis on securing contact attendance as soon as possible. The majority of contacts are expected to have attended within 4 weeks.

Verification

Attempts to verify attendance are recommended because patient reports may be unreliable. However, this may be difficult when the partner has attended a GP, or an unknown clinic. A separate record of the additional number of contacts whose attendance was reported but not verified might be useful, although these would not be counted in the above total.

CONCLUSION

Regular audit of partner notification methods and outcomes is essential to ensure interventions are as effective and efficient as possible at local level.

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Partner notification: further research

CHRIS FALDON

Partner notification in health advising has evolved over a substantial period of time and is largely dictated by custom and practice. Several aspects of partner notification lend themselves to closer scrutiny. Sexual health advisers need to do much more research. This will increase the knowledge base to strengthen and guide professional activity.

INTRODUCTION

A debt of gratitude is owed to previous generations of health advisers (previously known as medical almoners and contact tracers). Many endeavoured to establish rigorous methods that respected the rights of patients and contacts to a sensitive and confidential service. There is however a genuine desire within health advising to critically examine practice in order to refine policies and procedures. The commissioning of a literature review by SHASTD in order to encourage research is testimony to this.¹

Earlier in the manual a hierarchy of evidence and a grading of recommendations² is presented. In the realm of patient care, it is implicit in evidence-based medicine that two basic principles are respected:

- Evidence alone is insufficient in itself to make clinical decisions
- A hierarchy of evidence sets out to guide decision-making³

Not all health adviser work will easily fall under the spotlight of the research scientist and indeed in some areas this would be wholly inappropriate. It is also acknowledged that methodological pitfalls abound when undertaking research into the sensitive and largely private arena of sexual activity. Such work however is sorely needed.⁴

FURTHER INVESTIGATIONS

Areas of partner notification that would benefit from further investigations include:

Effectiveness

- Published papers pose the question of intervention efficacy and some studies report disappointing results.^{5 6 7} Dutch and British studies identify factors that hinder partner notification.^{8 9 10 11 12 13} Large-scale randomised controlled trials in measuring the effectiveness of alternative partner notification strategies are therefore needed¹⁴
- Casual or 'one-night-stand' partners, gay men, commercial sex worker clients, teenagers and ethnic minorities are variously cited as difficult to reach with traditional contact tracing methods. Traditional health promotion strategies with gay and bisexual men are held to have had limited impact on infection transmission. More rigorous health intervention strategies are called for.¹⁵ Partner notification takes on a greater significance in the light of such evidence. More studies looking at basic gender issues in partner notification are needed¹⁶
- There is scope for 'triangulated' methods to be employed in this area. This term is used in a research context to describe the use of a variety of data sources or methods to examine a specific phenomenon either simultaneously or sequentially in order to produce a more accurate account of the phenomenon under investigation. It would be interesting to explore variables such as gender, sexual orientation, diagnosis, relationship status and age on partner notification outcomes. Qualitative studies can bring a richness and depth to data collected through quantitative designs. Major limitations exist in the recruitment and retention of subjects for cohort studies. They hold potential nevertheless to capture outcomes other than attendance rates and diagnosis. They would make a unique contribution to our understanding of the long-term impact of partner notification

Operational issues

- The design and use of the 'contact slip' to facilitate and record attendance needs more research
- Communication pathways between clinic professionals to ensure more effective contact tracing could be examined
- A follow-up telephone call to index patients about partners has been shown to be effective (*Evidence III*).^{17 18} How widespread is this? What other measures do health advisers adopt to follow up patients that may only attend once?
- Comparing methods of contacting partners such as by letter, home visit, email would be useful

Health adviser resources

- The National strategy for sexual health and HIV acknowledges that the health adviser role needs to be strengthened and their numbers increased.¹⁹ A casualty of depleted resources is all too often research and audit activity. Just how much is done by health advisers and yet never gets published? It is not known
- Studies of partner notification for gonorrhoea have associated health adviser resources with outcomes. A contact is less likely to attend when the index case had been diagnosed in a clinic reporting inadequate health adviser time (*Evidence*

III).²⁰ Clinics with poorer partner notification outcomes may be as a result of greater workloads, fewer interview rooms or desk spaces, and less health adviser experience.²¹ Can these results be replicated on a wider scale? Do health advisers have good access to the Internet and email and harness their potential for tracing partners? What other resource limitations hinder progress?

- What are the economic costs for various models of partner notification in the UK? We simply do not know. This would merit further investigation²²

Patient & contact attitudes

- Surveys of patient attitudes to provider referral in the USA²³ (*Evidence Ib*) and Sweden²⁴ have been favourable. There is a need for similar surveys among patients in the UK
- There is a marked lack of research into the psychosocial aspects of partner notification, such as sexual behaviour modification. No study could be found that measured the ethical consequences of alternative partner notification strategies. A longitudinal survey study to examine the impact of coming into a contact tracing programme could reveal fascinating insights as yet unrecorded by researchers
- Practitioner research in this area is to be encouraged due to their 'insider' position of easier access to patients. However, studies from an 'outsider' perspective would hold merit, especially if traditional attitudes and values are to be confronted or service user views are sought²⁵

Professional attitudes

- Professionals have been shown to conclude that contact tracing is unacceptable to certain client groups with little or no evidence on which to base their beliefs (*Evidence III*)²⁶
- Do these attitudes continue to prevail and how widespread might they be?
- Do attitudes significantly contribute to partner notification outcome variations between provincial and metropolitan clinics in the UK? Published data from both local and national audits is needed

Community health advising

- Feasibility studies into partner notification outside GUM services are required
- As more testing for chlamydia is done in primary care settings research is needed on the use of non-traditional methods of partner notification. The use of videos, leaflets, nurse counsellors and lay counsellors require further investigation.²⁷ Referral pathways for patients and their partners to a GUM specialist service from a pharmacy²⁸ or community clinic need closer scrutiny.²⁹ The use of community pharmacies and other innovative methods of ensuring partners receive empirical treatment could be looked at³⁰
- Training of personnel in more effective interviewing skills is encouraged (*Grade C*).^{31 32 33} Health professionals such as practice nurses, GP's and school nurses

are playing an increasing role in sexual health work. Evaluating their effectiveness in partner notification holds out tremendous potential for developing programmes in community settings

- Utilising the skills of youth and community workers could be investigated
- Partner notification programmes for difficult to reach groups such as young gay men, clients of commercial sex workers are recommended (*Grade C*)^{34 35}

CONCLUSION

Several aspects of partner notification invite further investigation. Health advisers are key stakeholders in the process of improving standards through the application of evidence-based research. More attention paid within the profession to facilitate research projects will prove to be invaluable. A point of reflection is to note that published research work in the UK on partner notification emanates from professionals who are not practising health advisers. This fact ought to be addressed and resources made available to reverse this trend. As time progresses and opportunities are taken to conduct more research, sexual health advisers will have greater confidence that their work is influenced by the firmer foundation of research findings than custom and practice.

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Section B

Managing sexual infections

Sexually transmitted infections

Patient recall

Ethical issues in patient recall

Triage

Ethical issues in triage

Sexually transmitted infections

CHRIS FALDON

The sexual health adviser needs to possess an excellent knowledge of the infections dealt with in Genitourinary Medicine (GUM) clinics. With this they help people make informed choices for themselves and their sexual partners.

INTRODUCTION

This chapter is a brief introduction to some of the infections and conditions dealt with in Departments of GUM and Sexual Health. Detailed information can be found in the medical literature and it is vital that health advisers keep up to date with current research findings published in professional journals.

National UK guidelines on the management of sexual infections exist and are important documents that offer a practice framework to assist health advisers in their work.¹

The recommendations for partner notification (*Grade C*) in each condition are outlined and summarised in table 8.6. In general it should be noted that:

- Some conditions merit the offer of a 'provider referral' (for definition see Ch.1 Partner notification - introduction). In such circumstances where diagnosis is made in a non-GUM setting, clear and written referral pathways to a community or clinic health adviser are recommended
- Timely treatment of sexual partners is essential for decreasing the risk for re-infecting the index patient
- Patients will require instruction to avoid sexual intercourse until therapy is successfully completed (+/- test of cure) and they and their sexual partners no longer have symptoms. In the case of chronic conditions such as genital warts this may not be desirable or practical

TERMINOLOGY

Some commonly used terms and acronyms need defining:

Sexually transmitted infection (STI) - An unqualified use of the term 'genital infections' can be misleading since infection of the rectum, throat, and conjunctiva of the eye are also common, but initial infection of other parts of the body is rare.

Sexually transmitted disease (STD) - The term 'disease' is more archaic and holds social connotations that for some can be distressing. As such in the UK the STD acronym has largely fallen out of favour.

Sexually transmissible - Describes infections and conditions that could be passed on through intimate sexual contact but can also be present independent of sexual activity such as candida, scabies, molluscum contagiosum.

Venereal diseases (VD) - A term initially given to syphilis and gonorrhoea, which were once thought to be a single disease. It emphasises the part played by sex in the spread of diseases that would not otherwise be considered as a single group. These two infections along with chancroid constitute the legally defined venereal diseases in British law.²

EPIDEMIOLOGICAL TRENDS

Not only has there been a doubling of attendances at GUM clinics over the 10 year period between 1990 and 2000 but there is an upward trend in reported cases of STIs. Between 1995 and 2000, new episodes seen at GUM clinics in England, Wales & Northern Ireland rose from 887,760 to 1,185,285.³

Table 8.1

| <i>Major groups of sexually transmitted and transmissible conditions⁴</i> | |
|--|---|
| Bacteria | Responsible for gonorrhoea, including gonococcal pelvic inflammatory disease (PID), syphilis. |
| Mycoplasmas and chlamydiae | These are bacteria but they do not have rigid cell walls - mycoplasmas can be responsible for non-gonococcal urethritis (including chlamydial) and cervicitis. <i>Chlamydia trachomatis</i> is primarily responsible for chlamydial PID. |
| Viruses | The smallest known disease-causing agents - important viral STIs include hepatitis B, and C, genital herpes, molluscum contagiosum, human papilloma virus (HPV-genital warts), and the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). |
| Fungi | Plant-like organisms - causing candidiasis (thrush). |
| Protozoa | Single-celled microscopic forms of animal life - responsible for trichomoniasis. |
| Metazoan | All other parasitic animal life forms - causing scabies and pediculosis pubis (pubic lice or 'crabs'). |

Gonorrhoea⁵

Between 1995 and 2000, uncomplicated gonorrhoea seen at GUM clinics in England, Wales & Northern Ireland increased by 102% (29% since 1999). In women, highest rates of gonorrhoea are in those aged 16 to 19 years and, in 2000, 41% of females with gonorrhoea were aged under 20. In males, highest rates are in 20 to 24 year olds.⁶

The organism *Neisseria gonorrhoeae*. Gram-negative diplococcus

Infection sites Primary- Mucous membranes of the urethra, endocervix, rectum, pharynx. More rarely- blood, skin, joints and conjunctiva

Transmission Direct inoculation of secretions from one mucous membrane to another, therefore very easily passed on through vaginal, anal and oral sex. Sometimes it only takes close physical contact to spread. There is no evidence to show that it can be passed on from toilet seats or sharing towels and cups. An infected mother can pass it on to her baby's eyes at birth. It can be spread to the eyes from the genitals via the fingers

Infection to detection period Symptoms of infection may show up at anytime between 1 and 14 days

Table 8.2

| <i>Signs & Symptoms</i> | |
|---|---|
| <i>Women</i> | <i>Men</i> |
| Infection is frequently asymptomatic (up to 50%). Increased or altered vaginal discharge is the most common symptom (up to 50%). Lower abdominal pain may be present (up to 25%). Urethral infection may cause dysuria (12%) but not frequency. Gonorrhoea is a rare cause of intermenstrual bleeding or menorrhagia. Pharyngeal infection is usually asymptomatic (>90%). | Urethral infection commonly causes urethral discharge (80%) and/or dysuria (50%). Infection can be asymptomatic (<10%). Rectal infection in homosexual men may cause anal discharge (12%) or perianal/anal pain or discomfort (7%). Pharyngeal infection is usually asymptomatic (>90%). |

Complications Spread from the urethra or endocervix to involve the epididymis and prostate in men (1% or less) and the endometrium and pelvic organs in women (probably <10%). Dissemination may also occur from infected mucous membranes, resulting in skin lesions, arthralgia, arthritis and tenosynovitis. Disseminated gonococcal infection is uncommon (<1%)

PARTNER NOTIFICATION RECOMMENDATIONS

- Patients are to be encouraged to refer sexual partners and contacts for evaluation and treatment. Offer provider referral

- Sexual contacts are to be screened and treated for gonorrhoea and chlamydia infections using the following criteria applying to the index case;
 - a. For men with urethral symptoms, two weeks before onset of symptoms
 - b. For men without symptoms and all women, twelve weeks prior to diagnosis at urethra, cervix, rectum, throat
 - c. If a patient's last sexual intercourse was greater than eight weeks before onset of symptoms or diagnosis, the patient's most recent sex partner is to be treated

Chlamydia ⁷

Between 1995 and 2000, Genital chlamydial infection seen at GUM clinics in England, Wales & Northern Ireland increased by 107% (18% since 1999). Highest rates of diagnosis are seen in young people, particularly women in the 16 to 19 and 20 to 24 year age groups.⁸

The organism *Chlamydia trachomatis* is an intracellular pathogen. Types D-K are found in genital infection henceforth referred to as 'chlamydia'

Infection sites Urethra, cervix, rectum, pharynx, conjunctiva

Transmission Principally through vaginal intercourse. Can be through anal and orogenital contact. Vertical transmission to baby during delivery

Infection to detection period 1 to 3 weeks after exposure

Table 8.3

| <i>Signs & Symptoms</i> | |
|---|---|
| <i>Women</i> | <i>Men</i> |
| Asymptomatic in approximately 80%. Post coital or intermenstrual bleeding. Lower abdominal pain. Purulent vaginal discharge. Mucopurulent cervicitis and/or contact bleeding. | Asymptomatic in up to 50%. Urethral discharge. Dysuria. The severity of these is variable and may be so mild as to be unnoticed by the patient. |
| RECTAL INFECTIONS Usually asymptomatic, but may cause anal discharge and anorectal discomfort (proctitis). | |
| PHARYNGEAL INFECTIONS These are usually asymptomatic though a sore throat can be reported. | |

Complications

- Pelvic inflammatory disease
- Fitz-Hugh-Curtis syndrome (perihepatitis)
- Tubal damage (infertility, ectopic pregnancy)
- Chronic pelvic pain (adhesions)
- Transmission to neonate (conjunctivitis, pneumonia)
- Epididymo-orchitis

- Adult conjunctivitis
- Sexually acquired reactive arthritis/Reiter's syndrome (commoner in men)
- Facilitates HIV transmission

PARTNER NOTIFICATION RECOMMENDATIONS

- Patients are to be encouraged to refer sexual partners and contacts for evaluation and treatment. Offer provider referral
- Sexual contacts are to be screened and treated for chlamydia infections using the following criteria:
 - 4 weeks prior to the onset of symptoms in men
 - 6 months, or until the last previous sexual partner (whichever is the longer time period) for all women and asymptomatic men
 - A policy of current partner and previous one (1 + 1) can be applied to chlamydia infections

Syphilis^{9 10 11}

Following nearly two decades of consistent decline in England, numbers and rates of infectious syphilis have been steadily increasing since 1997.¹² Between 1995 and 2000, infectious syphilis seen at GUM clinics in England, Wales & Northern Ireland increased by 145% (57% since 1999). Unlike most other STIs, the burden of syphilis does not fall upon young people. Rates have increased sharply in males aged 20 to 44 years old and in females aged 16 to 34 years old.¹³

The organism *Treponema pallidum*. A systemic disease

Classification Syphilis is classified as acquired or congenital

- Acquired syphilis is divided into:
 - Early** (primary, secondary and early latent. Less than 2 years of infection)
 - Late** (late latent. Greater than 2 years)
 - Tertiary** including gummatous, cardiovascular and neurological involvement

The latter two are also sometimes classified as quaternary syphilis

- Congenital syphilis is divided into:
 - Early** (first 2 years)
 - Late** (including stigmata of congenital syphilis)

Transmission Sexual transmission occurs only when mucocutaneous syphilitic lesions are present. However 46-60 % of contactable sexual partners of patients and pregnant women with early syphilis also have the infection

Incubation period Up to 90 days

Table 8.4

| <i>Signs & Symptoms</i> |
|---|
| Primary syphilis |
| Ulcer. |
| Chancres. Classically single, painless and indurated with a clean base discharging clear serum in the anogenital region. However they may be atypical and present as multiple, painful, purulent, destructive and extragenital. It may also result in a syphilitic balanitis. |
| Regional lymphadenopathy. |
| Secondary Syphilis |
| Multisystemic involvement within the first two years of infection. Generalised polymorphic rash often affecting the palms and soles. It is classically non-itchy but may be itchy, particularly in dark-skinned patients. Condylomata lata, mucocutaneous lesions, generalized lymphadenopathy. Less commonly, patchy alopecia, anterior uveitis, meningitis, cranial nerve palsies, hepatitis, splenomegaly, periosteitis and glomerulonephritis. |
| Tertiary Syphilis |
| Cardiac, neurologic, ophthalmic, auditory, or gummatous lesions. |

PARTNER NOTIFICATION RECOMMENDATIONS

- Patients are to be encouraged to refer sexual partners and contacts for evaluation and treatment. Offer provider referral
- Transmission is uncommon after the first year of infection. However, persons exposed sexually to a patient who has syphilis in any stage needs to be evaluated
- The time periods for identifying at-risk sex partners are:
 - 3 months plus duration of symptoms for primary syphilis
 - 2 years for secondary syphilis and early latent syphilis

Non-specific urethritis (NSU) ¹⁴

Cases of uncomplicated non-specific infection seen at GUM clinics in England, Wales & Northern Ireland from 1990 to 1999 have remained fairly stable. 58,528 in 1999. ¹⁵

The causes

- *Chlamydia* (30-50% of cases)
- *Ureaplasma urealyticum* (ureaplasmas) and *Mycoplasma genitalium* (10-20% of cases respectively)
- *Trichomonas vaginalis* has been reported in 1-17% cases
- *N. meningitidis*, *herpes simplex* virus, *candida albicans*, bacterial urinary tract infection, urethral stricture and foreign bodies probably account for only a small proportion of cases (<10%)
- A possible association with bacterial vaginosis exists
- Between 20-30% of men with NSU have no organism detected. Urethral stricture, mechanical trauma and foreign bodies may play a small part

Signs & symptoms Urethral discharge, dysuria, penile irritation, asymptomatic

Complications Epididymo-orchitis, sexually acquired reactive arthritis / reiter's syndrome. These are infrequent, occurring in fewer than 1% of cases though incomplete forms may be more common

PARTNER NOTIFICATION RECOMMENDATIONS

NSU may play a role in the 40-60% of cases PID where the cause is unknown. Patients are to be encouraged to refer sexual contacts for evaluation and treatment. Provider referral may be offered.

Sexual contacts are to be screened and treated for uncomplicated chlamydia infection using the following criteria:

- 4 weeks prior to the onset of symptoms in men
- 6 months, or until the last previous sexual partner (whichever is the longer time period) for asymptomatic men
- Ideally, contacts details ought to be obtained at the first visit along with consent to contact either the patient or his partners if tests for chlamydia or gonorrhoea are found to be positive. This will greatly facilitate partner notification

Trichomonas ¹⁶

Between 1990 and 1999, trichomoniasis in men seen at GUM clinics in England, Wales & Northern Ireland has doubled but remained fairly static in women.¹⁷

The organism Trichomoniasis is caused by the protozoan *Trichomonas vaginalis*

Infection sites Only isolated in the genital area. Vagina in women and urethra in men (most common)

Transmission Almost exclusively sexually transmitted. Male to female (and vice versa), female to female. Male to male (very rare due to site specificity)

Incubation period 5 to 28 days

Table 8.5

| <i>Signs & Symptoms</i> | |
|--|---|
| <i>Women</i> | <i>Men</i> |
| 10 - 50% are asymptomatic. The commonest symptoms include vaginal discharge (varying thickness, sometimes frothy, often yellow-green), vulval itching, dysuria, or offensive odour. Occasionally the presenting complaint is of low abdominal discomfort. 2% have a strawberry cervix. | 15 to 50% do not have symptoms of infection. They often present as sexual partners of infected women. Commonest presentation is with urethral discharge and/or dysuria. Other symptoms include urethral irritation and frequency. |

Complications Vaginal trichomoniasis might be associated with adverse pregnancy outcomes, particularly premature rupture of the membranes and preterm delivery. Rarely there may be prostatitis. It may enhance HIV transmission.

PARTNER NOTIFICATION RECOMMENDATIONS

Patients are to be encouraged to refer current sexual contacts for evaluation and treatment.

Chancroid ¹⁸

The agent: *Haemophilus ducreyi*. Rarely diagnosed in the UK (less than 100 cases per year) though it is endemic in parts of the developing world, particularly sub-Saharan Africa and Asia

Infection sites Primarily found on prepuce of penis / coronal sulcus and the vaginal introitus

Transmission Skin to skin sexual contact

Incubation period 3 to 10 days

Signs & symptoms

- Painful (more so in men) ulcer (single or multiple) at inoculation site with indistinct borders
- Multiple lesions can merge
- Purulent exudate often observed. Vaginal discharge
- Painful intercourse and defaecation
- Tender inguinal lymph nodes (often unilateral). Can swell, rupture to release purulent material

Complications Tissue loss leading to scarring. Phimosis. Facilitates HIV transmission

PARTNER NOTIFICATION RECOMMENDATIONS

- Both patient and provider referral methods are to be encouraged
- Trace all partners ten days prior to onset of symptoms

Genital Warts ¹⁹

Anogenital warts are the commonest STI diagnosed in GUM clinics. 66,044 new diagnoses being made in England, Wales and Northern Ireland in 2000. For males and females, highest rates are found in the 20 to 24 and 16 to 24 year age groups respectively.²⁰

Cause Human papilloma virus. More than 20 have been detected in the genital area. Types 6 & 11 are the most common form of visible genital warts. 99% are sub clinical and therefore go undetected

Infection sites Cervix, vagina, labia, vulva, scrotum, urethral meatus, anus, penile shaft and glans

Transmission Overwhelmingly via sexual contact. Mother to baby during delivery. More rare by fomites and digits

Signs & symptoms

- Single or multiple spots
- Soft or keratinised. Broad based or pimple
- Usually painless but some itching possible

Complications Types 16,18,31,33,& 35 have been associated with cervical dysplasia. Disfiguring. Psychological distress

PARTNER NOTIFICATION RECOMMENDATIONS

- Not routinely offered. No evidence exists that this reduces transmission or prevents re-infection
- Screening current partners for other STIs may however be beneficial

Pubic Lice (Pediculosis pubis)²¹

Between 1993 and 1999, 19% (men) and 13% (women) increases respectively were seen for infestations of scabies and pubic lice at GUM clinics in England, Wales & Northern Ireland.²²

Cause An ectoparasitic infestation with the ‘crab’ louse, *Phthirus pubis*

Infection sites Course body hair, predominantly pubic, rarely eyebrows and eyelashes

Transmission Close body contact

Signs and symptoms

- Lice and/or eggs (nits) glued to hair
- Pruritis leads to itching as a result of hypersensitivity to feeding lice. This may take several weeks to develop
- Macules (blue) may develop

Complications Nil of note

PARTNER NOTIFICATION RECOMMENDATIONS

Patient referral for partners over the preceding 3 months

Scabies²³

Between 1993 and 1999, 19% (men) and 13% (women) increases respectively were seen for infestations of scabies and pubic lice at GUM clinics in England, Wales & Northern Ireland.²⁴

Cause An ectoparasitic infestation with the *Sarcoptes scabiei* mite. The female burrows into the skin laying 2 to 3 eggs per day which take about 10 days to turn into adult mites

Infection sites Many are found on the hands and wrists but can be found almost anywhere on the body especially in skin creases

Signs & symptoms Itching (especially at night) and raw broken skin (lesions) and lumps (nodules) may occur though this may be weeks after the initial contact. This results from the sensitisation to mite excrement. Silvery lines (burrows) may be observed

Complications Crusted lesions in HIV infection can be observed and contain many mites

PARTNER NOTIFICATION RECOMMENDATIONS

Patient referral for partners over preceding 2 months

Genital Herpes²⁵

From 1990 to 1999 diagnoses of first attack genital herpes simplex virus infection seen at GUM clinics in England, Wales & Northern Ireland increased by 52% in females but remained relatively stable in males.²⁶

Cause *Herpes Simplex virus* type 1 or 2

Infection sites Genital and perianal region (including buttocks and thighs) and mouth. More rarely on nipples and other parts of skin

Transmission Almost exclusively through skin to skin contact. Only scant evidence of spread via fomites

Incubation period Commonly between 2 and 10 days

Signs & symptoms No typical presentation therefore it is often misdiagnosed. Wide-ranging primary occurrence symptoms include:

- Tingling, itching and burning sensations
- Blistering and ulceration of genital and/or perianal region
- Urethral, vaginal discharge and dysuria
- Systemic involvement causing pyrexia, fever and myalgia

Complications Autonomic nervous system involvement leading to urinary retention and meningitis. Neonatal infection rare but carries a high mortality rate and damage to brain, skin and eyes

PARTNER NOTIFICATION RECOMMENDATIONS

- Not routinely offered due to limited therapeutic clinical intervention
- May be beneficial for health education or psychological support

Molluscum Contagiosum²⁷

Between 1995 and 1999 a 66% increase in males and 81% in females with molluscum were seen at GUM clinics in England, Wales & Northern Ireland.²⁸

Cause A species of molluscipoxvirus

Infection sites Skin lesions anywhere on the body. Principally in genital area through sexual contact

Transmission Direct contact or from non-living reservoirs (fomites), such as books or clothing

Incubation period 3 to 12 weeks

Signs & symptoms Distinctive lesions. Can be pearly, popular, smooth, or indurated. Usually less than 5mm in diameter

Complications Can be unsightly and therefore cause psychological distress. Secondary infection can result

PARTNER NOTIFICATION IMPLICATIONS

- None

Viral Hepatitis²⁹ - Type A

The incidence is grossly under estimated. In 1999 notifications of hepatitis A totaled 1676 compared to 1515 in 1998.³⁰

Cause An RNA strand virus

Infection sites Systemic infection initially involving liver

Transmission Most common route of transmission is faecal-oral by contaminated food or water. Sexual transmission is more common in gay men where 'rimming' or 'fisting' is involved. It is also more likely in multiple sexual partners, group sex and 'cottaging'. Outbreaks have been reported in injecting drug users. Viraemia in acute infection is rare but can facilitate bloodborne transmission. No evidence exists that saliva is involved in transmission

Incubation period 15 to 45 days

Signs & symptoms

- Approximately 50% of adults are asymptomatic
- Can begin with malaise, myalgia, fatigue and upper right quadrant abdominal pain in prodromal phase lasting 3 to 10 days

- Jaundice can follow in the later icteric phase with associated anorexia, nausea and fatigue for 1 to 3 weeks though can persist for 3 months

Complications Chronic liver infection is very rare. It carries an overall mortality rate of 0.2%. Miscarriage and premature labour have been reported

PARTNER NOTIFICATION RECOMMENDATIONS

- Patient or provider referral offered to male homosexual contacts (oro/anal, digital/rectal and penetrative anal sex) from 2 weeks before to 1 week after onset of jaundice
- At risk non sexual contacts (household contacts, those at risk from food/water contamination) referred to Public Health Authorities/Health Protection Agency

Viral Hepatitis - Type B

Notifications of hepatitis B infection increased from 886 in 1998 and 864 in 1999 to a total of 1035 cases in 2000. Of the notifications in 2000, 636 (61%) were in males and 393. (38%) were in females.³¹

Cause A DNA strand virus

Infection sites Systemic infection initially involving liver

Transmission

- Sexual transmission responsible for the majority of cases
- More common in unvaccinated gay men and sex workers (see Hep A)
- It can also be spread though parenteral and vertical routes

Incubation period 40-160 days

Signs & symptoms Up to 50% of adults may be asymptomatic in the acute phase. After this the symptoms are very similar to Hep A infection though often last longer and more pronounced

Complications

- Chronic infection may exist in up to 10% of cases and may lead to severe liver disease
- Death can result in 1% of acute presentations often results in the premature death of 50% of chronic carriers
- Miscarriage and premature delivery is more common in infected pregnant mothers

PARTNER NOTIFICATION RECOMMENDATIONS

- Patient and provider referral offered to any sexual contact (penetrative vaginal or anal sex) or needle sharing partners from 2 weeks prior to onset of jaundice until blood tests are surface antigen negative

- Risk assessment informs partner notification for asymptomatic cases
- Arrange screening for hepatitis B of children who have been born to infectious women if the child was not vaccinated at birth
- Other non-sexual contacts thought to be at risk: refer to Public Health Authorities/ Health Protection Agency

Viral Hepatitis - Type C

Laboratory reports of hepatitis C infection have increased each year throughout the 1990s. In 1999 there was a total of 5745 confirmed laboratory reports compared to 4483 in 1998.³²

Cause An RNA virus

Infection sites Systemic infection initially involving the liver.

Transmission

- Unidentified route in many cases
- Parenteral spread through sharing injecting equipment and pre-screening test blood/products transfusions
- Sexual transmission low. Estimated less than 2% per year of year relationship. Up to 11% reported infected in long-term relationships. This increases if HIV co-exists. Seen more in HIV positive gay men and sex workers
- Vertical transmission rarely reported

Incubation period 90% infected are antigen positive after 3 months. Up to 9-month seroconversion period reported

Signs & symptoms Up to 80% asymptomatic. Early stages are similar to Hep A. Chronic cases similar to Hep B

Complications Acute fulminant hepatitis is rare except with Hep A co-infection. 50-85% become chronic carriers. These are usually asymptomatic in the absence of liver disease and high levels of alcohol intake. Pregnancy – as for Hep A

PARTNER NOTIFICATION RECOMMENDATIONS

- Patient and provider referral offered for any sexual contact (penetrative vaginal or anal sex) or needle sharing partners during period of infectivity - 2 weeks prior to onset of jaundice
- Risk assessment informs partner notification for asymptomatic cases
- Consider testing children born to infectious women
- Other non-sexual contacts thought to be at risk: refer to Public Health Authorities/Health Protection Agency

Numbers of heterosexually acquired HIV infections diagnosed in the UK have risen steadily over the last 15 years and since 1999 have been greater than the number acquired through sex between men. However, cumulatively the majority of infections have occurred through sex between men and homosexual men remain the group at greatest risk of acquiring HIV infection within the UK. ³⁴

Cause Human Immunodeficiency Virus

Infection sites Multi-system disease due to a depleted immune system eventually causes Acquired Immune Deficiency Syndrome (AIDS)

Transmission Unprotected sex, blood to blood contact and vertical spread

Incubation period Seroconversion to form detectable levels of antibodies usually takes 45 days. Three months is thought adequate in UK testing centres. Extremely unlikely to occur after this

Signs & symptoms Seroconversion can be accompanied by transient sore throat, fever, rash. Rarely meningitis observed. Asymptomatic infection can last for years prior to an AIDS defining diagnosis

Complications Opportunistic infections and tumours with wide ranging symptoms

PARTNER NOTIFICATION RECOMMENDATIONS

- Patient and provider referral offered for partners (sexual and drug equipment sharing)
- Look back period depends on risk assessment and previous testing results

CONCLUSION

It is imperative that the health adviser is fully conversant with the range of conditions that may present at the GUM clinic. Short and long term effects on sexual health will vary considerably across the infections and indeed between patients. A summary of partner notification action per infection is presented in Table 8.6

Table 8.6

| <i>Infection</i> | <i>Partner Notification Method</i> | | <i>Trace period s = symptomatic as = asymptomatic</i> |
|------------------|------------------------------------|-------------------|--|
| | <i>'Patient'</i> | <i>'Provider'</i> | |
| Syphilis (early) | Yes | Yes | 12 weeks (primary). Up to 2 years (secondary, early latent). |
| Syphilis (late) | Yes | Yes | Vertical transmission possible 10 years post infection. Symptoms of: Gummata – 2 years Cardiovascular – 10 years Neurological – 15 years |

| | | | |
|----------------|-----|----------|--|
| Gonorrhoea | Yes | Yes | 2 weeks (s) males. 12 weeks (as) males and all females or last partner if longer. |
| Chlamydia | Yes | Yes | 4 weeks (s). 6 months (females and as) or last partner if longer. 1 + 1 partner. |
| 'NSU' | Yes | Possibly | 4 weeks (s). 6 months (as) or last partner if longer. |
| Chancroid | Yes | Yes | 10 days prior to onset. |
| Trichomoniasis | Yes | No | Current partner. |
| Scabies | Yes | No | 8 weeks. |
| Pubic lice | Yes | No | 12 weeks. |
| Genital Herpes | No | No | No |
| Genital Warts | Yes | No | Screen current partners. |
| Molluscum | No | No | No |
| HIV | Yes | Yes | Risk assessment informs partner notification for asymptomatic cases. |
| Hepatitis A | Yes | Yes | 2 weeks prior and 1 week after onset of jaundice. Risk assess others. |
| Hepatitis B | Yes | Yes | 2 weeks prior to onset of jaundice and until sAg negative. Risk assess others. |
| Hepatitis C | Yes | Yes | 2 weeks prior to onset of jaundice. Risk assessment for asymptomatic cases. |
| HIV | Yes | Yes | Depends on a thorough risk assessment and previous testing results. |

A good knowledge of these infections will assist in the partner notification implications that arise for the vast majority.

FURTHER READING - USEFUL INTERNATIONAL SOURCES

USA Guidelines

Sexually Transmitted Diseases Treatment Guidelines. 2002 Recommendations and Reports May 10, 2002 / Vol. 51 / No. RR-6 Centers for Disease Control and Prevention
<http://www.cdc.gov/std/treatment/rr5106.pdf> (Accessed 10th Nov 2002)

World Health Organisation

Global Prevalence and Incidence of Selected Curable Sexually Transmitted Infections: Overview and Estimates. WHO/CDS/CSR/EDC/2001.10 <http://www.who.int/emc-documents/STIs/docs/whocdscsredc200110.pdf> (Accessed 10th November 2002)

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 - 13 Public Health Laboratory Service. Op Cit. p4
 - 14 Clinical Effectiveness Group (Association for Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases). National guideline on the management of non-gonococcal urethritis. Horner P J, Shahmanesh M. www.mssvd.org.uk/PDF/CEG2001/NGU%2009%2001c.PDF (accessed 8th November 2002).
 - 15 Public Health Laboratory Service. Op Cit. p15
 - 16 Clinical Effectiveness Group (Association for Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases). Sherrard J. 2001 National guideline on the management of trichomonas vaginalis. <http://www.mssvd.org.uk/PDF/CEG2001/trv%200601.PDF> (accessed 8th Nov 2002)
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Patient recall

KATHRYN LEE

Effective management of a recall system for patients with a sexually transmitted infection will ensure that the infection is treated as soon as possible. This will prevent further medical complications and reduce the risks of transmission and re-infection.

INTRODUCTION

The aim of this chapter is to act as guidance in the recall of patients requiring treatment, further screening or medical follow up. These guidelines are not exhaustive but allow the health adviser to work to nationally agreed standards and provide quality patient care. Recall cannot be prescriptive, but requires the health adviser to exercise his/her judgment. It is also important to acknowledge that health advisers may be guided by local protocols, as responsibilities will vary within individual teams. Discuss uncertainties with a consultant, who is ultimately responsible for medico-legal decisions about care.

THE AIMS OF RECALL

Effective recall management plays an important role in streamlining the services provided by a clinic. Responsibility usually lies with the health adviser to recall patients for:

- Antibiotic treatment
- Diagnosis discussion
- Test of cure
- Repeat screen following incubation period
- Hepatitis vaccine and post vaccine serology
- Cytology
- Colposcopy
- Partner notification

RECALL FOR TREATMENT

The aim of the recall of patients with a sexually transmitted infection is to treat the infection as soon as possible in order to:

- Prevent further medical complications
- Reduce the risk of transmission
- Reduce the risk of re-infection to the index patient and partners

Clinics need locally agreed protocols for the management of positive results. These protocols will ensure that the health adviser is made aware of any positive results requiring action as soon as the results are returned to the clinic.

GENERAL INFORMATION ON CONTACTING PATIENTS

The best method of contacting individuals is best established at their first appointment. Patients should be prepared for the possible need for correspondence and asked how they would prefer to be contacted. The agreed address, telephone numbers (both landline and mobile) or e-mail address is to be recorded. Patients wishing to be contacted by telephone are to be asked whether it is also possible to write to them: this is helpful in case a mobile phone becomes unobtainable.

Document if patients less than 16 years of age can be contacted via a social worker, school nurse, youth worker or adult relative. For patients who don't speak English, permission may need to be sought for the interpreter to contact them by telephone, in which case these details ought to be recorded in the case notes. Prior to contacting a patient it is worth checking to see if they have an appointment booked. Unless urgent action is required it may be appropriate to wait until they attend.

No action is to be taken until the notes have been assessed. It is important to take into consideration the patients living arrangements and relationship(s), as the method of recall chosen could potentially breach confidentiality.

MOBILE PHONES

Mobile telephones can be extremely useful and are recommended as the first line approach for recall. This is often the quickest and most effective way of contacting patients (it is essential that these details be obtained when the patient is registered at the clinic). This method of recall often allows a greater degree of independence and privacy and gives the health adviser opportunity to contact a patient during the working day without potentially breaching confidentiality at home. Mobile phones can be especially useful when recalling young people as the autonomy they allow reduces the risk of parental interception.

TELEPHONE CALLS

Management of phone calls

- Telephone numbers that have not been supplied by the patient can often be obtained from:
 - BT directory enquiries

- The hospital Patient Administration System (PAS)
 - Internet services, such as 192.com
 - The general practitioner (GP)
 - The referring agency - for example, the family planning service
- If the patient has not specified which phone number to use, check the occupation and home circumstances to assess whether home or work is more appropriate to call. If it is necessary to leave a message on an answer phone, then be discreet: leave only a first name and a telephone number.
 - Consider the gender and age of the person: ideally the health adviser making the phone call is the team member who is least likely to arouse suspicion if a partner or parent intercepts the message.
 - Think about which telephone number you leave, it may be better not to give the reception number in case someone else rings back and learns of the patient's attendance at the clinic. An ex-directory line in the health adviser's office is an essential resource to protect confidentiality. Staff answering this particular phone ought never disclose its location and answering machine messages on this line are to be discreet.
 - Brief colleagues if you are expecting a patient to call: an alphabetical index file of expected callers, kept by the ex-directory phone, is a useful system for large teams.
 - Always check the persons' date of birth and confirm the date they attended before disclosing any information. If you are unsure that you are talking to the right person, ask for a description of the doctor seen.

When telephone calls fail

If the phone number is unobtainable, or there is no response to an answer phone message after three days, seek an alternative telephone number from one of the sources listed above, or consider a letter.

LETTERS

The advantage of sending a letter is that it can give full information in potential privacy. Disadvantages include delay, the risk of the letter not reaching the person, the risk of mail being opened by a third party, or the risk of the person being questioned about the contents of a letter. Again, it is good practice to agree on the best method of contacting the patient during clinic attendance.

Management of letters

When sending letters it is considered good practice to check that the person has agreed to written correspondence and consider the following:

- To protect confidentiality, use the person's full name, not initials
- Use an ordinary stamp rather than a hospital frank

- Consider whether, in the patient's circumstances, an ordinary hand written envelope is more or less likely to arouse third party suspicion than a buff envelope with a typed address
- Consider the benefits and risks of marking the letter "Private and Confidential": for some patients this may be protective; for others it can provoke questioning from a partner or parent
- Send all correspondence on Trust headed paper although the departmental heading may be excluded in circumstances where it would arouse significant suspicion from a third party
- Avoid sending letters on Friday as this may cause unnecessary anxiety
- If a person cannot read English, it is possible to get letters translated. However this can involve considerable delay and is expensive, it may be better to ask an interpreter to ring the patient, preferably by prior arrangement
- Wait one week from sending the letter before taking any further action, if any is required. Before sending a second letter check and confirm the address. If the GP details are available it may be possible to ask the surgery to confirm the address. (see 'When Recall Fails')
- Response to a letter can often be slow, so if a telephone number is available it may be more effective to phone first

When letters fail.

If there has been no response to communications sent by post then consider the following:

- Check that the address exists in the postal address book (supplied free of charge by the Post Office) or A-Z
- Compare details with the GP's surgery. It may be possible that the surgery has a more recent address. It is possible to gain this information without jeopardising the patient's confidentiality for example: "I am a healthcare worker from North Manchester General. We need to recall one of Dr (GP's name) patients. Could we check if they have changed their address?"
- Volunteer full details, including name, known address and date of birth to allay suspicions. If the practice receptionist wishes to ring back, to check that the call is legitimate, give the main hospital switchboard number and your own personal extension. This is better than giving the GUM reception number, where the location would be disclosed
- If the GP details are unavailable contact the local source of patient data
- If the known address is council accommodation, the town hall/neighbourhood offices may confirm whether the person is still resident, or has left a forwarding address
- If the patient is a student, the college office may forward their mail

- If the known address is sheltered accommodation staff may agree to forward their mail
- Negotiate access to a computer database such as hospital PAS, this may give an alternative address
- Consider a registered letter or visit (see below)

E - M A I L

E-mail can be a valuable way of communicating confidentially and efficiently with patients, there needs to be a category for these details on the registration form and permission to use this method should be sought during the patient's first visit. This is also a convenient way of resolving partner notification. It is important to establish whether this is a personal address, as this may influence the content of the correspondence.

R E G I S T E R E D L E T T E R S

Individual Trusts may allow health advisers to use this facility, although obviously it is more expensive than sending standard correspondence. However, sending a registered letter is a more cost-effective alternative to a home visit. This method of contacting patients clarifies whether the letter has reached the intended person or not. Sending correspondence via registered post emphasises to the recipient the seriousness of the matter. If the letter is not returned then one must presume that it has been successfully received. In some circumstances the patient may choose not to collect the letter, if it is returned to the clinic this ought to be documented in the case notes.

V I S I T S

If it has not been possible to establish contact with the patient by letter or telephone, and the risk to health is significant, it may be necessary to consider a home visit. Visits can generally be undertaken as a last resort because they are intrusive, time consuming and a potential risk to staff safety. However, they may be necessary if the patient requires an interpreter or signer, and a telephone translation service cannot be used. Benefits of home visits include the opportunity to discuss, face to face, the importance of re-attendance, and to address any difficulties that are preventing the patient from returning.

The fact that a health worker has taken the trouble to visit may, in itself, persuade the patient that the matter is too important to ignore.¹ It may be possible to ensure attendance by offering to take the patient back to clinic and arrange for them to be seen immediately. If the person is no longer at the address, a current resident may know how they can be contacted. Finding that the premises are empty indicates the need to seek an alternative address (see "When recall fails").

Visits are usually only undertaken within the clinic catchment area. If a patient lives nearer to another clinic, then the local health adviser may be able to do the visit. This will need to be discussed with the neighbouring clinic and may depend on staff resources. Some clinics may prefer to hand deliver a letter from the clinic where the patient was initially seen. If you are asked to do a visit by another clinic, then this may need to be discussed with the consultant. Not all services may be able to justify this use of resources.

Management of home visits

When undertaking a home visit it may be useful to consider the following:

- Check with the GP that the address is the most recent one available
- Consider who is best-placed to do the visit, in view of the patient's age and gender. For example, a female health adviser or a school nurse may be more appropriate for an underage female patient
- Take a prepared letter in a sealed envelope to post through the door or hand to a third party, in case the person is not available
- Take a mobile phone in case difficulties are encountered or appointments need to be booked. This also allows colleagues to make contact to check your safety
- Carry hospital identification to reassure the patient that the visit is legitimate
- Inform office colleagues of the planned visits and route. Reporting back to the office when visits have been completed lets colleagues know you are safe
- For reasons of personal safety two members of staff would ideally undertake visits, although this is often not practical due to poor staff resources. (The second person may not necessarily be a health adviser, although if it is not in the staff member's job description to undertake work away from the hospital site, they may not be covered by the Trust insurance)
- It is recommended that the health adviser remain on the doorstep of the person's home for safety reasons. Sometimes it is difficult to manage confidentiality on the doorstep because neighbours may be within earshot. In these situations it may be appropriate to step inside, providing you are confident that the patient is alone and poses no threat. The person visiting ought to assess the situation and avoid any unnecessary risks. It is essential that the individual's identity is verified; the person is to be asked for by their full name and their date of birth confirmed. A hospital identification card ought to be shown to the patient and an explanation given
- If the patient is alone, explain the reason for the call clearly. If others are within earshot be discreet, or hand the person the prepared letter, asking him or her to phone you. Once the patient realises who the health adviser is, they may wish to discuss their situation in a more confidential environment
- Consider offering the patient a lift to the clinic if compliance with appointments is poor

A health adviser is not obliged to visit any patient, alone or in pairs, if there is a known risk to personal safety. If a patient is known to be violent, or there are other reasons why a visit may be inappropriate, discuss with the consultant physician who carries ultimate medico-legal responsibility for the patient. In difficult cases, advice may be sought from a professional body, such as the Nursing and Midwifery Council, or the Medical Defence Union. Document the reasons for the decision in the case notes.

WHEN RECALL FAILS

If the patient has consented for the department to inform the GP of their attendance, then discuss with the consultant if this is appropriate. A letter can be sent to the GP explaining that the patient has an untreated infection and that you have been unable to inform them. This would need to be written by the consultant. It is considered good practice to inform the patient of this action by letter two weeks prior to the GPs letter being sent. This gives the patient chance to contact the department and protects their confidentiality.

DOCUMENTATION

It is good practice to enter a signed and dated record of the following in the case notes:

- All health adviser actions, including unsuccessful attempts to contact the person by telephone
- The outcome of actions, including whether contact was made, what information was given, and the patient's response
- A second copy of all letters sent
- Discussion involving recall management with any member of the multidisciplinary team

RECORDING FUTURE RECALL

It is the responsibility of the health adviser to ensure that patients are recalled for future follow up and normally that there is a fail-safe system in place. Reminder letters may be sent two weeks before the patient's appointment is due. Letters sent to patients need to clearly outline the importance of attendance explaining what the appointment is for, without being too explicit in case of interception.

CYTOLOGY

Ideally clinics would have a policy whereby patients requesting cytology are asked to sign a disclaimer allowing a copy of their smear results to be sent to their GP. This enables the patient to continue to be part of the National Health Service Cervical Screening Programme (NHSCSP), which will ensure that the health authority will generate future recall. If a copy of the smear result is not sent to the GP then the responsibility for recall rests with the clinic. (See recommended actions).

The NHSCSP recommends all women should receive their cytology result within six weeks from the date the smear was taken. All women ought to receive confirmation of their results in writing. It is the responsibility of the smear taker to insure that any recommended actions as a result of the smear are followed up.²

Current practice is that HIV positive women are recalled for cytology annually although there are no current guidelines for this in the UK. If the clinic manages a caseload of HIV positive patients the health adviser may be required to ensure that all women are sent a reminder letter when their cytology is due and followed up when they next attend.

RECALL OF PATIENTS WITH POSITIVE HIV ANTIBODY RESULTS

The recall of patients who have not returned to collect positive HIVab test results should be managed extremely tentatively. Use the pre-test assessment in the casenotes as guidance as to whether the result was anticipated by the patient. If this was the only investigation performed receipt of a recall letter will almost certainly alert the patient to the results. A balance between allowing the individual the chance to come back and discuss their result and the responsibility of the clinic to inform them must be reached. It should be made clear to the patient during the pre-test discussion that they may need to be contacted regarding this result. If the patient is unsure at this stage about receiving their result then this ought to be explored at the pre-test assessment and perhaps the test postponed. It is important to make clear to the patient that consent to test implies consent to receiving a result.

In this situation letters are often the most appropriate method of contact as telephone calls can be difficult. However, if a prior arrangement has been made with the patient about collecting their HIV result by telephone then this may be the best recall method. If the health adviser is making the telephone call then it is important to remember that the patient has no control over the circumstances in which the result is received and should be given an appointment to discuss the result as soon as possible. Equally, visits can be unpredictable; maintaining confidentiality may prove difficult if the patient is not alone. Visiting a patient at home does not allow them choices about the circumstances in which they receive their result.

It is important that recall letters do not state HIV, as the consequences if intercepted by a third party may be extremely serious. For example the letter may read: "could you please contact the department to make an appointment with the health adviser to discuss the results of your recent test".

Three documented recall attempts ought to have been made and if there is no response then the casenotes should be discussed with the consultant.

RECOMMENDED RECALL ACTIONS

Table 9.1

| <i>Purpose</i> | <i>Correspondence: letters/ telephone</i> | <i>Visit / registered letter recommended</i> | <i>Review case notes after action</i> |
|---|--|--|---|
| Needs antibiotic treatment | Minimum 2 Maximum 3, before registered letter or visit | Yes | 5 days (3 days if message left on answerphone) |
| Test of cure/ post treatment review (contact(s) attended) | Maximum 1 | No | 1 week |
| Test of cure/ post treatment review (contact(s) not attended) | Minimum 1 Maximum 2 | No | 1 week |
| Discuss new diagnosis - herpes | Maximum 1 | No | 1 week |
| Discuss new diagnosis (HIV/ infectious hepatitis) | Minimum 2 Maximum 3 | Yes | 5 days |
| Hepatitis B vaccine or serology | Maximum 1 | No | 1 week |
| Syphilis serology: first post treatment | Minimum 3 | No | 1 week |
| Annual syphilis serology, post treatment, if HIV positive, or recommended first line treatment not used ³ | Maximum 1 | no | 1 week |

| | | | |
|--|------------------------|-----|--------|
| Syphilis serology at 1,2,3,6,12 months ⁴ | Maximum 1 | no | 1 week |
| Repeat screening serology (STS, HIV, and Hepatitis B. High risk patients only) | Minimum 1 Maximum 2 | No | 1 week |
| Colposcopy | Minimum 2 Maximum 3 | Yes | 1 week |
| Cytology (abnormal) | Minimum 2 Maximum 3 | Yes | 1 week |
| Cytology (routine) | Maximum 1 | No | 1 week |

CONCLUSION

The implications of recall ought not to be underestimated, as there may be the potential for confidentiality to be broken or anxiety caused. Protocols should ideally be in place and foresight used when assessing the need for recall and the most appropriate method chosen. Work may be audited for its effectiveness as successful recall management plays a key role in streamlining patient care.

APPENDIX

EXAMPLES OF SAMPLE LETTERS

"Could you please telephone the department to make an appointment as we need to discuss the results of your recent tests."

"Following your treatment for an infection, I notice that you have not been back to the clinic since. We would like to repeat the test again to ensure the treatment has been effective and the infection has completely gone."

"We now have the results of your tests taken in clinic on 2nd May confirming the infection we treated you for. Please telephone clinic to speak to a health adviser about any follow up that may be necessary."

"We now have the results of your tests taken on 2nd May. One of your tests was positive for an infection. It is important that this infection is treated as it may cause problems if it is not. Your partner will also need to be treated. You can make an appointment to see a health adviser to collect your treatment, and it will only mean a very short visit to clinic."

"I notice you have not been back to clinic since your treatment. I was wondering if you could phone me when you get this letter, as I didn't get the opportunity to see you when you were in clinic."

"We now have the results of the tests taken on 2nd May. One of the tests was unable to be processed. This happens occasionally and does not mean there is a problem, but if you would like it repeated please phone for an appointment with the nurse."

"We now have the results of your smear test taken on 24th May. The result was negative, this means it was normal. You will be recalled by the Cytology Screening Programme when your next one is due."

"We now have the results of your smear test taken on 24th May. The result was inadequate. This means that there was insufficient material in the sample. It is nothing to worry about and you are advised to have it repeated in 3 months. We will write to you when this is due."

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4 Ibid

Ethical issues in patient recall

GILL BELL

Recalling patients for essential care may cause harm by jeopardising confidentiality. This section explores some of the ethical issues involved in this conflict of duties.

INTRODUCTION

Patients are recalled for treatment or further investigation in order to bring benefits, or reduce harm. However, situations arise when it is difficult to recall a patient without jeopardizing confidentiality, or contravening his or her stated wishes - thereby violating autonomy. The ethical challenge of recall lies in the need to ensure that the resulting benefits for the patient and/or their sexual contacts outweigh the potential damage done. The following situations explore some of the ethical choices that may need to be made.

Guidelines for the management of an ethical issue can be found in chapter 23, where ethical concepts such as *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* are discussed in detail.

THE PATIENT REQUESTED "NO LETTERS"

A patient is unaware she needs an urgent colposcopy as a result of severe dyskariosis on her cytology. She requested "no letters" and is not available by phone. Should the health adviser override her wishes and write to her, or make an even more intrusive home visit, or leave her to suffer the consequences of her decision?

It could be argued that the woman's request for no correspondence does not amount to an autonomous choice because she was not aware of the possibility of a serious risk to her health at the time, and therefore the decision was not fully informed. Even if the patient had been warned of the risk of unfavourable results, failure to inform her might be construed as negligent, in the context of a treatable life-threatening condition.

Consideration would, however, need to be given to the potentially negative consequences of her mail being intercepted by a third party, such as a parent or a partner, who would be made

aware of her attendance at genitourinary medicine (GUM). (This risk could be avoided by using the general hospital stationary, without reference to GUM). Confidence in the confidentiality of GUM services might also be undermined.

REPEAT RECALL

A man fails to present for treatment for gonorrhoea, as promised. Neither his regular partner nor his casual partner has attended for screening. Should the health adviser actively pursue the patient, at the risk of harassing him, or should he be left to assume responsibility for himself and his partners, now that he has been informed?

An argument in favour of taking no further action could be based on the principle that autonomy should not be violated. Another reason might be a concern that the patient's health may suffer more in the long term if he is not encouraged to take responsibility. The risk of alienating the patient in the future by harassing him would also be considered.

A decision to contact him again could be justified as an attempt to communicate the importance of the situation more clearly, thereby facilitating (rather than violating) autonomy. Some may argue that preventing further damage to health is more important than respecting autonomy, in this instance. Consideration may also be given to the rights and welfare of his sexual partners who may be at risk of infection.

INFORMING THE GP

A woman fails to return for chlamydia treatment, and cannot be located. Should the GP be informed? (This action is normally the responsibility of the doctor, but health advisers may be involved in the decision if they bring the case to the doctor's attention, or are involved in discussion).

Reasons for informing the GP include the duty to reduce the health risk to the patient by ensuring that the necessary medical attention can be accessed from elsewhere, at any point in the future. Onward transmission to partners might also be prevented.

Arguments against might point to the importance of safeguarding confidentiality: the patient may regard disclosure to be a breach of trust, or harmful to her relationship with the GP. From a public health perspective, the accessibility of GUM services depends upon public confidence in confidentiality, so consideration ought to be given to the wider consequences of unsanctioned disclosures.

DELIVERING MEDICATION

A female sex worker with a previous history of pelvic inflammatory disease has repeatedly failed to keep appointments for treatment of gonorrhoea. Should medication be delivered to her home?

Arguments in favour would cite an overriding duty to take the necessary steps to protect the woman, her immediate partners and the wider community from harm.

Arguments against would emphasise the importance of encouraging personal responsibility. There is also the danger of creating an expectation among sex workers that treatment will always be delivered. Such an arrangement could be counter-productive if inadequate staffing levels delay home visits: this could lengthen the average gap between diagnosis and treatment

for sex workers, thereby increasing the long-term risk of harm. Patients who did not benefit from this service could feel unfairly treated.

C O N C L U S I O N

There are complex ethical issues that need to be considered during patient recall. It is good practice to discuss difficult choices with colleagues, and document the reasons for the decisions made.

Triage

GILL BELL

Some patients need to be seen before the next available appointment. This chapter explains how a triage system may help to ensure priority access for those in need.

INTRODUCTION

Triage is a system for assessing whether an individual needs to be seen sooner than the next available appointment. The current pressure on genitourinary medicine services has created long waiting lists for many clinics.¹ This delay is unacceptable to many patients and potentially unsafe for those in need of immediate medical attention. Consequently, most clinics that operate an appointment system also have triage arrangements to ensure priority access for those needing to be seen quickly.

PRINCIPLES OF TRIAGE

Entitlement to priority access would be assessed in relation to the person's:

- Risk of developing avoidable complications before the next available appointment
- Level of suffering, related to acute pain, discomfort, anxiety or distress
- Likelihood of having an untreated acute sexually transmitted infection (STI)
- Likelihood of transmitting a potential infection before the next available appointment
- Likelihood of returning to the clinic in future if turned away
- Ability to contribute to STI control, providing good will is maintained

MANAGEMENT OF TRIAGE

Health advisers or nurses may triage by telephone or face to face. Reception staff require guidance on which individuals may be offered triage. The criteria would include those who:

- Are contacts of gonorrhoea, chlamydia, syphilis, HIV or hepatitis

- Complain of pain (abdominal, testicular or genital)
- Are acutely anxious or distressed
- Have been sexually assaulted
- Require emergency contraception or post HIV-exposure prophylaxis
- Are under 16
- Are unwilling to wait until the next appointment
- Have difficulty arranging a suitable appointment because of work or home commitments

THE TRIAGE PROCESS

The use of a proforma may help to ensure a thorough assessment and provide documentation. During triage the nurse or health adviser would:

1. Assess the person's level of **distress or anxiety**.
2. Take a **medical history**, to include the severity and duration of symptoms suggestive of STI, including:
 - Abdominal or testicular pain
 - Penile, rectal or vaginal discharge
 - Fever and/or malaise
 - Dysuria
 - Ano-genital blisters/pain
 - Genital warts or "lumps"
 - Soreness, itching, malodour
 - Take a **sexual history**, to establish the risk of an STI.
3. Enquire about whether any **sexual contacts** are known to have, or are symptomatic of, STI.
4. Consider the **risk of onward transmission** of presumed infection, if medical attention is delayed.
5. Consider the person's **ability to return** to clinic for a future appointment, if not seen. It is important to avoid turning potentially infected people away in case they do not return.
6. Arrange a suitable **appointment** that is compatible with the recommended waiting times (see table below). Liaison with nursing or medical staff may be appropriate if the person is eligible for a same day appointment, or is already in clinic. A senior doctor would be consulted if the person could not be easily accommodated within the recommended time.

7. **Suggest alternatives** if an acceptable/suitable appointment time cannot be offered. For example, a patient needing emergency contraception may be referred to an NHS Walk-in Centre, family planning clinic, GP, accident and emergency department, or a chemist who is able to dispense without prescription.
8. **Document** the patient's name, history, advice given, and appointments offered and made on a triage proforma and/or in the patient's clinic notes. Decisions made by senior staff regarding access would also be recorded. It may be useful to note the circumstances that influenced the decision, such as the waiting time for the next appointment, the patient's level of anxiety, or the workload in the clinic.

Regular evaluation is recommended to ensure the quality of this service.

Table 11.1

| <i>Recommended maximum waiting times</i> | | | |
|---|-------------------------|-----------------------------------|--|
| Complains of | Walk-in Maximum wait | Telephone Maximum wait | Suitable alternative service |
| Abdominal pain | Same session | 24 hours Same session if acute | Other GUM, A&E GP if level 2 service * |
| Testicular pain | Same session | 24 hours same session if acute | Other GUM A&E GP if level 2 service |
| Ano-genital blisters (undiagnosed) | Same session | 24 hours | Other GUM GP if level 2 service |
| Possible chancre | Same session | 24 hours | Other GUM |
| Urinary retention | Same session | Same session | A&E |
| Discharge or dysuria (males) | Same session | 48 hours | Other GUM, GP if level 2 service |
| Discharge and dysuria (women) | Same day | 48 hours | Other GUM, GP if level 2 service |
| Discharge and vulval itching or soreness | No priority | No priority | Other GUM, GP Anti- fungal, pessary and cream from chemist |
| Malodorous discharge | No priority | No priority | Other GUM, GP |
| Genital warts | No priority | No priority | Other GUM GP if level 2 service |
| Contact of syphilis | Same session | 24 hours | Other GUM |
| Contact of gonorrhoea | Same session | 48 hours | Other GUM GP if level 2 service |
| Contact of chlamydia Female, or symptomatic. | Same session | 48 hours | Other GUM GP if level 2 service |
| Contact of chlamydia Asymptomatic male | Same session | 1 week | Other GUM GP if level 2 service |
| Contact of HIV | Same session | 48 hours | Other GUM |
| Contact of genital warts | No priority | No priority | Other GUM GP if level 2 service |
| STI/HIV related anxiety (low risk) | 1 week | 1 week | Other GUM GP |
| STI/HIV related anxiety (high risk) | Same day | 48 hours | Other GUM |
| Post HIV exposure | Same session | Same session | Other GUM, A&E |

* The National strategy for sexual health and HIV suggests that STI screening, treatment and partner notification could be offered within primary care settings that opt to develop expertise in this area. This is described as a "level 2" service.

CONCLUSION

A triage system is necessary to ensure that patients who need to be seen before the next available appointment can be identified and given priority. The use of agreed guidelines is recommended to ensure decisions are fair and appropriate.

REFERENCES

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- 1 Foley E, Patel R, Green N, Rowen D. Access to genitourinary medicine clinics in the United Kingdom. *Sex Transm Inf* 2001; 77:12-14
 - 2 Department of Health. The national strategy for sexual health and HIV; 2001

Ethical issues in triage

GILL BELL

Giving some patients priority access to services inevitably raises the question of justice. This section considers what might make a triage decision fair.

INTRODUCTION

Guidelines for the management of an ethical issue can be found in chapter 23, where ethical concepts such as *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* are discussed in detail.

Whenever a person is added to an already full clinic list, patients with pre-existing appointments may have to wait longer and staff members are subjected to greater pressure. Few would argue that patients in need of urgent medical attention be turned away, but a decision to give priority on social or epidemiological grounds may be more controversial. In such situations ethical consideration would be given to the balance of justice, benefits and harms for the individual, other patients, staff and the wider community. Some examples are considered below:

THE KEY PLAYER

An asymptomatic man calls in without an appointment. He does not have a right or a need to be seen straight away. However, he is well known to the service as a local drug dealer who has a history of repeated STIs, and who has frequent sexual contact with several sex workers.

The argument for seeing the man immediately would be that it is particularly important to build and maintain good will with individuals who play a key role in the social and sexual networks associated with high rates of STI transmission. If he is given preferential treatment he may be more inclined to co-operate with partner notification and encourage associates to use the service. If he is alienated, it may be difficult to secure his attendance in future.

THE GP REFERRAL

A woman attends without an appointment, with a GP letter reporting a vaginal discharge. She has no other symptoms, and is not therefore in need of urgent medical attention. However,

the GP told her she could attend without an appointment. She has travelled across town on two buses with small children.

The argument for asking her to return for the next available appointment might be that she does not have a right or a need to be seen that day, and it would be unfair to others if the triage protocol were not followed for everybody. On the other hand, it may seem unfair to turn her away when she has made an arduous journey in good faith. Her social circumstances may make it difficult for her to return in the near future, and the opportunity to treat a potential infection could be lost, or delayed.

A C H A O T I C L I F E S T Y L E

A young woman has defaulted many appointments and failed to respond to health adviser communications in the past. She has a chaotic lifestyle, and limited ability to protect her sexual health. The woman calls in, expecting her vaginal discharge to be promptly investigated.

She may be turned away because she does not fit the triage criteria that should, in fairness, apply to all. Some may feel that she does not 'deserve' preferential treatment because she has been uncooperative in the past, and should not receive priority over patients who wait for appointments and keep them, without fuss. There could be a concern that, by seeing her on demand, the service is rewarding 'bad behaviour' and discouraging her from developing a more constructive approach to health services.

An alternative view would be that she is disadvantaged by an appointment system because of her poor capacity to organise her life and grasp the rules of service use. If the service is, in effect, less accessible to her than others, there is a sense in which it is fair to make allowances and give her access on the terms she can manage. Furthermore, there is the public health consideration that her chance of having an STI is relatively high and the likelihood of her returning for a future appointment is low. The only sure way of preventing her from developing complications or transmitting infection to others is to see her straight away.

A S E X W O R K E R

A sex worker with self-diagnosed bacterial vaginosis presents at the clinic.

Bacterial vaginosis (BV) is not a medical emergency. It does not cause serious morbidity if left untreated for a short time, and it is not normally sexually transmitted. However, the unpleasant odour associated with the condition can be embarrassing and distressing. This presents an acute problem for sex workers, who may feel unable to work. Effective and ethical health care requires a holistic approach, where due consideration is also given to psychological, social and economic needs. For a sex worker, BV might be a legitimate emergency that needs prompt attention. Consideration would also be given to the possibility of concurrent STI, and the potential for onward transmission.

A S C H O O L G I R L

A 15-year-old girl calls in requesting a check up, having slipped out of school. She does not have any symptoms, but has had unprotected sex with a 25-year old man who has other regular partners.

There is no indication that immediate medical attention is required, but there are several reasons for considering priority access. Firstly, she has been at risk of infection; secondly, she may find it difficult to be absent from home or school without explanation to return at a future time; thirdly, child protection issues need to be explored further.

There is also the importance of first impressions, because attending a clinic for the first time requires courage. The apprehension and embarrassment that many patients feel during a first visit may be more acute for the very young. If the girl is turned away she may find it difficult to come back, and may share her unsatisfactory experience with friends, who may also be discouraged from using the service. The importance of making sexual health services more accessible to young people is emphasised in the national strategy for sexual health and HIV.

C O N C L U S I O N

There are complex ethical issues that need to be considered during triage. It is good practice to discuss difficult choices with colleagues, and document the reasons for the decisions made.

A C K N O W L E D G M E N T S

The steering group would like to thank the following for their helpful comments
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Section C

Counselling in health adviser practice

Counselling

HIV testing and management

Ethical issues in pre and post HIV test discussion

Working with the 'worried well'

Hepatitis C testing and management

Psychosexual counselling

Pregnancy options

Rape and sexual assault

Counselling

GEORGE LEACH

The following topics are covered:

- The role of counselling
- A process model
- Crisis intervention
- Practice guidelines for contract-based counselling
- Clinical supervision

THE ROLE OF COUNSELLING

Defining the role of counselling

The British Association for Counselling and Psychotherapy (BACP) defines counselling as:

... a systematic process which gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well being. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through conflict, or improving relationships with others.¹

In health advising work, counselling is used in a variety of ways. A questionnaire responder in a recent national survey said that the specialised role of counselling in health advising consists of:

Offering containment, holding and support and providing, where appropriate, an opportunity to work through issues related to and/or impeding patients' sexual health, within realistic time frames. To use skills to convey complex information and allow patients to explore emotional responses that might obstruct absorbing information or achieving sexual well being. SHASTD National Survey²

This second definition captures some key aspects of the application of counselling to the task of health advising. These are:

- Sexual health is the primary focus of counselling in health advising work
- The type and level of counselling used depends on patient need
- Even information giving depends on the use of counselling skills
- There is a time frame that has to be worked within

Counselling, or using counselling skills?

All health advisers use counselling skills, which they bring from their respective professional backgrounds, and develop further in their clinical practice. Those with appropriate professional training and supervision are well placed to perform an enhanced role by offering time-limited counselling to suitable patients.

Health advising sometimes deploys a specialised form (or a number of specialised forms) of counselling, but always makes use of counselling skills in the support of other aspects of the role.

Counselling skills are fundamental

There are five core roles of health advising and counselling skills are fundamental to all of them. The five core roles are:

- Partner notification
- Sexual health promotion
- Pre- and post- HIV test counselling
- Health education and information giving
- Counselling and using counselling skills

When is counselling appropriate?

It is not possible to provide an exhaustive list, but there are several types of presentation that indicate that counselling needs to be considered as an intervention, either directly or via a referral:

- Sexuality issues
- Pre- and post termination of pregnancy
- Sexually transmitted infections (for example herpes diagnosis)
- HIV testing issues
- Relationships
- Psychosexual
- Abuse/ rape
- Worried well

Patients have changing needs over time, and may relate to multiple categories. For example a patient with HIV may see a health adviser when they have been newly diagnosed or are transferring their care. With the same patient over time, they may subsequently work with adjustment issues, treatments, progression issues, coping, depression and anxiety, partner notification and safer sex. At any time, relationship or psychosexual issues may arise.

The range of counselling interventions

There is a great diversity of patients, counselling modes and contexts. An understanding of counselling is relevant across a wide spectrum of clinical work, such as:

- Crisis intervention counselling
- Contract-based time-limited counselling
- On-going and intermittent supportive work
- Advocacy and casework
- Assessment and referral

Also, these interventions can take place in a variety of contexts:

- One-to-one, couple or group settings
- Face-to face or telephone work
- Outreach
- Ward-based, clinic based or in community health care settings
- Drop-in work in other agencies

Theoretical approaches: the value of time-limited work

There are 300 - 400 models of counselling and psychotherapy in existence. Health advisers may be influenced by a variety of theoretical models in the counselling aspects of their role, but there is a convergence of practice, as evidenced by the findings of the SHASTD National Survey.

In the counselling field generally, there is an increased emphasis on time-limited approaches. A review of the literature reported findings that support the efficacy of time-limited work.³ Some studies suggest that the therapeutic effectiveness of time-limited work is indistinguishable from long-term, or more open-ended, work.⁴ Findings included the following:

- Most significant therapeutic change happens early on in therapy - 62% of patients are helped within 13 sessions⁵
- Patients are less likely to drop out of therapy or counselling when a time constraint is applied⁶ (this is particularly true of younger patients)
- Therapists' estimates exceeded patients' of the number of sessions needed by a factor of 3 to 1⁷
- 78% of patients getting only one session thought they had benefited.⁸ This is particularly important when evaluating the effectiveness of crisis intervention counselling. Patients who drop out of counselling are not necessarily counselling 'failures'. Positive changes can continue to be made by the patient after the intervention

Applying a time-limited approach to health advising

A number of principles need to be borne in mind when doing this kind of work.

Health advisers have to prioritise the interventions they can use within the constraints imposed by their workload and clinical setting. Some may have an affinity, and the necessary professional training for doing longer-term work, but it is practically and ethically more important that as many people as possible are to be offered the help they need. This exerts a pressure on the length of intervention that will be possible.

Where there is some room for compromise (some flexibility in the length of interventions that health advisers can offer to particular patients), this will help with developing skills, maintaining morale, and targeting particular interventions to meet particular needs. Practitioners can be adversely affected by exposure to purely 'one-off' work, especially if they have inadequate support and supervision.

Some patients do benefit from 'ongoing' work of a sporadic kind, and health advisers sometimes assume a casework role when this happens. This may be seen as a serial form of time-limited work.

Methodology of time-limited counselling

Time-limited approaches are not there to reconstruct the personality and although some personal growth may result, that is not the sole aim. There is more concern with the relief of symptoms and the resolution of crises. More active advice and guidance is involved. It is also important that the patient believes that the practitioner can help them. Conversely the practitioner needs to establish that an intervention is appropriate, and therefore, accurate assessment is essential.

It is important to engage with the patient quickly and form a good working alliance. The importance of this is highlighted in the SHASTD National Survey, where there was considerable agreement that patients seeing a health adviser for the first time would not know what to expect, and that first impressions are therefore very important. Health advisers work at putting the patient at their ease through demeanour, dress and a relaxed manner, and by explaining their role.

An effective working relationship depends on the establishment of trust, and this in turn partly rests on a realisation of the importance of confidentiality. Supportiveness, accurate empathy and reassurance help to build patient confidence and an awareness of their choices. This is an empowering interaction.

It is important to be clear about the type of intervention that is being used at a particular time. Delineating between a "one-off" information-based session, a time-limited contract, or a crisis intervention supports clarity of thinking and effective work.

There is an emphasis on negotiating behavioural goals, and on establishing a focus for the work.

There is more interaction with the patient, more structure and less interpretation than in longer term counselling work. Even so, counter-transference awareness is an important source of additional information to the therapist/counsellor. That is, that the feelings the patient invokes in the health adviser can give important clues about their mental state and underlying issues.

Appropriate self-disclosure can be helpful as part of the dialogue, for example sexuality

Long silences are inappropriate.

The setting and maintenance of clear boundaries helps with the difficult balance that has to be struck when managing complex processes of prioritisation and juggling - within time constraints, and between the clinical task and what the patient feels they need.

Pushing the limits: health advisers work with and acknowledge negative and difficult aspects for the patient, and challenge them in a non-threatening way to confront reality. In this way it becomes possible to have a dialogue about stigmatised issues. This is central to effective health advising and enables strong feelings and distress to be faced, contained and explored.

There needs to be a balance of talking and listening. Language is important - and should be simple, clear, matter of fact, non-judgemental, with open questions to elicit deeper levels of dialogue. Listening to what is not being said is important too.

Knowing when to refer on, and when not to open up areas for exploration. Containment and referral are always kept in mind “we tread a balance between opening up issues and keeping people safe” as one health adviser put it, in the National Survey.

Working with difference. Health advisers need to be adept at working with cultural difference, and have evolved skills in getting alongside individuals who may be from a culture that has not been encountered by them personally before. The attitudes and abilities health advisers have that would make this possible include: being good at finding things out from people, learning without making assumptions, being accepting and adaptive, being good at defusing situations, and tailoring a different approach to different people.

A PROCESS MODEL FOR HEALTH ADVISING

Rationale for a model

Health advisers have been evolving their practice over time. They have developed individual and shared constructions of the nature and purpose of that practice and of the theoretical ideas underpinning it. These constructions could be seen as forming an implicit model that has not been formally described.

An action research project, supported by SHASTD, was completed in 2001, which turned this implicit model into an explicit one.

The model enables health advisers to conceptualise their practice within a shared frame of reference, and therefore act as a foundation for further research, discourse and enquiry. It also allows for the monitoring and evaluation of health advising services in relation to specific outcomes, and can be used to educate service users and other health care professionals.

People become health advisers after training in other professions, and consequently they import aspects of other models into their work. The study confirmed that health advising has integrated these diverse influences into a distinct and specialised role.

Methodology for establishing the model

The term ‘action research’ is used to describe a type of co-operative enquiry that grounds theory in experience.⁹ Accordingly, health advisers themselves were consulted about what

they do and how they do it, and about the beliefs and values that underpin their practice. Focus groups and a national questionnaire provided the information.

The model

Diagram 1

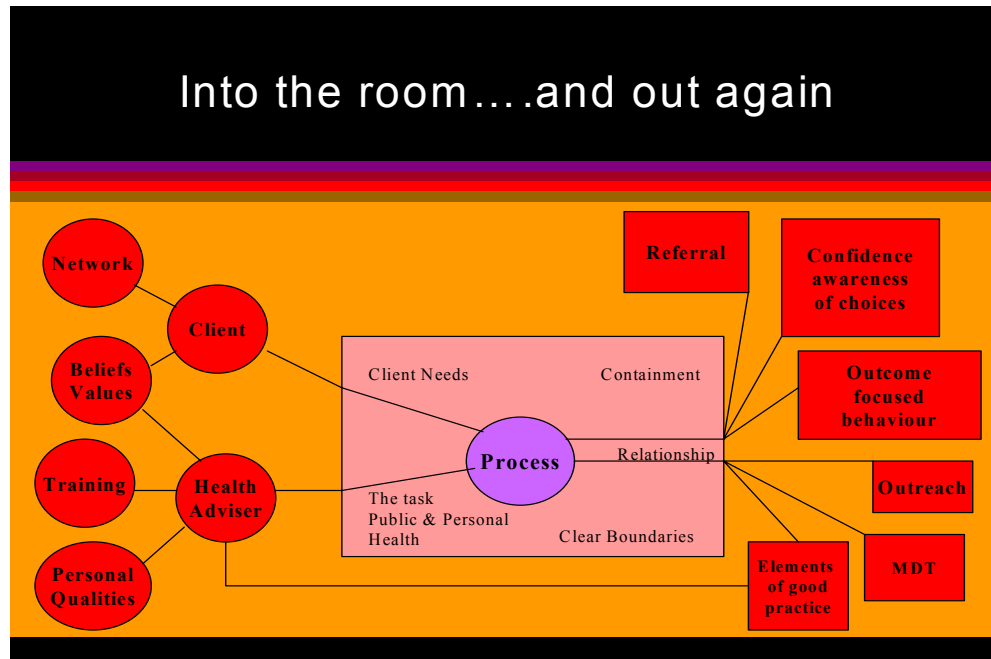


Diagram 1 shows the way that the health adviser and the patient are influenced by factors before their encounter begins. The area in the centre of the diagram contains the process of the encounter itself, which is expanded in diagram 2.

Before going into the room the patient may be seen as being related to a background network and as holding beliefs and values of their own. The health adviser too goes into the room with beliefs and values, with the influence of their training, with their personal qualities and also having reflected on the elements of good practice learned in previous encounters with patients - a kind of feedback loop, depicted as a line back to the 'start' of the diagram. Colleagues within the multidisciplinary team also influence them.

The patient enters the room with some idea of their needs. The health adviser enters with an awareness of the task and armed with the dual and sometimes conflicting concepts of personal and public health. The two of them get into a process which hopefully brings them alongside each other in a parallel relationship as indicated by the parallel lines going into the room. The relationship is supported by the patient's sense of containment and by the health Advisers awareness and use of clear boundaries.

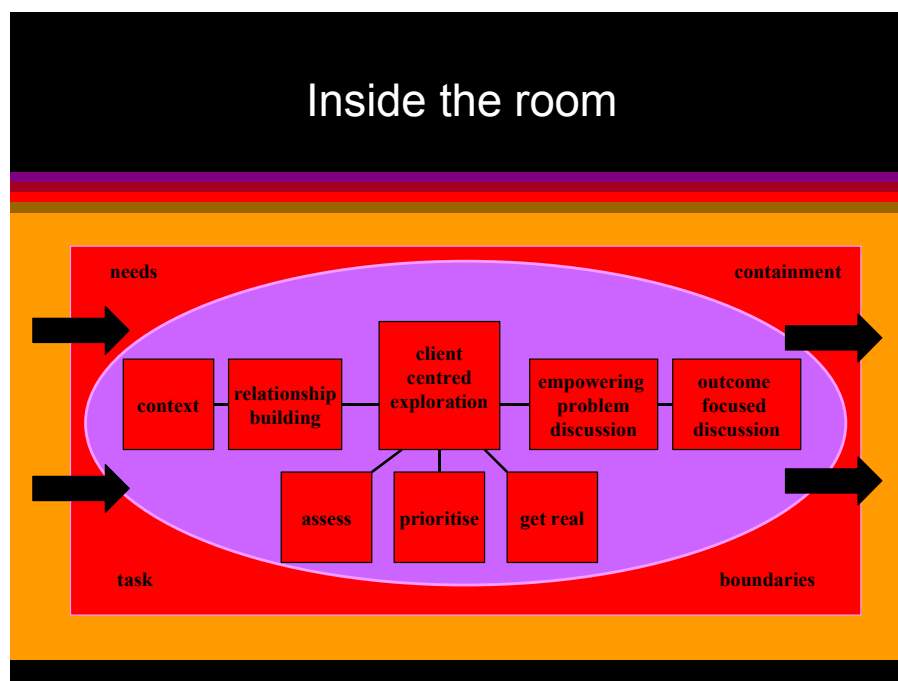
The aim is that the patient emerges from the room at the end of the process, or one of the stages in the overall process. They may be referred on. They may have an increased level of confidence and awareness of choices. They may also show more 'outcome-focused' behaviour.

This concept can be illustrated by the example of a young woman diagnosed with syphilis who becomes more likely to complete her course of treatment, and

more likely to use condoms with her partners. There may be an ultimate public health goal of eradicating syphilis, but health advisers do their work at various points along that path, making the journey an easier one to take.

The health adviser also learns from their experiences in the room and this in turn informs practice, for example, outreach is informed by their clinical experience. Again there is a feedback loop, in that the elements of good practice potentially feed back to the start of the next patient encounter.

Diagram. 2



To focus in on the detail of the process that happens within the room look at diagram 2, which is a “blow-up” of the circle at the centre of diagram 1.

In this process, even before anything is said, the health adviser will be gathering important contextual information. Is anything known about the patient already? What do they look like in the waiting room? Is there anything significant in the notes, or in the way the doctor hands them over?

Then there is a rapid process of relationship building that makes the rest possible. The health adviser uses the way they dress, their manner and interactions, all of which put the patient at their ease and generate a sense of trust.

There is then a phase of patient-centred exploration. This is when the issues are opened up. All the time the health adviser is assessing, prioritising and ‘getting real’ - that is, gently confronting the patient with reality and pushing the limits of what they are prepared to look at.

It is then possible for the health adviser to focus in on a shared understanding of the problem areas, but in a way that empowers the patient. The patient might, for example, feel ‘dirty’

because they have an sexually transmitted infection. That fact might emerge in the patient-centred exploration, but could be re-framed as a problem about feeling unable to talk things over with their partner. Or, more empoweringly, “shall we think about some ways that you might be able to talk this over with your partner?”

There is then a shift to an outcome- focused discussion, about (for example) completing treatment, agreeing to come back and say how they got on discussing the issue, or whatever is possible. It may not be very much, but it is important to remember that health advisers are more involved in facilitating outcome-focused behaviour than medical end-point outcomes.

CRISIS INTERVENTION

Brief intervention during crisis periods can have maximum effect when compared to other approaches.¹⁰

People in crisis are at a turning point. They face problems that cannot be overcome by using their existing coping mechanisms. Anxiety and helplessness can interrupt the tasks of daily life, and people can feel powerless to function effectively. However a crisis, if positively resolved can also provide an opportunity for growth and development.

Crisis intervention is really a specialised form of time-limited counselling, and one which health advisers encounter more than the contract-based type. It is something which health advisers become very skilled at over time, if they have the opportunity to learn from their experiences. Health advisers also encounter a significant number of patients with mental health problems or borderline mental health issues that present in crisis, even though they might not have psychiatric histories.

It is important to understand that reactions to crisis are normal, but that sometimes they can be resolved in dysfunctional ways. This can lead to post-traumatic stress disorder, for example, in vulnerable individuals.

Caplan was the first to define crisis in psychosocial terms as being:

‘when a person faces an obstacle to important life goals that is, for a time, insurmountable through the utilisation of customary methods of problem solving. A period of disorganisation ensues, a period of upset, during which many abortive attempts at solution are made.’¹¹

There were early influences from military psychiatry through work on battle fatigue.¹² Prompt treatment was elsewhere reported to be effective in keeping soldiers at the front.¹³ One-off interventions have since been shown to be useful in many areas, for example in reduced self-harming behaviour.¹⁴

Lindemann¹⁵ was an early pioneer. Following 500 deaths in a Boston fire he looked at the effects of bereavement follow-up, and found that the duration, severity and resolution of the crisis was affected by timely crisis intervention. Indeed he coined the term ‘grief work’ and promoted a view that human behaviour in an acute crisis was not abnormal or pathological.

The normative developmental and existential crises that confront all people at some time may be acutely activated (or interfered with) as a result of trauma.^{16 17} Finding out that one is HIV positive and having to re-evaluate one’s life goals and values, serves as an example. Indeed many of the patients that health advisers engage in productive work are in one kind of crisis or another.

Crises are not purely traumatic. The Greek derivation of the word points to it being seen as a decision-making turning point. The Chinese pictogram for 'crisis' combines two others representing 'danger' and 'opportunity'.

Roberts saw crisis as:

*'a temporary state of upset and disequilibrium characterised chiefly by an individual's inability to cope with a particular situation using existing methods of problem solving, and by the potential for a positive or negative outcome.'*¹⁸

Carkhuff states that:

*'while crises or anticipation of crises lead the individual to seek help, they also provide the potential vehicle within the helping process that will enable him to go on to function at higher, self-sustaining levels.'*¹⁹

After catastrophes there is immediate stability or pseudo-stability. Then 24 to 48 hours later, emotional collapse, then some adjustment (functional or dysfunctional) days to weeks later. Seligman²⁰ produced evidence that suicidal crises, for example, tend to pass within a few weeks. Caplan²¹ emphasised that crisis is self-limiting (usually lasting 4-6 weeks and therefore determining the length of therapeutic contract).

The outcome depends on the availability of appropriate help together with individual and environmental factors. The importance of early intervention on outcome is highly significant for health advisers. Referring on the patient in crisis too soon may be more likely to result in a dysfunctional adjustment, and more mental health problems later.

Other theorists have produced models that lend themselves to crisis intervention approaches. Interestingly these are also models which have developed at least in part as a response to the need for crisis intervention work. Examples include: Egan²² (who advocated a focused, problem-solving approach to counselling) and writers adhering to a systemic approach (Riva Miller and Robert Bor²³ in the HIV field, for example), together with the cognitive-behavioural approach that prevails in clinical psychology.

Features of a crisis intervention approach

A useful overview of the field²⁴ makes the following statements about crisis intervention work:

- It is essential that the therapist views the work being done not as a second best approach but as the treatment of choice for an individual
- Accurate and rapid assessment of the presenting problem and underlying factors is more important than a lengthy diagnostic evaluation
- It should be kept in mind that the treatment is sharply time-limited (one to six sessions) and the therapist should persistently direct their energies to the resolution of the presenting problem and work in a 'here and now' way
- It follows that time must not be wasted dealing with irrelevant material
- The therapist must be willing to take an active and sometimes directive role

- Maximum flexibility of approach is encouraged: the therapist may need to be a resource co-ordinator or information giver
- The therapeutic goal is explicit and directed to helping the individual to regain at least their pre-crisis level of functioning

Methodology

It is important to take a view of the adult survivor's behaviour as an understandable rather than pathological reaction to stress, and assuming an active and directive role overall strategy to increase the individual's remobilisation and return to functioning.

A seven-stage model for crisis intervention is described:

- Assessing lethality and safety needs - is the patient suicidal or in danger?
- Establishing rapport and communication
- Identifying major problems
- Dealing with feelings and providing support
- Explaining possible alternative pathways
- Formulating an action plan
- Providing follow-up²⁵

PRACTICE GUIDELINES FOR CONTRACT-BASED COUNSELLING

SSHA recommends two key points for good counselling practice:

- Having appropriate counselling supervision
- Working within the British Association for Counselling and Psychotherapy (BACP) Ethical Framework for Good Practice in Counselling and Psychotherapy²⁶

A Department of Health document aids decisions about which forms of psychological therapy are most appropriate for which patients.²⁷ It is recommended that health advisers make their treatment and referral decisions with reference to this key document.

The type of counselling undertaken

This is usually dictated by patient need, the training and experience of the health adviser, and the counselling supervision available to the health adviser.

If a health adviser has had no counselling training (for example if they are a trainee or new to health advising, and does not have a supervisor who agrees to them undertaking 'counselling' work, but has appropriate vocational experience, then it is good practice that the health adviser sees patients for mainly crisis or information work, making use of counselling skills. Where contracted counselling is indicated, the patient would be referred elsewhere for assessment: to an appropriate relevant health adviser or other counsellor, internally or outside the immediate clinical setting.

Number of sessions offered

In a time-limited counselling contract, 3-6 sessions may be agreed, continuing in multiples of six after review, and in consultation with the manager and counselling supervisor, where the service permits. Where a health adviser is undergoing counselling training and would like to develop their patient work/ patient hours then they may be able to negotiate to have one 'longer term' patient (for example for a six month contract).

The caseload

It is not good practice for a full time health adviser to see more than 5 counselling patients per week or more than 3 if part-time. Service needs may necessitate a lower limit, and the size of caseload needs to be discussed with the senior health adviser.

Preventing role confusion

Sometimes there is a difficulty when a patient is being seen for counselling who simultaneously requires a different type of input. This may disrupt the counselling - for example in the case of the patient being diagnosed with an STI and requiring information and partner notification which is unrelated to the focus of the counselling work. Referral to another health adviser in such circumstances, is recommended.

Referring on

There are some patients where it may be more appropriate that they are referred to another agency or professional within the multidisciplinary team (for example clinical psychologist, counsellor, psychiatrist or social worker). These include:

- People being referred for counselling who have no 'GUM/HIV/ sexual health' issues
- People already being seen by another counsellor or psychotherapist or by psychiatric services. In these cases, the health adviser may still offer a "one- off" session - for example if they have been diagnosed with an STI or are being tested for HIV
- Where drug or alcohol abuse is the main presenting issue
- Where relationship counselling is indicated, the couple needs to be appropriately referred unless the health adviser is trained/ has vocational experience in this type of intervention. The health adviser may still see a couple where a joint information session is of benefit to the patient and their partner, and their relationship, for example with an HIV discordant couple
- With children (who are not competent under Fraser guidance)
- People who are acutely psychotic, abusive or severely disturbed will not be able to engage in counselling, but may need to be seen as part of a referral or in the course of managing a complaint. At no time should a health adviser risk their own personal safety

Sometimes it may be more appropriate for a colleague to work with a particular patient. In this situation an assessment with that colleague would be arranged (with their permission).

When referring to a clinical psychologist or psychiatric services, a referral letter needs to be sent, whether this is for further intervention or for the assessment of mental health problem, including people with suicidal ideation, anxiety, depression, bipolar disorders, obsessive-compulsive disorders, hypochondriasis, phobias or panic attacks.

When referring to agencies outside the Health Service, the health adviser needs to beware of making a premature referral. Often the patient will have engaged with the health adviser, as the first person they have discussed their problem with, and an important therapeutic attachment may be broken at a critical phase.

Assessment and referral are complex processes. The competence of others can be over-estimated. The worker or agency being referred to may have less experience and training in the critical area of sexual health than the person doing the referring. Also, trainees largely staff counselling agencies, and sometimes there are lengthy waiting times. These factors need to all be borne in mind when considering making a referral.

Documentation

As a minimum it is important to document in the medical notes for each session that a patient has been seen, and what the number of the session is.

In the interest of making the work more inclusive to others from the multidisciplinary team then (whatever system is adopted) any counselling notes need to be regarded as confidential to the clinic and need to contain an overview of the session including any medical implications or medico-legal concerns. There needs to be an explicit focus for the work, and recording of partner notification issues and risk reduction work. The Data Protection Act makes no distinction between formal and informal notes, so any additional notes (for example for supervision) must be kept at least as securely as the medical notes.

At the end of the agreed contract of sessions the health adviser will write a closure letter or summary and put this in the medical notes.

Level of training

Managers and supervisors need to work with health advisers to ensure that they do not take on counselling work for which they are neither trained nor adequately supervised. Many health advisers have counselling qualifications, or undertake further training in this area once in post. Some may seek formal accreditation (with the BACP for example).

Counselling training is not purely academic. It is usually composed of four elements: clinical experience, theory, supervision of work in progress and some personal therapy. Health advisers can be encouraged to identify areas where they need to develop and seek appropriate training opportunities that build on their existing skills: whether they undertake formal courses of training or not.

There are some specialist areas of work (for example couple work and psychosexual counselling) where even a generalist diploma or masters level training in counselling is not enough to support effective and ethical practice.

Suitability: issues of recruitment, selection and training

Some counselling skills cannot simply be learned, but depend on specific attitudes and personality traits.

The SHASTD survey revealed a strong belief that specific personal characteristics are central to being an effective health adviser. The 'top five' characteristics were: being non-judgemental, working well in a team, having good boundaries, self-awareness and sensitivity. Qualities related to responsiveness to others were generally rated more highly than individualistic qualities such as: assertiveness, honesty and confidence.

CLINICAL SUPERVISION

The SHASTD national survey revealed that 93% of health advisers agree that clinical supervision is essential to good practice. 100% felt it was important to reflect on and learn from experience. Clinical supervision is one way of facilitating that process.

What is clinical supervision?

‘Clinical supervision’ is a term used to describe a series of formal, planned and regular discussions between an expert practitioner and one or more supervisees which has the purpose of facilitating reflective practice so as to support the practitioner(s) in their role, encourage the development of practice skills, and maintain professional and ethical standards in the context of on-going professional development.

Why do health advisers need clinical supervision?

STANDARD

Receiving regular clinical supervision is intrinsic to the work of the health adviser.

The "Good practice guidelines for health advisers" also looked at clinical supervision. SHASTD states:

‘Clinical supervision involves both managerial and counselling supervision. As individual activities managerial and counselling supervision contribute to the quality and effectiveness of the health advisers work. As health advisers have a counselling role they should use counselling skills when dealing with patients who have issues with HIV/AIDS, sexual assault, sexual abuse, relationship problems and sexuality. SHASTD believe that all aspects of clinical supervision are an essential part of the support and education of health advisers.’²⁸

Counselling Supervision

SHASTD support the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy:

‘There is a general obligation for all counsellors to receive supervision/consultative support independently of any managerial relationships’²⁹

It is not good practice for counselling supervision to be undertaken by the line manager although managerial support and agreement are essential when establishing a system of counselling supervision. Counselling supervision needs to be inclusive within a health adviser post and be undertaken in the health adviser’s work time.

A counselling supervisor ideally will not be an immediate clinical colleague (for example not be involved with the same patients as the supervisee) However, if the counselling supervisor works within the same agency as the supervisee, boundaries, ground rules and expectations must be made clear and adhered to by both parties in the same way as if the counselling supervisor is external to the agency. It is also important for the individual health adviser to have an input into the selection of their supervisor.

STANDARD

SHASTD suggests three points for good practice:

1. Having one to one or group supervision not less than monthly
2. Having a counselling supervisor who has extensive supervisory experience and is a qualified counsellor, psychotherapist or clinical psychologist

3. Having a supervisor who has BAC supervisor accreditation

How does clinical supervision relate to health advisers and their work?

In the course of clinical practice, health advisers can engage in many kinds of supportive discourse located within a network of professional and managerial relationships. For example, after a problematic session with a patient, a health adviser might discuss various aspects of the encounter with their immediate colleagues (peer supervision), with other professionals in the team, or with their managers.

The term 'clinical supervision' is reserved for a highly specific kind of interaction that complements these other interactions. Its purpose is to provide the supervisee with a reliable and regular 'thinking space' where they can choose to bring issues connected with the development and maintenance of their professional practice, including the impact that such work has on the practitioner her/himself.

Another difference is that clinical supervisors can sometimes be external to the supervisee's own agency (and therefore neutral from a managerial point of view).

In the **counselling** profession, clinical supervision is understood as being collaborative, and as being concerned with monitoring, developing and supporting practitioners.

There is not sufficient space here for a detailed discussion of the various models and theoretical concepts that underpin supervision, or the growing amount of research that demonstrates its effectiveness.^{30 31} Good theoretical overviews and introductions exist.³²

Clinical Supervision might be used by a health adviser to discuss a wide variety of issues that emerge for them in relation to the many facets of their role. The aim is to ensure that the challenging or traumatic nature of some aspects of the role is neither damaging to the patient or the health adviser

Health advisers may only rarely be subject to direct physical attack while working with patients, but they are certainly exposed to large amounts of emotional 'fall-out'. They do psychologically dangerous work, and they may become casualties themselves if protective measures are not in place. Otherwise they will have no alternative but to leave, or defensively withdraw from effective contact, a process described by Menzies.³³ Clinical supervision has the potential to offer some protection to both patient and practitioner.

If clinical supervision and other activities designed to support professional practice are beneficial, it follows that failure to consider these interventions can have undesirable consequences. Recent research, notably in the context of HIV, has enabled greater articulation of the stresses of sexual health care work,³⁴ but actual interventions to ameliorate staff stress have often been rudimentary,³⁵ and sometimes leave individuals feeling pathologised, when in fact they may be responding appropriately to organisational pressures.³¹

A lot of research on the phenomenon of 'burnout' illustrates the ultimate dangers of a lack of support in the workplace.^{36 37 38} Clinical supervision provides an important arena for such support.

The features of 'burnout' are:

- Emotional exhaustion

- Withdrawal from interpersonal relationships
- A sense of low personal accomplishment

In fact, burnout is a concept that lacks confirmed theoretical underpinnings, but is consistent with a considerable body of evidence confirming the appropriateness of the original constructs of 'emotional exhaustion' and 'depersonalisation' ³⁹The Maslach Burnout Inventory ³⁴ is the most widely used psychometric scale for measuring work-related burnout in helping professions.

Of specific relevance here is Miller's work looking at 'burnout' phenomena among health care workers in the HIV field. ⁴⁰ He identified a long list of physical, cognitive and emotional and behavioural symptoms, including, for example: physical exhaustion, lingering minor illnesses and over-identification with patients.

The term 'burnout' is understood to relate to the end-stage of a chronic, corrosive and dynamic process of response to occupational stress. While it has connotations of irreversibility and finality, professionals who can detect early signs of burnout in themselves are at least in a position to start facing the problem in themselves and in the environments in which they are working.

The functions of clinical supervision

It is important not to confuse clinical supervision with managerial supervision of clinical work, consultation with colleagues, or educational and other support activities (essential though all of these activities are). Otherwise there may be a dangerous blurring of roles which could have a destructive effect on the patient work, the quality of supervision, and the well-being of the practitioner, the manager, the peer group, and the organisation itself.

A manager provides managerial supervision which has been described as meaning observation by an administrative superior who inspects, directs, controls and evaluates both clinical and non-clinical aspects of the practitioner's work. ⁴¹Adequate managerial supervision is, of course, crucial to good professional practice. The clinical supervisor needs to be seen as a separate and distinct activity rather than as a rival source of authority. Sometimes a practitioner's line manager may also act as their clinical supervisor, and this can make it harder to keep the two roles separate. The issues that this raises are discussed in more detail later.

Neither is clinical supervision the same thing as personal counselling or therapy. It may be experienced as supportive, but the focus is primarily on the work with the patient, and the support given is of the supervisee in their working role.

Where clinical supervision has been implemented with health advisers, a number of benefits have been identified. In one evaluation study clinical supervision was felt to:

- Enable health advisers to stand back and take a reflective and objective view of practice issues
- Increase the understanding of their professional role
- Allow the integration of theoretical ideas with clinical practice
- Increase confidence

- Permit the confidential exploration of important and complex issues
- Provide a safe space where stress can be acknowledged, difficult feelings understood, and where health advisers can feel supported in their work ⁴²

According to Proctor's widely accepted model, clinical supervision can be thought of as having three basic functions: 'formative', 'supportive' and 'normative'. ⁴³

These functions are also of some relevance in relation to less formal types of clinical supervision, for example in discussions with colleagues or managers:

Formative

Developing the skills, understanding and abilities of the supervisees. This is done through the reflection on and the exploration of the supervisees' work with their patients. They may:

- Be helped by the supervisor to understand the patient better
- Become more aware of their reactions and responses to the patient
- Understand the dynamics of how they and their patient are interacting
- Look at how they intervened and the consequences of their interventions
- Explore other ways of working with this and other similar patient situations

Restorative

Responding to how any workers who are engaged in intimate therapeutic work with patients are necessarily allowing themselves to be affected by the distress, pain and fragmentation of the patient and how they need time to become aware of how this has affected them and to deal with any reactions.

Normative

Nearly all supervisors, even when they are not line managers, have some responsibility to ensure that the work of their supervisee is appropriate and falls within defined ethical standards. ⁴⁴

It is also important that the clinical supervisor pay attention to features of the context within which health advisers' are working. Health advising does not take place in a vacuum. Work with patients may resonate with key organisational dynamics. Equally, features of the relationship between the supervisor and the supervisee may reflect aspects of the dynamics that exist between health advisers and their patients. This has been described as 'parallel process'. ⁴⁵ Supervisors with a psychodynamic orientation are particularly likely to draw on psychodynamic and systemic theory in this way.

KEY POINTS

Clinical supervision is a specialised activity that complements other kinds of supervision and support in the workplace

Clinical supervision needs to be provided by an expert practitioner external to the supervisee's line-management structure

Research has firmly established the value of clinical supervision

Clinical supervision has formative, normative and supportive functions

Clear boundaries and a primary focus on the supervisor-patient relationship are essential if all forms of clinical supervision are to be effective

There are several, inter-related factors that make clinical supervision a necessity for health advisers: the nature and complexity of the role itself, professional ethics, and inter-disciplinary issues

There is a parallel between health advisers' need for thinking space and the need of their patients for such a space

Inadequate clinical supervision increases the risks of stress and burn-out

Professional ethics

There is an important ethical dimension to the supervision of work undertaken by health advisers.

STANDARDS

There is a general obligation for all counsellors to receive supervision/consultative support independently of any managerial relationships.⁴⁶

Also according to SSHA's own Code of Ethics:

*Health advisers should identify the boundaries within which they work and be aware of their professional limitations in offering services to their patients/patients. Support and supervision are a vital part of the health adviser's professional framework...*⁴⁷

These ethical requirements are non-negotiable. Clinical Supervision needs to be seen as a vital part of the health adviser's professional framework, supporting the fulfilment of their responsibility to both their patients and themselves. No health care professional should view their development and expertise as complete once they have gained a professional qualification, but rather as an ongoing process for which they share responsibility with their professional body and their employer.

Selecting a Clinical Supervisor

Who should clinically supervise health advisers?

When health advisers receive some of their clinical supervision from non-health advisers, those clinical supervisors must have a thorough understanding of the diverse elements of the health adviser's role. Otherwise the professional standards of practice of health advisers might be undermined and distorted.

The selection of suitable clinical supervisors is a matter for the health advisers concerned, but there are perhaps some attributes that it would be helpful for potential supervisors to possess. At least some of the following characteristics would be needed:

- Previous experience and/or training in clinical supervision
- A recognised counselling, clinical psychology or psychotherapy qualification together with several years of relevant clinical experience
- An explicit ethical framework
- Professional indemnity insurance (if external)
- A theoretical and professional background compatible with health advising
- A familiarity with and understanding of the health adviser's role
- Experience of work within a Health Service setting
- Knowledge about referral and support resources
- A sound knowledge base about HIV, AIDS and G.U. Medicine issues
- An ability to make a regular and on-going commitment to providing clinical supervision
- Affordability!

Research involving health advisers, medical, nursing and paramedical colleagues in the UK has identified the preferences for staff support, and for facilitators in these groups.⁴⁸ Facilitators were preferred from outside the organisation, as they were seen to embody the qualities of impartiality and confidentiality. While 'insiders' were seen to offer the advantages of inside knowledge and a more intimate understanding of the pressures leading to work stress, they were also seen to be less confidential.

However the benefits of local colleagues' insight into the health adviser role are clear and the appropriate choice of supervisor would ensure that confidentiality can be maintained and other professional responsibilities adhered to.

If difficulty is experienced locating a suitable clinical supervisor, the national organisations for counselling and psychotherapy (British Association for Counselling, the British Psychological Society, and the psychotherapy organisations belonging to the U.K.C.P.) would be able to help identify local resources.

What theoretical orientation should clinical supervisors have?

There is also the question of the theoretical orientation of the potential clinical supervisor: they might have had a humanistic, cognitive, psychodynamic, psychiatric or eclectic professional training. Which are going to be of most use to a particular health adviser or team of health advisers? In practice, a wide range of models of clinical supervision is in use and a research-based discourse within the profession will be needed if these different approaches and models are to be evaluated. Health advisers need, as far as possible, to make their own choices about all aspects of clinical supervision and evaluate it regularly to ensure that it is meeting their needs.

How much clinical supervision should health advisers receive?

In addition to the type of clinical supervision decided on, there is the question of the amount of supervision that is necessary. Experience (and the results of evaluation exercises) would suggest that one hour every two weeks is desirable. Holidays, sickness and study leave mean that sessions are sometimes missed, with the result that individuals would receive approximately 20 sessions of counselling supervision annually, and this would meet the standard set by the British Association for Counselling, an important consideration for health advisers undertaking counselling training and intending to seek accreditation as counsellors. If a health adviser is doing a lot of on-going casework it might be advisable to consider increasing this amount. An adjustment would also have to be made if clinical supervision is taking place in a group setting, to ensure that the participants get enough time. It might be hard to see how one hour every two weeks could provide enough support, given the enormous number of patients who might be seen during this time, yet health advisers do not need to examine every clinical encounter: the thinking that goes on in relation to one situation can be used in other situations. Also, themes can be discussed that relate to a number of patients. Health advisers have a professional background sufficient for them to be capable of a higher level of thinking about their work, selecting appropriate patients to discuss as part of their preparation for the supervisory encounter. Even trainees who arrive with skills gained in their previous profession (although it is likely that trainee health advisers have a need for more intensive supervision to start with).

In reality, choices about the type and frequency of clinical supervision might be restricted more by financial and organisational constraints than by anything else. Yet it is also important to remember when considering the alternatives available that it may be preferable to have no clinical supervision if the alternative is poor clinical supervision!

Example guidelines for clinical supervision

Here is an example of a set of guidelines for an external clinical supervisor to work to, that could be adapted as appropriate for clinical supervisors internal to the organisation, or used as the basis for a discussion to negotiate a contract:

1. Clinical supervision will take place every two weeks on (day) at (times). The supervisees are responsible for identifying appropriate material to bring to supervision and thinking in advance about how they want to use the time
2. All the existing lines of managerial and clinical responsibility and accountability will continue and will not be affected by external supervision
3. The supervisor will work in accordance within the British Association for Counselling's Code of Ethics for Supervisors, for example confidentiality

4. The strictest confidentiality possible will be maintained in terms of patients and supervisees. Supervisees' confidentiality would only be breached if the supervisor (or indeed the senior health adviser) was gravely concerned about the supervisee's welfare or the welfare of their patients, *and* the supervisee was unable or unwilling to take appropriate professional action themselves
5. Any written notes made by the clinical supervisor, or discussions with their *own* supervisor will be anonymous and non-identifiable
6. (If relevant) The clinical supervisor will be paid £____ and will be responsible for submitting invoices to the appropriate manager
7. The clinical supervision provided will be evaluated at appropriate intervals to be decided between all parties. Any reports prepared for management on the basis of such evaluations will be about appraisal of the supervision provided and not about the performance of the supervisees
8. The relationship between the line manager, professional manager and Supervisor should be made explicit to all concerned before any supervision begins (for example the supervisor might be involved in assessment of the supervisee)
9. In the event of cancellations due to holidays or sickness as much notice as possible should be given. There will be no charge if the supervisor is absent or on leave
10. These arrangements can be changed by mutual negotiation, and can be terminated with a reasonable period of notice: (number of months)

Additionally, research already referred to has identified key questions to ask when initiatives that support the professional functioning of staff (clinical supervision is an example) are being planned. Thorough planning, open negotiation and rigorous evaluation is essential to successful initiatives.

KEY POINTS

Health advisers and their managers should decide on the appropriate combination of clinical supervision and other forms of professional support (from the manager, from peers or from other colleagues) and the desired format (individual or group)

Health advisers in a team should establish criteria for selection of appropriate clinical supervisors

For individual clinical supervision, one hour every two weeks (or the proportional equivalent if a group approach is adopted) is desirable

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HIV testing and management

SANDRA JARRETT AND DORINDA THIRLBY

This chapter looks at the role of the health adviser in:

- Pre-test HIV discussion and risk assessment
- Methods of giving HIV results, including face-to-face and over the telephone
- Ongoing support and counselling for the HIV positive patient and significant others
- Ethical considerations are discussed in chapter 15

INTRODUCTION

HIV infection is less common in the UK than in many other areas of the world, but it is increasing steadily and continues to be a serious threat to both individual and public health.

In 2000, there were the highest number of new infections in the UK since reporting began, a 14% increase on the previous year.

The largest group of people living with HIV are men who have sex with men (MSM), but there are now more new diagnoses amongst heterosexuals (48% of diagnoses in 2000). Much of this transmission is taking place abroad, with the highest prevalence in the UK African communities.¹

Together with the increased rates of infection, people with HIV are generally living longer due to improved treatment and care. There has also been an increase in the rates of infection of other sexually transmitted infections, in particular chlamydia, gonorrhoea and syphilis.

The incidence of HIV in drug users has remained relatively small; however there has been a rise in Hepatitis C infections. Co-infection with HIV and hepatitis needs particular care and management.

Good clinical management of HIV infection requires a multi - disciplinary approach involving a range of services and interventions in order to provide optimal care medically, socially and psychologically.

HIV TESTING

Test sites

Those who wish to have an HIV test need to be able to do so with the minimum of inconvenience. It is important, therefore, that HIV testing be available from a variety of health care settings including genitourinary medicine (GUM), other hospital departments, open access same day testing clinics, primary care, and drug dependence clinics.²

Health advisers can play an important role in providing and developing HIV testing and support services on different sites, as well as training and supervising other professional staff to carry out pre-test discussions.

Pre-test discussion (PTD)

This is one of the core roles of health advising, and health advisers are seen as key providers of pre- and post-test counselling.^{3*} Several studies have shown this aspect of the work covers a significant proportion of the health adviser workload.^{4†} It is best practice that all health advisers are involved in carrying out PTD with patients, as well as developing policies for good practice in the local clinic and wider community.

The National strategy for sexual health and HIV recommends that all patients attending a GUM clinic are offered an HIV test.⁵ It may not be possible or necessary for the health adviser to see all patients before a test, and many clinics have developed a protocol whereby medical and/or nursing staff will carry out PTD for routine, low-risk patients, and those patients at higher risk or with more complicated histories are referred to the health adviser. This enables time to be spent with those whose behaviour puts them at higher risk of acquiring HIV or other STIs, or who have other social or psychological difficulties.

It is important to ensure that anyone carrying out PTD has ongoing training and supervision,⁶ which can be co-ordinated by the health adviser. It is good practice to have a written protocol on the clinic's HIV testing policy, as well as a written 'checklist' or proforma in each set of notes. This could comprise of:

- A list of each category that warrants automatic referral to the health adviser
- A list of prompts to be covered in the PTD as a reminder for all staff that they have covered all necessary issues
- A specific question on informed consent
- The identity of person doing PTD
- Any other issues that may be relevant

This will enable clinics to audit HIV testing in their local area, and use findings to improve practice within clinics as well as the wider community by developing prevention initiatives

* A survey of related counselling practice in the UK with guidelines and recommendations. Health advisers seen as the key providers of pre and post test counselling. Counselling training recommended for HIV counsellors was 450 hours of training. A combined system of line management supervision and independent counselling supervision is recommended.

† A detailed study of 20 GUM clinics in England 1990-91, which looked at the role of the health adviser, although not specifically with HIV. Role priorities were associated with the size and HIV workload of the clinic (pg. 74) Most of the focus is on pre and post test counselling and little written on longer term HIV support although the review reported that those health advisers in larger clinics had a considerable amount of HIV counselling work.

for those most at risk, or reaching communities that may be under-represented in the GU setting.

The following guidance for health advisers on best practice in what needs to be covered at PTD is based on the Department of Health guidelines ⁷ and the CDC Guidelines ⁸

This guidance states that the primary purpose of pre-test discussion is to establish informed consent. To establish informed consent three conditions need to be met:

- The individual must be competent to consent
- The individual needs to understand the purpose, risks, harms and benefits of being tested and those of not being tested
- The individual must consent voluntarily

However informed consent is only one of the purposes of the discussion. Other issues such as risk reduction and health promotion also need to be addressed. It is recommended that the health adviser goes through the pre-test discussion checklist and covers the following issues:

1. Ensure the individual understands the nature of HIV infection; provision of information about HIV transmission and risk reduction:

- Modes of transmission
- Understanding of HIV and AIDS
- Methods that may reduce transmission that the individual currently uses or can be encouraged to use, for example, condom demonstrations

2. Discuss risk activities the individual may have been involved in with respect to HIV infection including the date of the last risk activity (3 month antibody production 'window period') and the perception of the need for a test

- Sexual risks including penetrative vaginal, anal and/or oral sex
- History of drug use and especially injecting exposure. History of exposure to blood/blood product transfusion particularly prior to screening of donations and the heat treatment of factor VIII (introduced in 1985 in UK)
- Tattooing
- Occupational risk
- Overseas travel with exposure to high-risk activity or medical treatment

3. Take a history of any previous HIV tests - when, where and the results - this will help to identify repeat testers and/or the 'worried well'; STI and medical history; psychiatric history

4. Discuss the advantages and any difficulties of testing and the implications of a positive or negative result for the individual and his or her family and associates

Advantages

- Allows the individual to form strategies to protect subsequent sexual partners
- Allows interventions to reduce vertical transmission
- Allows for appropriate medical and prophylactic care
- Allows for decisions about the future to be made
- Reduces needless anxiety about HIV infection

Difficulties

- Psychological complications
- Possible adverse impact on relationships including family, partners and work
- Possible restrictions for those who are positive on testing, for example, on travel
- Possible insurance implications when the company is aware an individual has taken a test

5. Discussion of issues in relation to partner notification, past and current

6. Discussion of support networks and who they may tell if positive or negative

7. Providing details of the test and how the result will be provided, including a brief discussion regarding positive, negative and equivocal results and information about follow up

8. Obtaining informed consent on whether or not to proceed with the test. It is important that this consent is documented with the details of who carried out the PTD

In addition:

- Offer routine screening for syphilis
- Discuss hepatitis A, B and C risks, and testing if appropriate
- Offer hepatitis A and B vaccination if appropriate
- Offer a full GU screen (if not referred by doctor)
- In women, check whether their cytology screening has been done in line with national guidance.
- Discuss contraception issues with both men and women

- Pregnancy wanted/ unwanted
- Method of contraception
- Referral to relevant family planning service

DOCUMENTATION

Ensure the main points of the PTD are documented clearly and concisely. It is good practice to have a proforma to record on and filed in the notes.

RESULTS OF HIV TESTS

At present, most clinics require patients to return in person to collect their HIV result, although a few do give them over the telephone. (See below)

It is recommended that a written policy on result giving is available in the clinic, and that the health adviser takes a lead in co-ordinating results.

Ensure that results are given in private, and patient details checked to ensure the right person receives the correct result.

For some patients who may be at particular risk and are likely to be HIV positive, it may not be appropriate to give a result on a Friday afternoon, or at a time when there is no medical cover. It is important to bear the practicalities in mind when organising appointments for results and ensure there is adequate access to medical assessment and care if necessary.

The aims of post-test counselling are to:

- Address immediate concerns and provide support for those who are positive
- Provide information on the prevention of HIV transmission for those who are diagnosed HIV positive and HIV negative

HIV negative result

Health advisers may not give all the negative results nor may it be appropriate to do so. Each clinic will have its own policy and some health advisers have separate clinics for giving results, but generally it is recommended the health adviser give negative results to those most at risk, or within the 3 month 'window period', or to those who require further support around safer sexual practices and behaviour change.

- Give result immediately to the patient
- Inform the patient of the result clearly
- Give the patient the opportunity to read the result, pointing out the clinic number and date of birth
- Clarify the patient's understanding of the result
- Discuss safer sex message again, re-offer condoms and a GU screen if necessary
- Address any main concerns

Administration

Document the patient has attended for their result and any relevant discussions on the PTD proforma sheet filed in the patient's notes.

Equivocal HIV result

An HIV equivocal result is an infrequent outcome from an HIV test and is an extremely difficult result for the health adviser to impart and difficult for the patient to understand. Given that this is an unusual result to give, it is important that lots of time and support are given to the patient if necessary. The technicalities of such a result need to be carefully conveyed.

An equivocal result is where the tests taken in the laboratory from a patient's first blood sample are neither positive nor negative. The tests have differing 'cut off points' so it is essential the consultant/senior doctor/health adviser discuss with the virologist which tests have been taken and what the virologist's opinion is on the likely outcome of the result, given the patient's risk and health issues, for example, the possibility of recent sero-conversion. It is important that the health care worker documents the outcome of the discussion and probability of the result within the patient notes.

- Ensure the patient is informed of the nature of the equivocal result as clearly as is possible
- Give the patient the opportunity to read the result, pointing out the clinic number and date of birth
- Clarify the patient's understanding of the result
- Discuss the need for the patient's initial blood sample to be tested further at the reference laboratory for a more definitive result
- Give clear guidance based on the laboratories information of when results will be available and arrange the patient's re-attendance
- Explain the need for a further blood specimen on the day of receiving the result for repeat testing, which may provide a more conclusive result
- Address the patient's immediate reactions. Each patient will receive the news in his or her own way. Most equivocal results do turn out to be negative, but it is important to check the history and nature of risk, and the timing of the last risk activity.
- Offer further support if patient requires, and organise a follow-up appointment for confirmatory results

Administration

Document the patient has attended for their result and any relevant discussions or comments on the impact of their HIV equivocal result, on the PTD proforma sheet filed in the patient's notes. Ensure the patient is diaried to check attendance for results or further tests.

Positive HIV result

It is recommended that the health adviser is made aware of any positive results as soon as possible by virology so that care and management can be co-ordinated appropriately.

Always discuss a positive result with a senior doctor, and ensure there is medical support when giving a result. Remember that it is a medical diagnosis and the doctor has responsibility in interpreting that result. It is essential that positive results are not dealt with single-handedly, and require a multidisciplinary approach so that the patient is seen promptly and the service is responsive to the needs of the individual.

It is preferable, if possible, for the person who carried out the PTD to give the result. It is recommended that the health adviser be involved at the start even if someone else carried out the PTD, and to refer the patient to the health adviser at the earliest opportunity after the result.⁹ ‡¹⁰ §

- Give result immediately
- Inform the patient clearly of the result
- Give the patient the opportunity to read the result, pointing out the clinic number and date of birth
- Address the patient's immediate reactions. Each patient will receive the news in his or her own way. Ensure there is time for discussion of immediate concerns. Find out what the patient will be doing in the next 24-48 hours
- Carry out a risk assessment for suicidal thoughts or other mental health issues
- Clarify the patient's understanding of the result
- Discuss the need for a repeat test for confirmation. It is preferable to take the second blood sample on the same day as receiving the result
- Refer for specialist management, including treatment where appropriate. Make an HIV appointment with consultant and give the patient an appointment card confirming the dates and times. If the relevant doctor is available introduce the patient to him/her
- Check if the patient has any immediate medical problems. In case of any symptoms, an immediate link with a doctor is indicated
- Offer follow-up appointments and ongoing support for the patient, partner or family
- Find out who the patient may tell, and clarify support systems

‡ Recommends referral to Health Adviser of all newly diagnosed or transferring HIV positive patients (pg4). The health adviser plays key roles in the prevention of STI's and HIV in terms of partner notification and discussing safer sex strategies for those who are positive.

§ 1988 Monk report. Recommended development of GUM departments

2.11: (6): Counselling should be available in dedicated sound-proof accommodation integral to the department.

7.1: "most counselling offered in GUM clinics related to HIV infection and AIDS, although this is not the full extent of the service".

7.2 "Health advisers undertake the majority of the counselling including HIV inpatient counselling" and that services should have access to the support of clinical psychologists or psychiatrists

7.8 (1)"All clinics should continue to provide comprehensive counselling for patients and clients".

29 "HIV and testing should only be offered with informed consent and with pre and post test counselling and support". The advent of HIV increased the workload of health advisers as this became part of their role

- Clarify transmission issues, and how to minimise risk to themselves and others (for example, other STIs, drug resistance, breastfeeding). Reassure around everyday social interaction and how it is NOT transmitted
- Give details of support services and resource material
- Give patient written details of the ways s/he can contact the health adviser, and help line numbers, for example National AIDS Helpline
- Raise partner notification. It may be appropriate to address partner notification issues in the immediate post-test session. Patients will often raise partner notification at this point. It is important to respond to the patient's immediate concerns and ensure that partner notification is addressed in subsequent sessions

Administration

Document the patient has attended for their result and any relevant discussions or comments on the impact of their HIV positive diagnosis, on the PTD proforma sheet filed in the patient's notes.

NON-ATTENDANCE FOR A POSITIVE RESULT

Always discuss with a senior doctor.

It is important to remember that this is the patient's result and if the clinic has the means of contacting the patient it is recommended that an attempt be made to do so. Please refer to the Recall chapter for further guidance.

WRITTEN CONFIRMATION OF HIV RESULTS

If positive - discuss with a senior doctor.

If negative - Ascertain why confirmation is required. Explain why this is not usually encouraged, in that it is not a 'free from infection' certificate, and only relates to a specific time period. It does not guarantee immunity from infection in the future. For those wanting written confirmation (some people attend simply for this), for example, for insurance purposes or to meet visa requirements, it is preferable to have a written letter rather than a photocopy of the result. This would clearly state the patient details, the date of the test and the date of last risk, to indicate whether the patient is in the 'window period'. It is recommended that there be a written policy to clarify which patients receive written results, how much to charge and the procedure for financial transactions within the clinic.

GIVING HIV RESULTS BY TELEPHONE

As GUM services continue to expand, there is a growing pressure on time and resources within individual clinics, and a need to prioritise, whilst maintaining an accessible and professional service.

There is an increase in the use of communication technology, and patients are making more use of mobile phones, text messaging and email facilities, and often wish to be contacted by these methods. Services need to keep pace with these developments to ensure choice and accessibility, whilst considering confidentiality and data protection.¹¹

The National strategy for sexual health and HIV recommends that all new patients attending a GUM clinic are offered an HIV test, with a goal of reducing newly acquired HIV infection by 25% by 2007, as well as reducing waiting times for urgent appointments.¹²

This has resulted in many clinics providing, or beginning to provide, telephone services for patients to collect results, as the number of patients taking up the test increases.

Many clinics already have a telephone results service for other, routine sexual health screening tests, and health advisers also have experience in telephone counselling, giving advice or information, and contacting patients via the telephone for treatment purposes, follow-up, and partner notification. This strategy can also be applied to notifying patients of their HIV results.

13

The benefits of the use of telephone counselling can be demonstrated in other fields, such as help lines (smoking cessation, phobias), crisis lines such as The Samaritans, Rape Crisis Centre, and in related fields such as The National Aids Helpline.¹⁴

The issue of collecting results is raised in the pre-test discussion, which takes place in a face-to-face interview. Some clinics use a risk assessment to determine which patients are referred to the health adviser (see above). Those patients deemed to be at low risk are often seen by the medical or nursing staff. Therefore there may be different routes by which the patient receives their result - from the health adviser, the nurse or the doctor.

Benefits of telephone results¹⁵

- It allows the patient a choice and gives a feeling of control of how and where they can receive their result
- It provides more immediacy, as the patient does not have to wait to be seen
- It provides more convenience if the patient has far to travel to the clinic to get results, or if there are childcare issues, taking time off work, mobility problems
- It saves time for the clinic staff, particularly health advisers, and frees up appointments for new patients
- It offers flexibility for both patient and health adviser in terms of time and resources
- It allows an assessment to those who require further follow-up with a face-to-face interview, for example, those who receive a positive result, those within the window period, and those who have other sexual health issues

Disadvantages of telephone results

- It removes the visual, and non-verbal communication that is present in a face-to-face interview
- There is uncertainty over correct identification
- Because the practitioner cannot see the patient or their surroundings, it can bring up feelings of unease about a patient's reaction, for example, if there are long silences or the patient hangs up, or the patient does not return to the clinic after receiving a positive result

RECOMMENDATIONS FOR GOOD PRACTICE

To maximise the benefits and reduce the difficulties it is important to take into account the type of service that is required according to geographical location, clinic population and clinic resources. A written policy is recommended.

Co-ordination of service

It is important to identify who will co-ordinate the service to ensure adequate resources, consistency, and evaluation.

Times of service

This will obviously depend on clinic times and resources so it is essential to provide a service that is accessible but manageable, and to ensure the patient is fully aware of the date, time and person they need to ring.

Who gives results?

This again will depend on clinic resources and culture, so it may be that the health advisers give all results or the nurses may share giving them. Whoever is giving results by telephone, there needs to be consistency of how this is done.

Procedure for giving results

This needs to begin at pre test discussion, which takes place face-to-face. After the risk assessment, if appropriate, the patient can be offered a choice of how they get their result, either face-to-face or by telephone. (For exceptions to this - see below).

If they choose the telephone, then it is important to discuss the following:

- The time and date to get their result
- Ascertain where they will be - at home, work, a friend's
- Ascertain whether they will have anyone with them, or who would be there for support if necessary
- The number they will be ringing from or a contact number if there is a problem
- A password to ensure the confidentiality of the patient if so needed
- Written information including the telephone appointment, the clinic phone number and the person they need to speak to
- The pros and cons of giving a result over the phone, and the procedure if it is positive

There will be some patients, however, for whom receiving a result over the telephone may not be appropriate or desirable.

This may include:

- Those who are at high risk of being HIV positive
- Those with a psychiatric history or risk of self-harm or suicide

- Those for whom English is a second language
- Those under 16
- Those who are particularly anxious or vulnerable (although sometimes it can be a benefit for the patient to be in control and in their own home, thereby lessening the anxiety)

This is not an exhaustive list and there may be others that the practitioner would prefer to come back in person. It is important to assess each patient individually, and allow for flexibility between the patient's wishes and the practitioner's.

If the patient insists on receiving their result by telephone, even if the practitioner would prefer them to come back, it is recommended the implications and outcome, as well as the clinic's responsibilities in terms of contact and follow-up, be fully discussed with the patient. It is recommended the health adviser give equivocal or positive results on the phone.

This is why it is important to have a written policy on both telephone results and recall to give clear guidelines in situations like this – does the health adviser insist the patient returns against their wishes? Does the health adviser contact them if they do not call? If positive, is the patient followed up with a phone call, letter or home visit if they do not come back? There may be different policies in different clinics, but whatever the policy it is important that staff understand it and ensure this is communicated to patients and documented in the notes that the patient understands. However, it is best practice to recall patients if they do not return, if there is the means to do so.

Giving the result

- Ensure the practitioner has the case notes in front of them
- Identify the patient - ask for name, date of birth, clinic number, and password if arranged
- Ensure the practitioner identifies themselves clearly
- If negative, give result and ensure the patient understands. Check the window period. Check any further issues regarding sexual health. Arrange follow-up appointment or referral if necessary
- If positive, discuss with the consultant or senior doctor beforehand. Give result and ensure the patient understands
- Check where they are, and whom they are with
- Check support systems
- Discuss main concerns
- Arrange a follow-up appointment within 48 hours to take a second sample and continue support face-to-face

- Check the telephone number and ensure the patient has the health adviser name and number. Give information about other support available if necessary, such as out of hours help lines and support groups ¹⁶

For further details on giving results, see above in the face-to-face interview.

Documentation

It is important to document the outcome of the pre-test discussion, and the patient has given informed consent to both the test and the method of getting a result. Document the result and any action to be taken.

Data collection

It is important to include all telephone contact with patients in the clinic activities and statistics, as this can sometimes be overlooked and not regarded as a 'real' patient.

Monitoring and evaluation of quality of service and service delivery

It is important audit and patient feedback is used to ensure the service is effective, responsive, and accessible, and to ensure development of good practice.

Staff training, supervision and development

It is recommended that staff have regular training on telephone skills, and the issues that can arise through any patient contact when giving HIV results. It is important for staff to have access to supervision if they are involved in pre-test discussion and post-test counselling. ¹⁷

This enhances the skills and development of staff and provides for a more effective and professional service.

SOCIAL AND PSYCHOLOGICAL CARE OF THE HIV POSITIVE INDIVIDUAL

Psychological care can continue throughout the course of HIV infection from initial diagnosis to death, and supporting patients and significant others on issues such as disclosure, risk reduction, relationships, treatment adherence, and bereavement.

The health adviser's input to this process will depend upon prevalence, clinic policy, expertise and training. However, post-test counselling is a core role of health advising, and health advisers are most appropriate in giving results, assessment, on-going counselling, and referral.

^{18 ** 19}

It is essential that those involved in counselling receive adequate training and supervision. ²⁰

See also the chapter on Counselling and Clinical Supervision in this Manual.

Specific issues that affect HIV care:

- Stigma and discrimination
- HIV disproportionately affects minority groups

^{** 4.4.2 HIV Social Care} "In most clinics, health advisers offer counselling following an HIV diagnosis" (3 clinics referred to specialist HIV units) "In most cases post-diagnosis support amounts to between two and six sessions with the health adviser although some smaller clinics provide long-term support." (pg 23) These sessions usually concentrate on people coming to terms with their diagnosis. Referrals are made for specific advice internally and externally for example psychiatry/ psychosexual counselling.

Common issues that may present at diagnosis

- Adjustment to living with HIV
- Shock and uncertainty
- Beliefs: health, medical, religious, cultural
- Partner notification
- Risk reduction and behaviour change
- Personal and social relationships
- Fear and anxiety for the future
- Guilt
- Disclosure of status to friends and family
- Employment issues
- Legal or immigration concerns
- Social/financial situation
- Children / pregnancy issues

Common presenting issues requiring psychological input

Relationship issues

- Disclosure of HIV status
- Safer sex / concern for partners
- Testing partners / children
- Coping with a potentially life threatening illness
- Fear of rejection in family, work, social circle
- Psychosexual issues such as loss of libido and erectile dysfunction
- Pregnancy
- Death of partner / friend / child
- Bereavement issues for significant others

Personal issues

- Maladaptive coping mechanisms, for example, depression, anxiety
- Deterioration in health
- Changes in life circumstances
- Self-destructive behaviour such as unsafe sex or drug / alcohol use

Medical issues

- Starting / changing / stopping HAART
- Non-adherence of medication
- Change in body image, for example, lipodystrophy
- Hospitalisation
- Conception choices
- Testing children
- Dementia
- Terminal illness

A variety of interventions can be used to provide appropriate care, support, and management.

These can include:

- Education
- Crisis support
- Counselling or psychotherapy
- Cognitive behavioural therapy
- Psychosexual therapy
- Psychiatry
- Medication, for example, anti-depressants

Health advisers are key providers of psychological and social care and are an important link between acute and community services and resources.

Health advisers can:

- Provide ongoing support to patients, their partners, families and friends

- Refer to other statutory and voluntary agencies for practical support, for example, housing, welfare rights, social services, HIV support groups, immigration and legal services
- Act as advocate on patients' behalf with medical staff and other agencies
- Refer to psychology or psychiatry
- Address partner notification issues ²¹ ††
- Discuss risk reduction and behaviour change strategies
- Explore other sexual health and health promotion issues

This section has given an overview of the issues affecting HIV positive patients.

It is recommended that further reading be undertaken for more detail, as there are already some excellent publications on HIV counselling. Recommended reading includes:

- Bor R, Miller R, Goldman E; "The theory and practice of HIV counselling: A systemic approach", Cassell, London 1993.
- Bor R and Elford J; "The Family and HIV", Cassell, London 1994.

†† Conclusions:

31. There should be discussion about informing sexual and drug injecting partners whenever a person is found to be infected. The person should be encouraged to inform his or her partner(s) but should be counselled in an unbiased way and not put under undue pressure.
32. Each Health Authority or Trust, in consultation with health professionals and other interested parties, should provide adequate facilities for partner notification by clinic staff (provider referral) when this is requested by the infected person.
33. Partner notification both by the infected person and through provider referral is an issue for all settings in which testing for HIV infection is performed. Managers and clinicians will need to consider how best to utilise the expertise of Health Advisers in settings other than GUM clinics.
34. All staff with responsibility for informing a person that he or she is infected with HIV should have appropriate education and training about partner notification and the need to maintain confidentiality.

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Ethical issues in pre and post HIV test discussion

GILL BELL

Patients and health advisers may have different views on what is in the patient's best interests. This section considers the ethics of overriding the patient's wishes for their own protection, in the context of HIV-related counselling.

Guidelines for the management of an ethical issue can be found in chapter 23, where ethical concepts such as *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* are discussed in detail. This section gives some examples of the ethical choices that may have to be made in relation to HIV testing. Ethical dilemmas tend to arise when the patient's wishes are at variance with clinic policy and/or the health adviser's perception of the person's best interests, or the interests of others.

SHOULD HEALTH ADVISERS ENCOURAGE TESTING?

A patient presents knowing he has a high risk of being HIV positive because his partner is positive, and they have had unprotected anal sex on numerous occasions. He is also showing some signs of HIV-related illness. The man is reluctant to test because he wants to avoid the distress of facing a diagnosis. He also wants to protect his partner, who was positive before they met, from guilt. If the man were to test positive, he would have access to medication that would improve his health and life expectancy considerably.

What should the health adviser's ultimate goal be? Is it, as a health care worker, to protect physical health by -in this case- encouraging testing? Or is it to respect the man's autonomy by supporting free decision-making?

This dilemma of professional duty is not made any easier by considering what is in the man's best interests. On the one hand, physical health and life expectancy may be less important than emotional well being to this man, in which case he is acting in his own best interests. On the other hand, his decision may be based on false assumptions about the impact of a positive diagnosis, or the value of health. Ultimately he has the right to make his own choice, but the health adviser has a duty to explore the implications in some depth to ensure that the decision

is fully informed. It is unclear whether such discussions violate autonomy by applying pressure, or support autonomy by offering the patient a different perspective.

This dilemma would be more complicated if there were reason to believe the man was practising unsafe sex with other partners of unknown status. The duty to protect others might justify pressurising the patient into being tested: but only if there were reason to believe that confirmed knowledge of positive status would change this behaviour.

CAN A PATIENT REFUSE PRE-TEST DISCUSSION?

Clinic protocols for HIV testing invariably include a requirement for pre-test discussion to allow the patient to make an informed decision and prepare for the possibility of a positive result if the risk is high. Some patients resent the extra time or intrusion that pre-test discussions involve, and may express a desire to “just get on with it”.

Should testing be refused without prior discussion, or should the patient be able to take his or her own risk? Consideration would need to be given to the patient’s capacity to understand the risk of proceeding without preparation, and hence his/her ability to make an autonomous decision. Further consideration might be given to the likelihood of resulting harm: if the risk of a positive diagnosis is remote, the case for insisting on pre-test discussion is weakened; if the HIV risk is high and the patient appears unprepared for this, the harm might be substantial. The public health implications of effectively restricting access to testing by insisting on pre-test discussion would also be considered.

CAN A PATIENT INSIST ON HIV RESULTS BY PHONE?

Patients often express the wish to receive HIV results by phone. Many clinics have resisted offering such a service because of the potential trauma of a positive result, and the difficulty of giving appropriate support over the phone.

Is it fair to insist that all patients return for this result, when only a very small minority are likely to be positive? When there is a risk of a positive result, should the patient or the clinic decide what is in the patient’s best interests? If there is a risk to patient welfare, can health advisers surrender responsibility for safe practice by citing patient autonomy? The implications for public health would also be considered: on the one hand, refusing telephone results may discourage testing; on the other hand, giving results by phone reduces the opportunity to discuss future risk discussion or partner notification.

CAN TESTING BE REFUSED?

When suicidal thoughts are expressed?

If the patient states that s/he would commit suicide in the event of a positive result, the health adviser must be sure that the decision to test is rational, and not distorted by mental illness. If the choice is rational, and therefore autonomous, it is necessary to decide whether the duty to protect the patient’s long-term interests overrides the duty to respect autonomy.

Consideration would be given to the balance of anticipated harms and benefits. If the risk of a positive result were low, the likelihood of dire consequences might be negligible. If the patient has been disabled by acute fear of HIV, the benefits of establishing negative status might outweigh the (small) risk of a positive result.

When there is no identified HIV risk?

It may be counterproductive to test patients who have HIV anxiety in the absence of identifiable risk, or in spite of having received a negative result three months after the last risk. Such tests are not likely to succeed in reassuring the patient. They may even exacerbate fear by suggesting lack of confidence in the reliability of tests, or doubts that all transmission routes have been identified. Testing may also delay confrontation with underlying anxieties and referral for appropriate help. (See Ch.16: Working with the 'worried well') However, this view is paternalistic (See *Paternalism* in Ch.23 - Ethical issues in sexual health advising) and can only be justified if the patient is judged unable to make a rational decision, or the duty to protect welfare overrides the duty to respect autonomy.

CAN THE PATIENT AVOID A POSITIVE RESULT?

If the patient fails to return for a positive result, should the health adviser try to contact the patient? Failure to return may indicate a desire not to know, which may be the patient's right. Or there may be no such right: acceptance of a test, following pre-test discussion, might constitute agreement to receive the result. It could be construed as unfair to put health advisers in the invidious position of having to conceal a diagnosis that was voluntarily sought. Even if the patient does retain a right not to know, this must be balanced against his or her need for medical care and the risk to sexual partners, past and future, who need to be notified and protected respectively.

CONCLUSION

There are complex ethical issues that need to be considered during pre and post HIV test discussion. It is good practice to discuss difficult choices with colleagues, and document the reasons for the decisions made.

Working with the 'worried well'

SANDRA JARRETT

This chapter explores some of the characteristics of the 'worried well' and gives some recommendations and guidelines for health advisers in managing what are perceived to be difficult and time-consuming patients.

DESCRIPTION OF THE 'WORRIED WELL'

Some patients can present with multiple physical complaints, which they interpret as evidence of HIV infection or other chronic illness. They are not reassured by doctors that they do not have an identifiable medical problem, and fear and anxiety in the patient can reach obsessive proportions.

Patients will often deny that there may be a link between emotional problems and their somatic expression. This is because somatic symptoms are often a more socially acceptable presentation and carry fewer stigmas than psychological problems. They are viewed as physical by the patient, and the patient can receive a 'reward' in the form of attention from professionals.¹

The problem can directly affect the patient/healthcare worker relationship, and feelings of exasperation and hopelessness often result in negative views of the patient, who is seen as willful, resistant to change, and a drain on professional and personal resources.²

CHARACTERISTICS OF THE 'WORRIED WELL'

These can include the following:^{3 4}

- Repeated negative tests and investigations
- Low risk sexual history, including covert and guilt-inducing sexual activity
- Poor post adolescence sexual adjustment
- Social isolation
- Those with relationship problems

- Multiple misinterpreted somatic features
- Psychiatric history and repeated consultations with GPs or physicians
- High levels of anxiety, depression, and obsessive behaviour
- Increased potential for suicidal gestures
- Misunderstandings of health education messages

MANAGING THE WORRIED WELL

If a patient is concerned about their health, it is important that s/he is always referred to the doctor to address any medical issues first. Only after physical illness has been excluded can the patient be defined as 'worried' and 'well'.⁵

Patients may have different degrees of worry or concern about HIV, and it is important to first establish the nature and background of those concerns in order to decide on the most appropriate intervention.

- Ask the patient what his/her concerns are, assess their knowledge of HIV and provide information where needed
- Ask the patient what risks s/he has been at regarding HIV, both actual and perceived, and why s/he is presenting at this particular point
- Find out if there are any other issues that are concerning the patient such as relationships, work or other life events
- Find out if the patient would believe or be reassured by a negative HIV test
- Find out if the patient has been elsewhere for other tests, or sought help or advice regarding HIV
- Offer a test if appropriate

Often, these methods on their own will resolve a patient's worry over time.

However, some patients are not reassured for long by negative results, and continue to fear they have contracted a particular infection or complain of signs and symptoms of disease, when there is no medical evidence for this. These patients are often referred to the health adviser after failure to reassure, and sometimes after repeated negative tests. They may be labelled as hypochondriacal, compulsive, obsessive or hysterical.⁶

To try to overcome this cycle of 'yes, I am' - 'no, you're not' impasse,⁷ it is useful for the health adviser to adopt a different strategy and resist the temptation to reassure, or to offer yet another HIV test, as this can be counterproductive and send a mixed message to the patient. If the patient has not been reassured by other professionals, it is unlikely they will be by the health adviser. This means accepting the patient's view, whilst at the same time introducing the possibility that these concerns might be stressful and cause anxiety to the patient.

Questions can be asked about how the patient has coped with the symptoms and his/her worries. This helps construct a wider view of the problem, for example:

- How long has s/he been worried about this?
- Does anyone else know of this worry?
- How has it affected his/her relationships or everyday life?
- How has s/he coped with this so far?
- Has anything helped to make them less worried?
- How would s/he cope if the worry persisted?
- Are there any advantages to the worry?
- What would s/he lose if they stopped worrying?
- What might s/he gain?
- What other worries does s/he have in their life at this moment?
- Would s/he consider a referral on for further psychological help?⁸

This gives the patient the opportunity to talk about his/her view of the problem and the impact it has had on him/her. It can facilitate referral for further psychological or psychiatric help to alleviate the patient's distress and break down resistance, which can cause high levels of frustration for both patient and staff.

Many of these ideas in working with the worried well come from understanding and responding to resistance in counselling and psychotherapy⁹ and through psychiatric definitions of abnormal illness behaviour.¹⁰

CONCLUSION

The health adviser needs to be familiar with these concepts of resistance and change, and if dealing with a 'worried well' patient, it is strongly recommended that health advisers have the necessary counselling qualifications and experience to do brief therapy. If not, it is essential that health advisers are capable of carrying out a thorough assessment and referring on as appropriate to a clinical psychologist or psychiatrist. Whatever level of intervention, working with these patients can be frustrating and time-consuming, and it is highly recommended that these cases be discussed in clinical supervision.

ACKNOWLEDGMENTS

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Hepatitis C testing and management

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A specific protocol is recommended for hepatitis C testing/screening

It is recommended the health adviser see high-risk individuals for pre-test discussion

Infected injecting drug users may benefit from the early involvement of health advisers in planning care strategies

INTRODUCTION

Hepatitis C (HCV) is a blood-borne virus and may be transmitted:

- Most commonly by injecting drug users (IDUs) and is readily transmitted by sharing contaminated equipment (needles and syringes, spoons, water and filters). It is estimated that over 30% of IDUs attending specialist services have evidence of hepatitis C infection, and some smaller studies have suggested 50-80% prevalence amongst IDUs¹
- By sexual transmission; this may occur but it is inefficient compared to hepatitis B virus (HBV). Estimates for sexual transmission are less than 5% in regular sexual partners²
- By blood transfusions/ blood products before 1991 in the UK.
- By vertical transmission to children. This is usually low but depends on the hepatitis C RNA level and co-infection with HIV with an overall transmission rate of up to 6%, increasing to 15-20% where there is co-infection with HIV.³ There is no association as yet between breastfeeding and HCV transmission
- Through medical or dental procedures abroad where infection control may be inadequate

- By occupational exposure, for example, needle stick injuries or bites
- Through tattooing, ear piercing, body piercing and acupuncture where infection control may be inadequate
- Possibly through sharing toothbrushes and razor blades

Of 100 people diagnosed with HCV 20 will clear the virus in 2-6 months, of the 80, 20 never develop liver damage or physical symptoms. Of the remaining 60 some will develop some level of long-term symptoms or signs of liver inflammation, 16 of these will develop cirrhosis of the liver over 20 years, and of the 16, 1-2 with cirrhosis may develop liver cancer after a further period.⁴ Factors that influence HCV progression are:

- Increased alcohol consumption
- Older age
- Gender- men are more likely to progress than women
- Co-infection with HIV or hepatitis B⁵

There is currently no place for routine or universal screening in genitourinary medicine (GUM) because of the low prevalence of hepatitis C in the UK. Opportunistic screening is appropriate for some patients attending GUM services. It is considered good practice that the health adviser, with other members of the multidisciplinary team, develop a protocol of those people to be screened, for example:

- Current or past IDU regardless of when last injected* (with consent)
- Blood transfusion recipient prior to September 1991, or blood products before 1986
- Regular sexual partners of those with HCV
- Patients with persistently abnormal liver function tests (LFTs) (for example for 3 months or more)
- Patients with acute hepatitis when antibodies to hepatitis A (anti-HAV) and hepatitis B surface antigen (HbsAg) tests are negative
- Patients with a risk from tattooing, ear piercing, body piercing and acupuncture where infection control may be inadequate
- Patients who have had medical or dental procedures abroad where infection control is inadequate
- Health care workers following a needlestick injury (usually occupational health)
- Patients from high prevalence areas, for example, South and East Asia and Eastern Europe⁶
- Patients diagnosed as HIV antibody positive, as a baseline screening test and repeated according to risk

* It may be advisable to screen IDU patients when they present, even if they are within the 'window period', as many IDU are sporadic attenders.

In many clinics, patients undergoing hepatitis C testing may only see a health adviser for pre and post-test discussion/ counselling, as part of the clinic protocol. Where a positive result is likely, it is good practice results are given to the patient in person.

PRE-TEST DISCUSSION OF HEPATITIS C

- As with HIV testing, the primary purpose of a pre-test discussion is to establish informed consent. To establish informed consent three conditions need to be met:
- The individual must be competent to consent
- The individual needs to understand the purpose, risks, harms and benefits of being tested and those of not being tested
- The individual must consent voluntarily

However informed consent is only one of the purposes of the discussion. Other issues such as risk reduction and health promotion also need to be addressed. The health adviser will need to go through the pre-test discussion check list and cover the following issues:

1. Ensuring the individual understands the nature of HCV infection; provision of information about HCV transmission and risk reduction
2. Modes of transmission
3. Risk reduction/ harm minimisation
4. A discussion of risk activities the individual may have been involved in with respect to hepatitis C infection including the date of the last risk activity (6 month antibody production 'window period') and the perception of the need for a test
 - History of drug use and especially injecting exposure
 - Had unsafe sex with a partner who is known to be HCV positive
 - Transfusion recipient prior to September 1991
 - Tattooing
 - Occupational risk
 - Overseas travel high prevalence areas with exposure to high-risk activity
 - Health care workers following a needlestick injury (usually dealt with by occupational health)
5. Ensuring the patient understands the long-term implications of the disease

6. Discussion of the advantages and disadvantages of testing and the implications of a positive or negative result for the individual and his or her family and associates.

Advantages

- Allows the individual to form strategies to protect subsequent injecting/ sexual contacts/ partners
- Allows interventions to reduce vertical transmission
- Allows for appropriate medical care
- Allows for decisions about the future to be made
- Reduces needless anxiety about hepatitis C infection

Disadvantages

- Psychological complications
 - Possible insurance implications when the company is aware the person is known as HCV positive
 - Possible adverse impact on relationships including family, partners and work
 - Possible restrictions for those who are positive on testing, for example, travel / life insurance
7. Discussion of issues in relation to needle using contacts/ sexual partner notification, past and current
 8. Providing details of the test and how the result will be provided. Including a brief discussion regarding positive, negative and intermediate results and information about follow up
 9. Obtaining informed consent on whether or not to proceed with the test
 10. Many patients may present for one particular concern but it is important to consider all sexual health needs and discuss and/ or offer:
 - Routine screening for syphilis
 - HIV testing if appropriate
 - Hepatitis A and B testing if appropriate
 - GU screening as appropriate
 - In women check whether their cytology screening has been done in line with national guidance.
 - Discuss contraception issues with both men and women
 - Pregnancy wanted/ unwanted

- Method of contraception
- Referral to relevant family planning service

RESULTS OF HEPATITIS C TESTS

There needs to be discussion about local management of positive/ reactive results, for example how specific/ sensitive the result is, when a provisional result is available and when confirmation is available. This information will inform practice, for example where a reactive result may be given after one week or a confirmed result given after three.

Hepatitis C negative result

- Inform patient of the result clearly
- Give the patient the opportunity to read the result, pointing out the clinic number and date of birth
- Clarify the patient's understanding of the result
- Offer repeat testing if the person is believed to have had a recent risk, as antibodies may take six months to develop
- Discuss safer injecting messages again, offer drug services referral if indicated
- Discuss safer sex messages; offer condoms and GU screen if necessary

Document the patient has attended for their result and any relevant discussions in the patient's notes.

Positive hepatitis C result

- Inform the patient clearly of the result
- Give the patient the opportunity to read the result, pointing out the clinic number and date of birth
- Address the patient's immediate reactions. Each patient will receive the news in his or her own way. The health adviser needs to allocate adequate time for the patient and their information/ counselling needs
- Clarify the patient's understanding of the result
- The need for a repeat test for confirmation. If the patient is willing the blood can be taken on the same day as receiving the result
- Discuss treatment (for example combination of Interferon/ Ribavirin)⁷ and follow up options including referral for specialist management. Blood samples are usually sent for LFTs and HCV RNA PCR (checks for active infection). If the RNA is positive there is a risk of chronic liver disease even if the LFTs are normal. The patient may be referred to a HCV/ Liver specialist. The patient may be advised to have a liver biopsy, particularly if he/ she wishes to consider treatment

- Future lifestyle management re drugs and alcohol
- Avoidance of paracetamol
- Check the patient does not have any immediate medical problems
- Offer follow up appointments and ongoing support
- Make health adviser appointment for same day as consultant appointment or before if the patient wishes. Ideally both these appointments are to be made within a few days of patient receiving diagnosis. This may include support for carers and partners
- Give details of support services and written details of the ways he/she can contact the health adviser, and helpline numbers, for example National AIDS helpline. Give leaflets about HCV, for example from the British Liver Trust
- Raise partner notification. It is appropriate to address needle contact, partner notification, vertical transmission issues in the immediate post test session. Post test patients will often raise this themselves. The health adviser needs to respond to the patient's immediate concerns and ensure partner notification is addressed in subsequent sessions
- Document the patient has attended for their result and any relevant discussions or comments on the impact of their hepatitis C positive diagnosis in the patient's notes

A provisionally reactive / equivocal result

A provisionally reactive equivocal result is a rare outcome, but the technicalities of such a result need to be carefully conveyed. It is important that lots of time and support are given to the patient about the possible outcomes of the test.

- The patient needs to be informed of the nature of the result as clearly as is possible. Give the patient the opportunity to read the result, pointing out the clinic number and date of birth
- Clarify the patient's understanding of the result. The need for further results following further tests at the reference laboratory for a more definitive result. Give clear guidance based on the laboratory's information of when results will be available and arrange the patient's re-attendance. The health adviser needs to explain the need for a further blood specimen on the day of receiving the result for repeat testing, which may provide a more conclusive result
- Address the patient's immediate reactions. Each patient will receive the news in his or her own way. Stay with the patient as long as necessary
- Offer follow up appointments and ongoing support
- Make a health adviser appointment for their result appointments. Where the patient has specific medical concerns they will need to be also seen by a consultant. Offer support and advice for partners where appropriate

- Give details of support services. Give patient written details of the ways s/he can contact the health adviser, and helpline numbers, for example the National AIDS Helpline or the British Liver Trust
- Document that the patient has attended for their result and any relevant discussions or comments on the impact of their hepatitis C reactive/ equivocal result, in the patient's notes

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Psychosexual counselling and therapy

L I N D A L E W I N G T O N

The health adviser's patient has come to a genitourinary medicine (GUM) clinic suffering from a medical problem. In the medical world, their problem is described as "genitourinary". To the layman, it is already a "sexual" problem – something to do with their sexual organs.

I N T R O D U C T I O N

A GUM clinic may be the first port of call for patients with a sexual problem. They will undergo an intimate physical examination, which they may well find very embarrassing. Then they may be referred to the health adviser to explain the nature of the problem, how and when the condition was contracted, what they can do to prevent it in future and how to avoid giving it to someone else. For many people, this may be the first opportunity they have had to talk openly about sexual issues within a safe professional environment. As a result, having discovered that the doctor and health adviser are people to whom they can talk about intimate matters in confidence, the patient is more likely to mention they have another problem they want to talk about.¹ This may be a specific psychosexual problem.

P S Y C H O S E X U A L N E E D S A N D H E A L T H A D V I S E R I N T E R V E N T I O N

The health adviser can be faced with a patient asking for more than routine advice about a sexually transmitted infection and must deal with issues of accountability for the patient's care. It becomes part of the health adviser's role to decide whether the patient's problems may be in all likelihood organic in nature, arise out of a relationship problem which may be helped by counselling or whether there are specific psychosexual problems requiring the skills of a trained therapist.

W H A T I S A P S Y C H O S E X U A L T H E R A P I S T ?

A dictionary of psychological terms defines "psychosexual" as being "broadly relating to all aspects of sexuality, the mental as well as the physical or psychological".² Psychosexual

problems are defined in a variety of ways but consist mainly of sexual problems arising from psychological causes. The psychological nature of the cause differentiates them from a range of other sexual problems, often with similar signs and symptoms, which can be treated by surgery or drug therapies. A psychosexual therapist therefore, is someone trained in facilitating patient resolution of sexual problems using a broad range of psychological therapies, is accredited with a professional body and receives regular clinical supervision for their therapeutic practice.

THE SEXUAL HEALTH ADVISER'S ROLE

The availability of counselling or psychosexual therapy in a GUM clinic will vary from clinic to clinic. In some cases, this is due to a lack of trained psychosexual therapists to offer the service: in others, service constraints may prevent an effective psychosexual service being offered.³

The health adviser's primary task is therefore to decide whether the patient's problems can be addressed within the service of the clinic and if not, what alternative agencies may be available.

Individuals and couples can present for therapy and the approach will be suited to patients whether they are partnered or not. It is of note that lesbians and gay men may present with specific psychosexual problems but may have their presenting problem(s) embellished with issues of internalised homonegativity (previously referred to as homophobia).

COUNSELLING AND THERAPY

Many people who seek help for sexual problems may not require a full, formalised course of psychosexual therapy. For example, a woman may present to her GP complaining of pain on intercourse and be referred to the GUM clinic. On testing in the clinic, she may be found to have chlamydia trachomatis infection or PID. Otherwise, in the absence of an STI, she might be menopausal, causing a dry vaginal mucosa with increased friction and pain on penetrative intercourse. Once these and other possible organic causes have been tested for and excluded there might be an indication of a need for detailed psychosexual history taking.

It should be emphasised that all patients presenting to a clinic or other centre for help with a psychosexual problem should have possible organic causes ruled out first before considering psychotherapeutic interventions.

Before recommending any kind of help, the health adviser should conduct an assessment to ensure they have a clear understanding of what lies behind the presenting problem. For example, a man may complain he is having difficulty maintaining an erection: on further elucidation it may become clearer that the difficulty only arises when he puts on a condom. Explanation of how he can put on a condom as part of sexual foreplay and in a way that does not impinge on his sexual arousal may solve a seemingly intractable problem.

The individual's sexual development and any current relationship also need to be elicited as much as possible in assessment. As explained below, one of the early tasks in a course of psychosexual therapy is to take a full and detailed history of the patient's sexual development and activity. Such a history may take more than two or three sessions and therefore may not be a practical consideration for health advisers in very busy clinics.

The attached protocol attempts to set out the basic key questions that are likely to provide indication for appropriate referral and treatment. With this information the health adviser can

identify whether the patient needs therapy to resolve the problem or whether an instructive discourse with an experienced counsellor is a more appropriate course of action.

A counsellor is someone trained to help patients help themselves, usually outside of a medical setting, by facilitating their making choices about their lives, their behaviour and their relationships through a regular process of active listening and impartial feedback. The therapist differs significantly by diagnosing problems and suggesting courses of action based on a variety of therapeutic models to help the patient overcome the block(s) to a satisfying sex life.

Just as one of the medical practitioner's skills is diagnosis, so one of the key skills of the therapist lies in examining histories and identifying predisposing, precipitating and perpetuating factors in blocking the patient's sexual gratification.

A course of psychosexual therapy requires commitment to the process from the patient or couple. Different organisations advocate different protocols in the course of therapy, the RELATE model, as an example, require a couple to commit to abstaining from sexual intercourse and spending three hours a week doing homework exercises designed to rediscover the sensuality of their physical relationship before working on to the sexual aspect of their relationship. These are called sensate focus exercises. Feedback is given to the therapist on a weekly or fortnightly basis. For the therapist, feedback from the individual (doing solo sensate focus exercises) or the couple can be diagnostic as well as therapeutic for the patients as sessions progress.

The therapist will plan a specific and individualised course of therapy for every couple or individual seen. Not only will the initial plan differ depending on the analysis of the problem and the sexual developmental history, but also each plan will develop and be fine tuned session by session as the patient(s) report physical and emotional responses to sensate focus exercises to the therapist.

The way in which in potential psychosexual problems present can vary dependent on sexuality and gender. Women tend to present fairly openly to the extent of admitting a problem involving the partner, but tend to withhold information, most commonly on the grounds of social acceptability and concerns about confidentiality.⁴ Men tend to present less frequently, and are typically more likely to put blame on their partner. Although gay men may present with sexual problems, these are more commonly to do with problems coping with the sexuality, or general medical problems. The incidence of psychosexual problems in gay men is comparatively low.⁵

Before recommending any kind of help, the health adviser must first carry out an adequate assessment to ensure they have a clear understanding of what lies behind the presenting problem (see Appendix). A man may complain he is having difficulty maintaining an erection: on further investigation it may become apparent that the difficulty only arises when he puts on a condom, and explaining how to fit a condom in a way that does not interrupt the sexual arousal process may solve a seemingly serious problem.

The individual's personal sexual development and the current relationship also need to be understood to assess this. As explained below, one of the early tasks in a course of psychosexual therapy is to take a very full and detailed history of the patient's sexual development and activity. Such a history typically takes about 2 hours to complete, and is not, therefore, a practical alternative for the health adviser. The attached protocol, however, attempts to set out the key basic questions which are likely to provide indications for

appropriate referral and treatment. With this information, the professional can identify whether the patient needs active behavioural therapy to resolve the problem, or whether simple education or discussion with an experienced counsellor to resolve relationship or attitudinal problems is a more appropriate course.

A counsellor is someone trained to help patients, usually outside a medical setting, to help themselves by making better choices about their lives, their behaviour and their relationships.⁶ The therapist intervenes directly by “diagnosing” the patient’s problem and describing courses of action, based substantially on the theories of behavioural psychology, to help the patient.

WHAT SORT OF PROBLEMS ARE “PSYCHOSEXUAL”?

As we have already discussed, a psychosexual problem is any problem of a sexual nature which has psychological origins. Examples of typical problems encountered by the therapist include:

Vaginismus An involuntary spasm of the muscles in the lower third of the vaginal barrel, produced in some women when sexual or genital approaches are made either by a penis or a finger. The muscle spasm renders penetration impossible

Dyspareunia Pain on intercourse

Anorgasmia (female) / retarded ejaculation (male) The individual fails to be able to reach orgasm and finds this a problem

Erectile dysfunction The inability to achieve or maintain an erection sufficient for penetration

Premature ejaculation Ejaculation which occurs before vaginal penetration or immediately after penetration

Disorder of desire Loss of desire for sex can be apparent in both males and females, and can be a result of a variety of organic or non-organic causes

Sexual identity issues Where an individual may have concerns about elements of their sexual identity and/or attraction

In all cases, the sexual difficulties may be:

- Primary - when the difficulties are always present
- Secondary - when a condition has not always been evident and has become a difficulty following apparently “normal” sexual functioning
- Total - where the sexual difficulty is apparent in all sexual situations
- Situational - where the difficulty is evident at certain times or with certain people, but functioning is perceived to be fine at other times or with other people.

HOW CAN THE HEALTH ADVISER HELP?

The health adviser needs to appreciate how much courage it takes for the patient to admit to

having a sexual problem, however serious or trivial it may appear to the adviser. The health adviser is placed in a position of trust and reliance which the patient may not have experienced before and may not experience again for a long time.

Before any effective help or referral can be offered, however, the health adviser needs to assess the nature of the patient's problem, which involves the following key strategies:⁷

- Listening – to hear what the patient *feels* is wrong with them, without attempting to diagnose or interpret the information at this stage
- Reassurance – like any other patient, someone with a sexual problem needs the comfort of knowing their problem is not unique and not incurable
- Giving permission – remaining open to build the patient's confidence that otherwise "secret" issues can be mentioned and addressed without embarrassment (for the patient or the listener)
- Providing information – having the ability to answer questions professionally or refer the patient to an appropriate agency who can deal with them
- Encouraging communication – the patient will need to be able to discuss their problem with their partner, but may need encouragement to open such a dialogue

This set of strategies, built around the protocol suggested in the appendix, enables the health adviser to allow the patient to explain the problem. In the light of this assessment, the health adviser may be able to make specific suggestions or recommend some self-help process (such as suitable further reading material) or refer the patient to an appropriate agency.

Suggesting to a patient that they be referred for psychosexual therapy is likely, in many cases, to cause a degree of alarm, often based on worries about what the therapy will actually entail. The health adviser's ability to reassure the patient by explaining at least in outline the procedures a psychosexual therapist is likely to follow may do a lot to ease the patient's concerns and assist in the opening phase of the therapy.

WHAT WILL THE PSYCHOSEXUAL THERAPIST ACTUALLY DO?

With a few exceptions, psychosexual problems involve both parties to a sexual relationship. The therapist will therefore almost invariably deal with a couple together rather than treating the patient alone. It is by no means uncommon for one party to a relationship to present with a problem, only to find on further investigation that the problem lies as much with the other party as with the presenting "patient".

The first step will therefore usually be a joint interview to understand the patient's perception of the problem. This will allow the therapist to assess whether the problem is appropriate for psychosexual therapy or whether the patient should be referred first, for example, to their GP if there are indications of other possible causes for physical conditions.

If the therapist feels psychosexual therapy would be appropriate, the partners are then seen separately while the therapist takes a sexual history from each of them. These interviews are undertaken separately because the history, which will start from childhood and examine all aspects of the patient's sexual and relationship past in considerable detail, must obviously be

full and in depth: there may be aspects of that history of which the other partner is not aware and which the patient does not want to disclose to them (although such disclosure would usually be encouraged at an appropriate stage.)

Just as one of the medical practitioner's key skills is diagnosis, so one of the key skills of the therapist lies in examining the histories and identifying from them possible underlying causes for the presenting problem. The couple will then be invited back for a "round-table" at which the therapist will explain some of the issues giving rise to the problem and propose that the couple are (or are not) taken into a course of behavioural therapy to work with the problem.

The course of therapy requires commitment and determination from both partners. Although different organisations follow different protocols in the course of therapy, the *Relate* model, as an example, requires the couple to commit to abstaining from intercourse and spending three hours per week doing their "homework" (in addition to a weekly session of about an hour with the therapist) over course which they can typically expect to last for 16 – 20 weeks. The "homework" will involve following a programme of "sensate focus", in which the couple gradually explore each other's bodies and discover what they like and don't like. Initially, they will be told to have no genital contact. This will lead, in the next stage, to touching and exploring the genital area, and then to arousal and possibly to producing orgasm before permission is given to resume sexual intercourse. The aim of the process is to enable the partners to explore their feelings in a situation which has been made safe by the removal of any fear of sexual intercourse being inevitably involved in it.

The outline above is nothing more than a very generalised description of the process a therapist would follow. The therapist will plan a specific, individualised course of therapy for each individual couple. Not only will the initial plan differ depending on the analysis of the problem and the sexual histories, but each plan will develop and be "fine-tuned" week by week as the partners report their physical and emotional responses back to the therapist.

WHAT SUPPORT IS AVAILABLE FOR HEALTH ADVISERS?

Where this is not possible, or where extended waiting lists exist, the health adviser will need to know what appropriate referral agencies exist.

There is no standard training requirement and no universally recognised qualification to practise as a "sex therapist". Many general counsellors and counselling organisations will offer sex therapy as a part of their skill set. Self-styled "sex therapists" even advertise in some local newspapers. The complexities of possible medical and psychological issues which give rise to psychosexual problems, and the possibility of these being made worse rather than better by ill-informed, unqualified practitioners, is obvious.

There are, however, various organisations which are generally respected for the training and the quality of their clinical supervision and management in the sphere of psychosexual therapy. The health adviser needs to take steps to check the credentials of organisations and therapists in his/her geographical area.

In most local settings, the only organisation with a national network of centres offering psychosexual therapy is *Relate*. Some larger hospitals and psychiatric hospitals also offer psychosexual therapy and individual therapists carry on their own private practices.

The most widely accepted accreditation system is that offered by the British Association for Sexual and Relationship Therapy (BASRT), who will be able to provide addresses and contact points for their members in any particular region.

USEFUL ADDRESSES

For further information about psychosexual therapy, training, availability of therapists and general information, try contacting:

The British Association for Sexual and Relationship Therapy tel: 020-8543-2707; info@basrt.org.uk

Relate, Herbert Gray College, Little Church Street, Rugby, Warwickshire CV21 3AP, tel: 01788-573241; fax: 01788-535007; enquiries@national.relate.org.uk

South London & Maudsley NHS Trust, Bethlem Royal Hospital, Monks Orchard Road, Beckenham, Kent BR3 3 BX tel: 020-8777-6611; www.slam.nhs.uk

The Tavistock Institute, 30 Tabernacle Street, London EC2A 4EU; tel: 020-7417-0407; fax: 020-7417-0566; central.admin@tavinstitute.org.uk

SUGGESTIONS FOR FURTHER READING

Litvinoff S. *The Relate Guide to Sex*. London: Vermilion, 1992

A good general introduction to sexual matters and sexual problems with in relationships generally

Zilbergeld B. *Men and Sex* Glasgow: HarperCollins, 1978

A widely-acclaimed introduction to men's thoughts and attitudes to sexuality and sexual problems

Heimann J.R. & LoPiccolo J. *Becoming Orgasmic* London: Piatkus 1988

A sexual and personal growth programme for women recommended by *Relate* and the Family Planning Association

Kaplan H.S. *The Illustrated Manual of Sex Therapy* second edition New York: Brunner Mazel, 1987

Essential and beautifully illustrated reading for therapists

Bancroft J. *Human Sexuality and its Problems* second edition Edinburgh: Churchill Livingstone, 1989

This is the technical study "bible" for student therapists

ACKNOWLEDGEMENTS

The steering group would like to thank Ronnie Seery for his helpful comments

APPENDIX

Sample questionnaire

When did you first notice the problem?

Does the problem arise whenever you attempt intercourse or only sometimes?

Can you identify anything in particular about the situation or circumstances in which it arises (for example after a drink / late at night / when the children are being difficult)?

Does the problem make you try to avoid sexual situations?

What sort of relationship are you currently in? Married? Long-term relationship? Short-term relationship? One-night stands?

How is the relationship generally?

How do(es) your partner(s) react to the problem?

How does your partner communicate their reaction?

How well do you communicate in the relationship generally?

How does their reaction make you feel?

Information about family and home background (for example young children / sharing accommodation / living with relatives)

Information about pregnancies, childbirth, miscarriages/terminations

History of past illness and operations

Use of alcohol, drugs or medication

Any history or psychiatric illness

What sort of work do you do?

Can you identify stresses arising from work or home situations, wide family relationships, current lifestyle?

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Pregnancy options

HELEN MCILVEEN

Health advisers can facilitate the patient through a significant life event of a positive pregnancy result and bring clarity by developing the options that are available. They can create conditions that allow autonomous decision-making through exploring ambivalence, alternatives and encompassing wider circumstances. This will shape the reproductive decision, whether that is to continue to term with the pregnancy and mother the child, consider adoption or to terminate the pregnancy.

INTRODUCTION

This chapter should be used as guidance alongside pertinent chapters exploring in more detail issues of working with young people, ethics, counselling, legal aspects and code of conduct for sexual health advisers. These are crucial frameworks for the practice of health advising which need to be set against other professional responsibilities and developments such as making reproductive choices.

These guidelines are not prescriptive and do not determine that this is a definite responsibility for health advisers. But after the shock of the diagnosis of pregnancy comes the difficult area of making decisions. Some patients are able to take control and have a clear idea of what to do next. However, as unwanted pregnancy is often seen as an aspect of sexual ill-health it seems pertinent to consider it for professional development. The impact of unintended or unwanted pregnancy in adolescence, in particular, is serious for future life chances and warrants a “joined-up” working approach, rather than leaving it to other sexual health service providers.¹

² There is also an expressed need from patients to have facilitators who are familiar with any medical interventions as well as being experienced in using counselling skills³. This fits well with the role of health advising.

It is not uncommon for pregnancy to be diagnosed within the genitourinary medicine (GUM) setting, particularly when departments are placed within sexual health centers. Some patients discover this on home testing. When pregnancy has been confirmed a woman may need and value support with the decision-making process, whether to continue with the pregnancy, terminate the pregnancy or proceed with adoption.

Without an opportunity to evaluate her situation, the immediate reaction is often to try to appease others to the detriment of her own needs. An internalized sense of duty due to externally imposed obligations means she may try to live up to the expectations of others and keep up appearances. ⁴ If the health adviser's response was to give immediate medical referral for termination of the pregnancy it implies the patient has completed her decision-making. It would be wise not to assume the patient will be offered some other counselling somewhere else along the line, unless they are specifically referred for that reason.

Termination clinics are often very busy places and running to tight schedules that also assume the patient has been referred because she is sure of her decision. Research shows she will then experience difficulty disembarking from a medical roller-coaster and this could lead to regret later. ⁵

PRINCIPLES

Pregnancy tests

It is recommended that pregnancy testing is only be carried out following a department protocol (appendix 2.) and ensuring the patient has had an opportunity to explore the consequences of either a negative or a positive result for her situation, before it is taken. It requires the recording of a sexual history, of contraception use and may call for further advice about reliable contraception methods. Pregnancy testing is often a task delegated to untrained workers or support staff, as it is perceived as a simple procedure. This is obviously inappropriate. The patient needs to be prepared and fully informed. The consequences for some women may be overwhelming.

Barriers

There may be barriers within the G.U.M. department to providing conditions that allow autonomous decision-making. In particular, time constraints can lead to pressure in the consultation as well as the actual length of gestation at presentation and create a sense of having to come up with a quick solution. By creating the atmosphere that allows the woman to consider all aspects of her situation and not just on the reduction of the immediate distress, it will clarify ambiguity and reduce the threat of post-termination regret. ⁶ Offering this time will not only empower women to make choices that reduce negative long-term psycho-social consequences ⁷,but will also give her sufficient information if she wishes to proceed with a medical referral.

Before commencing an in-depth intervention, assess the time necessary for quality support. The health adviser may need to negotiate with the patient that she returns outside of a busy session. If pregnancy has only just been diagnosed, after a brief exploration of thoughts and feelings the patient will benefit from at least a day to discuss her situation further with a partner or significant others, or to just assess her own situation. However, this may be crisis intervention, where the patient is in extreme distress, or is threatening self-harm, or is assessed as at some other high risk. It is important to consult with colleagues if in doubt whether to continue with the process at the first consultation.

Consider the gender of the facilitator. There may not be a choice about who offers the intervention, but same-sex support may need to be considered by the team. A professional and empathic approach is what is important. Giving a choice to the patient will contribute to the effectiveness of the work.

Contraception

Contraception choices are linked to emotional, sexual and reproductive health and it is important for health care professionals to provide up-to-date and objective information in a way in which it can be understood by patients. How contraception methods are discussed and delivered will often determine how they are accepted and used. ⁸

AVAILABLE CONTRACEPTION METHODS ⁹

1. Combined oral contraceptives (COC)
2. Progestogen-only pill (POP)
3. Contraceptive implants
4. Injectable contraception
5. Intrauterine contraceptive devices (IUDs)
6. Female barrier methods: diaphragm or cap and spermicide and female condoms
7. Male condoms
8. Spermicides and vaginal contraceptive sponge
9. Natural family planning
10. Male and female sterilisation.
11. Emergency/post-coital contraception: hormonal or IUD.

Contraception use needs to be considered. It is an issue for now if the pregnancy test is negative or for the near future if termination is the chosen route. This is a common area of exploration for the health adviser. The health adviser has a responsibility to decide their level of competency and the depth of the exploration. A health adviser with a nursing background may have Family Planning qualifications. Without this accreditation there would still be an expectation when employed by this speciality to have a broad understanding of methods available. More importantly there is a need to raise the awareness, and then directing the patient to a specialist service, preparing them with written information for future choices. ¹⁰

CONTRACEPTION CHECK LIST

- Discuss contraception with all heterosexually active men and women as appropriate
- Keep up to date with methods of contraception, their efficacy and their side effects
- Display and make freely available to all clinic patients resources on methods of contraception and local family planning services
- Explore the consequences of contraceptive failure including use of emergency contraception, unplanned pregnancy and termination of pregnancy

- Ensure that the inclusion of men is normalised. Encourage them to take responsibility for contraception and consider their attitudes toward paternity. Offered the opportunity to discuss different methods and participate in contraceptive choices
- Assist appropriate decision making by considering following up an assessment of the contraceptive needs of clinic patients with a referral to a family planning professional. For those sexual health clinics where family planning services are not integrated, health advisers need to establish links with local services and have arrangements for referral

OTHER SEXUAL HEALTH ISSUES

Within this setting it may be pertinent to raise the risk of STIs if appropriate, and offer the opportunity to be screened. Again this situation is often similar to the patient seeking an HIV test where their focus has not been on other risks, but only on the immediate worry of pregnancy.

TERMINATION OF PREGNANCY (TOP)

Termination of pregnancy occurs in every country in the world on a daily basis. The World Health Organisation estimates 50 million pregnancies are therapeutically aborted every year. Since the Abortion Act was passed in 1967 there has been a gradual rise in the numbers each year, sometimes explained by demographic changes. Britain is seen to have a relatively low rate compared to other developed countries and this is thought to reflect the network of comprehensive contraceptive services. This rate is estimated at 9-14 per 1000 women aged 15 to 45 years.¹¹

Termination of pregnancy is not on demand; there must be specific indications as defined by law. The conditions of the 1967 Abortion Act, amended in 1990, state that:

“The abortion can be performed if two registered medical practitioners, acting in good faith, agree that the pregnancy should be terminated on one or more of the following grounds”

- The risk to the woman’s life is greater if the pregnancy was to be continued with than if the pregnancy was terminated.
- The termination will prevent serious, permanent illness to the physical or mental health of the pregnant woman.
- Gestation is no more than 24 weeks, and that continuing with the pregnancy involves a greater risk of injury to the physical or mental health of the pregnant woman, than if terminated.
- Gestation is no more than 24 weeks, and that continuing with pregnancy involves a greater risk of injury to the physical or mental health of the existing children of the family, than if terminated.
- There is substantial risk that at birth this child would suffer physical or mental abnormalities causing a serious handicap / or special need.¹²

There are differences in the law between different parts of the UK. The 1967 Abortion Act does not apply to Northern Ireland, where abortion is only legal to save the life of the mother.

Therefore, it will be the two medical practitioners who ultimately sign to say that the legal requirements are fulfilled. There is a move by the Royal College of Obstetricians and Gynaecologists (RCOG) to have this changed to one signatory in the future.

Once the woman has completed decision-making a gynaecology referral needs to be made without delay. The incidence of complications of abortion is directly related to the period of gestation.¹³ Obviously a few days for reflection are needed.

Provision varies widely across the UK. Within Scotland and the North-East of England, 90% of terminations are performed by the NHS, while in other parts of the country they are also done privately. Health advisers involved in this area of work will need to be aware of local provision, referral methods and waiting times. It may influence the decision-making process for the woman.

The health adviser will also need to be aware of the techniques available and most commonly used in their local area. The last decade has seen advances in safe and effective methods for termination in almost all stages of gestation. Within the first nine weeks of pregnancy, referred to as the first trimester, a medical abortion can be performed without the need for invasive instrumentation or general anaesthesia. Mifepristone 600mg is given as a single oral dose. This is followed 48 hrs later by a vaginal pessary, Gemeprost 1mg (a synthetic derivative of prostaglandin) causing the uterus to contract and expel the fetus, usually within 4 hours. This procedure is performed as an outpatient. Not all women are suitable candidates and patients with asthma, on steroids, or with adrenal insufficiency should not be given Mifepristone.¹⁴ Some women may have an option in this first trimester of vacuum aspiration (VA) under general anaesthetic. At 9-14 weeks (late first trimester) the method of choice will be VA. Mid-trimester, after 14 weeks, termination becomes more difficult and has more complications. Many gynaecologists will only perform them for life-threatening conditions or those unaware of congenital abnormalities before the 14th week. Termination at this stage could be either medical or surgical. Again it is good practice to be aware of most commonly used local procedures so that the patient will be able to make informed choices.

There is a very low incidence of complications, particularly for medical terminations. Problems could be retained products of conception or missed abortion, damage to the reproductive tract from surgical procedures, pelvic infections from undiagnosed STIs and reduced fertility.

HEALTH ADVISER COUNSELLING SKILLS

Some healthcare providers have specialist counselling provision to refer women needing help with their decision-making, others may not. Some health advisers are trained counsellors or have gained counselling skills and experience. Some women may refuse referral and would value further exploration with the health adviser with whom they have developed rapport and trust.

The health adviser will be aware of their own level of competency, whether through accreditation or experience and will work within these boundaries. You may assess that the patient would benefit from being referred elsewhere or to a colleague more competent in dealing with these issues.

Health advisers will be accountable for the level of psychological intervention they decide they are skilled to provide in each situation. In-depth psychological interventions, or counselling, would not be provided if the health adviser was not having regular counselling supervision.¹⁵

Working as a reflective practitioner, keeping a reflective diary and utilising clinical supervision both individually and within a group will help the health adviser identify strengths and weaknesses and also where there are training and education needs.

The health adviser may have personal values regarding termination of pregnancy that make it difficult to be objective. However, a paternalistic attitude in any aspect of a professional role does not empower the patient but will violate autonomy. Such ethical dilemmas should be explored in clinical supervision, monitoring personal, strong responses and creating an awareness of personal limitations. The ethical principle of autonomy also implies a responsibility for oneself.¹⁶ This work draws heavily on the health adviser's personal resources; it may be that clinical supervision has made the adviser aware that they are unable to offer in-depth support for this situation. The Abortion Act (1967) allows healthcare workers to opt out of offering direct care when there is a conscientious objection.¹⁷

DOCUMENTATION AND WRITTEN INFORMATION

For a young person under 16 years an objective assessment of Fraser guidelines competency and child protection issues is required and the health adviser may be best placed to do this.¹⁸ The health adviser will also have established a mutually agreed contact, either an address or person such as the school nurse, in the event of her not returning. It is important that there is no discharge of a pregnant young person into the community without a forwarding point of contact. One always needs to consider a duty of care to the patient and to the unborn baby.¹⁹

A directory of referral points should be accessible to the health adviser, alongside other useful documentation.

Written information regarding all options should be available in waiting areas and given to patients when appropriate.

Using a pro-forma or pathway will help with the process.^{20 21} Integrated, multi-disciplinary, pathways are practical tools used successfully in healthcare for locally agreed practice.²² Such a tool means you don't have to rely on memory when managing complicated care. It can also be a useful document for audit to show you have covered all aspects. Usually only what is documented will be accepted as proof of practice in a court of law.²³

The patient could have a copy of this pathway for herself or to take it with her when referred elsewhere. It would be useful for her to look back at when doubting she made the best decision under her present circumstances.

AREAS FOR EXPLORATION TO FACILITATE PREGNANCY DECISION-MAKING

An assessment of the patient's situation would encompass the biological, personal and contextual aspects:

- **Pregnancy gestation.** This information is necessary to inform the patient of types of medical intervention that could be offered by your service provider if termination is an option for example Medical, surgical or mid-trimester, or too late for this option.

Each provider has different criteria. You will need to be aware of what they are. Private clinics may offer terminations to those refused by the NHS

- Patient's thoughts and feelings towards the pregnancy. Establish before all the other life issues
- **What views had the patient about termination before becoming pregnant?** It can help the patient obtain some clarity when circumstances are overwhelming. Ambivalence can impact the future mental health of the patient, for example, if the patient is acting to please someone other than herself and this in turn causes conflict with her own aspirations
- **Partner involvement or not.** Level of support and partner's thoughts and views on pregnancy
- **Assess any child protection issues.** Underage /age of partner / rape / coercion
- **Assess level of support and home situation.** Who are the significant others and what is the level of relationship or interaction?
- **Assess level of coping and mental health.** Verbal and non-verbal communication from the patient is used to assess how they are able to rationally weigh up their situation. How is their present situation, or chosen option, going to impact on their mental health? Are further interviews, or a different type of intervention required?
- **Assess physical health.** Is there any known medical condition?
- **Assess level of risk to post-abortion regret.** Literature identifies the main risk factors as:
 - Termination for medical conditions (mother or fetus)
 - Termination later in pregnancy
 - Ambivalence about proceeding with a termination
 - Poor social support
 - Being a teenager
 - History of previous psychiatric problems
 - Being subject to undue influence of partners and parents and belonging to religious and socio-cultural groups antagonistic to abortion ^{24 25 26 27 28}
- **Explore aspects of any coercion.** Doing it for others may lead to regret in the future
- **Other life-style issues,** for example alcohol and drug misuse
- **Have they had a previous pregnancy or T.O.P.?** What was their experience? How does this effect the present situation?

- **Explore options.** Continue / terminate / adoption. Constantly using reflection and summarizing, (remaining objective and impartial)
- **Assess understanding of the implications of chosen option.** This is especially important when referring for termination of pregnancy
- **Socio-economic situation.** For example; accommodation, finances, employment, student
- **Consider referral to social worker.** Housing, benefits, difficult home situation, violence are all issues that need specialist intervention. Some social workers specialize in adoption
- **Consider referral to clinical psychologist.** More in-depth or on-going psychological support needed. Previous history of mental ill-health, suicide intent or other self-harm, unresolved ambivalence
- **Refer to termination clinic.** Some service providers have a protocol for nurse referral. Establish if this could be available to GUM, to save referral back to family planning or primary care, unless the patient chooses an intermediate referral. Be aware of how the 2 medical signatures are obtained
- **Post-termination support.** Establish where the patient can access this
- **Offer another support session.** Time and space are invaluable to decision-making
- **Facilitated decision-making.** The patient may need more time to herself to decide on her course of action. The health adviser may not need to know the outcome if she has an avenue for self-referral or she has been signposted her in the right direction. (However, follow-up would be needed if under 16years.)

This assessment tool would be useful for the health adviser to explore all of the relevant factors in a structured way that would enhance the decision-making process for the woman. Such facilitation will allow women to feel they made the best possible decision under their present circumstances. The health adviser will have contributed to the process of autonomous decision-making during this significant life event. It will undoubtedly be an area for reflection in the future for both patient and professional.

A P P E N D I X 1

Example of an integrated care pathway for discussing pregnancy options or reproductive decision-making.

PATIENT NO..... D.O.B.....AGE.....POST-CODE.....
 ETHNICITY.....REFERRED BY.....
 DEPARTMENT.....GESTATION BY DATES.....DATE.....

FACILITATOR 1..... DATE.....
 FACILITATOR 2..... DATE
 FACILITATOR 3..... DATE.....
 MEDICAL CONSULTANT..... DATE.....

| GUIDELINE | assessed yes / no | SIGN |
|-----------------|----------------------|------|
| 1. Under 16yrs. | | |

| | | |
|---|--|--|
| <p><i>Fraser Guidelines applied.</i></p> <p><i>To inform parent or other adult?</i></p> <p>Comment:</p> | | |
| <p>Estimate pregnancy gestation. <i>This information is necessary to inform the patient of types of medical intervention that could be offered by your service provider if termination is an option for example Medical, surgical or mid-trimester, or too late for this option. Each provider has different criteria. You will need to be aware of what they are. Private clinics may offer terminations to those refused by NHS.</i></p> <p>Comment:</p> | | |
| <p>Patient's thoughts and feelings towards the pregnancy. <i>Establish before all other life issues.</i></p> <p>Comments:</p> | | |
| <p>What views had the patient re' termination prior to being pregnant? <i>It can help the patient sort the wood from the trees when circumstances are over-whelming. Incongruence can impact the future mental health of the patient for example if the patient is acting to please some-one other than herself.</i></p> <p>Comment:</p> | | |
| <p>Partner involvement or not. <i>Level of support and partner's thoughts and views on pregnancy. Does patient want him included in this process?</i></p> <p>Comments:</p> | | |
| <p>Assess child protection issues. <i>Underage / age of partner / rape / co-ercion</i></p> <p>Comments:</p> | | |
| <p>Assess level of support and home situation. <i>Who are the significant others and what is the level of relationship or interaction?</i></p> <p>Comments:</p> | | |
| <p>Assess level of coping. <i>Verbal and non-verbal communication from the patient is used to assess how they are able to rationally weigh up their situation. How is their present situation, or chosen option, going to impact on their mental health? Are further interviews, or a different type of intervention required?</i></p> <p>Comments:</p> | | |
| <p>Assess physical health. <i>Is there any known medical condition?</i></p> <p>Comments:</p> | | |
| <p>Assess level of risk to post-abortion regret. <i>Literature identifies the main risk factors as:</i></p> <ol style="list-style-type: none"> 1.Termination on medical grounds 2.Termination later in pregnancy 3.Ambivalence about proceeding with a termination 4.Poor social support 5.Being a teenager 6.History of previous psychiatric problems 7.Being subject to undue influence of partners and parents and belonging to socio-cultural groups antagonistic to abortion | | |

| | | |
|---|--|--|
| <p>Comments:</p> | | |
| <p>Explore aspects of any coercion. <i>Decisions to please others may lead to regret in the future.</i></p> <p>Comments:</p> | | |
| <p>Other life-style issues <i>for example Alcohol and drug use</i></p> <p>Comments:</p> | | |
| <p>Have they had a previous pregnancy or T.O.P.? <i>What was their experience? How does this effect the present situation?</i></p> <p>Comments:</p> | | |
| <p>Explore options. <i>Continue / terminate / adoption. Constantly using reflection and summarizing, (remaining objective and impartial).</i></p> <p>Comments:</p> | | |
| <p>Assess understanding of the implications of chosen option. <i>This is especially important when referring for termination of pregnancy.</i></p> <p>Comments:</p> | | |
| <p>Socio-economic situation. <i>Accommodation, finances, employment, student etc.</i></p> <p>Comments:</p> | | |
| <p>Introduce referral to social worker. <i>Housing, benefits, difficult home situation, violence, are all issues that need specialist intervention. Some social workers specialize in adoption.</i></p> <p>Social worker: name tel:</p> <p>Comments:</p> | | |
| <p>Introduce referral to psychologist. <i>More in-depth or on-going psychological support needed. Or disclosure of history of mental ill-health, suicide intent or other self-harm. Heavy drug or alcohol use.</i></p> <p>Psychologist: name tel:</p> <p>Comments:</p> | | |
| <p>Introduce referral to community midwife. <i>Patient has decided to continue with pregnancy. Advice re' accessing Primary Health Care Team is given.</i></p> <p>Comment:</p> | | |
| <p>Refer to termination clinic. <i>Or continue with medical consultation if within the department</i></p> <p>Comments:</p> | | |

| | | |
|---|--|--|
| <p>Post-termination support. <i>Establish where the patient can access this.</i></p> <p>Comments:</p> | | |
| <p>Offer another support session. <i>Time and space are invaluable to decision-making. Assess where this would be most appropriate.</i></p> <p>Comment:</p> | | |
| <p>You have facilitated decision-making. <i>The patient may need more time to herself to decide on her course of action. You do not need to know the outcome if she has an avenue for self-referral or you have sign posted her in the right direction. (However, you would need to follow-up if under 16yrs.)</i></p> <p>Comment:</p> | | |
| <p>Could the patient say how useful this session has been, and in what way?</p> <p><i>"have you found this session supportive and has it offered you enough information"</i></p> <p>poor.....o.k.....excellent</p> <p>1.....2.....3.....4.....5</p> <p><i>"say how it could be improved"</i></p> | | |
| <p>Highlight any action to take forward for the patient or service provision.</p> <p><i>for example referral method / need more up to date local info re' procedures</i></p> <p>Comment:</p> | | |
| <p>What written information does the patient have?</p> <p>Leaflet for t.o.p</p> <p>Adoption</p> <p>Contraception</p> <p>STIs</p> <p>Other?</p> | | |
| <p>The facilitator may wish to comment on the process</p> | | |

Please ensure this written pathway is a joint process with the patient
A copy will need to remain in the medical record
The confidential nature of this record will be explored with the patient.

APPENDIX 2

| | |
|--|-----------------|
| <u>PREGNANCY TESTING PROTOCOL</u> | |
| Patient identifier | |
| D.O.B. | Age |
| Fraser guidelines applied | yes / no |
| Fraser competence achieved | yes / no |
| Date of last menstrual Period normal yes / no | |
| Menstruation cycle regular yes / no | |
| Date of last sexual intercourse | |
| Contraception use | |
| History of Previous pregnancies | |
| Patients expectations | |
| Consequences of a negative result for the patient | |
| Consequences of a positive result for the patient | |
| Relationship issues | |
| Child protection issues | |
| Future contraception needs | |
| S.T.I. screening explored | |
| Further pregnancy test needed yes / no To return Date | |
| Written information given | |
| TEST RESULT POSITIVE / NEGATIVE | |
| Further test needed yes / no to return Date | |
| IF POSITIVE AND UNDER 16YRS WHO WILL SHE INFORM | |
| PATIENT CONTACT DETAILS MOBILE NO | |
| ADDRESS | |
| SCHOOL ATTENDED | |
| REFERRED TO | |
| LETTER WRITTEN | YES / NO |
| signed date | |

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Rape and sexual assault

DORINDA THIRLBY AND SANDRA JARRETT

It is recommended that health advisers are involved in drawing up guidelines for managing patients reporting a sexual assault and be introduced early to the patient in their attendance.

It is recommended that health advisers keep abreast of the legal, ethical and psychological factors of rape and ensure they have adequate clinical supervision

Patient as well as professional information on rape and sexual assault is presented.

INTRODUCTION

Sexual assault may be defined as any type of sexual act committed without the informed consent of one of the parties.

Within departments of sexual health/ genitourinary medicine (GUM) the aim is to provide a supportive, sensitive, respectful and comprehensive sexual health service to women and men who have been sexually assaulted.

It is recommended that the health adviser, with other members of the multi-disciplinary team, be involved in writing protocols regarding the management of patients reporting sexual assault/ rape at a GUM clinic.

It is important that the locally written guidelines are based on national and regional guidelines. They are to be interpreted with a degree of flexibility dependent on the risk of infection, as well as an assessment of the physical and emotional state of the patient. A pragmatic and compassionate approach is needed for a patient who may be trying to regain control after the assault.

The benefit to the patient of any investigation needs to be weighed against the risk of exacerbating or prolonging the patient's distress.¹

FORENSIC EXAMINATION

Ascertain whether the assault has been reported to the police. If the assault has been reported

to the police, the patient will have already undergone a detailed forensic examination, which does not usually include a GU screen.

The purpose of a forensic examination is to obtain evidence for legal proceedings. Having a forensic examination does not commit the person to legal proceedings as a statement can always be withdrawn at a later date if the patient wishes. However, if a forensic examination is not done, vital evidence may be lost. It is never too late to report sexual assault; whilst intimate swabs may yield DNA if the assault occurred within the last 7 days ago, semen can remain on some materials, for example clothing, until washing.

If the patient wishes to report to the police, do not perform any examination or the forensic examination may be compromised. Discuss with a consultant. If the person who has been assaulted attends soon after the assault and is going to have a forensic examination, then it is best if they do not pass urine or have their bowels open. If they do then it is important to save the toilet tissue as it may have forensic use.

Most sexual health clinics/ GUM are not able to perform forensic examinations. If the patient wishes to proceed to a forensic examination it is recommended that they are referred to the police, before a GUM screen is performed.

In some larger cities there are specific sexual assault centres where people may self refer for a forensic exam and support without having to be seen by the police.

Patients who do not want a forensic exam may still wish to report the crime to the police. It is important that the police are aware of assaults particularly where there may be a serial rapist where reporting could identify the assailant in the police investigation. It is good practice to create links with local police stations to facilitate referral and support for the patient; this would include links with chaperones and victim support organisations.

ROLE OF GUM IN SEXUAL ASSAULT

The role of the GUM clinic in sexual assault is primarily to diagnose and treat STIs and to provide support. Unless requested by a court of law the clinic notes remain confidential and are not disclosed to any third party. The difference between forensic and therapeutic examination needs to be explained to the patient. The patient can be offered the choice of a GU screen.

LEGAL IMPLICATIONS

Information gained in a consultation and of a diagnosis of an sti after sexual assault has legal implications. The patient may attend alone or be accompanied by a police officer or a representative from Victim Support. A police officer is obliged to disclose any new information learned regarding the case to his/ her superiors and to the defence team so it is good practice to inform the patient of this. Disclosure of multiple partners, previous STIs, terminations of pregnancy or psychiatric illness may harm her/ his case in court.

It is recommended the police officer is not present during the consultation, but if the patient prefers them to be present then the history will need to be modified, for example the patient need not be asked about previous STIs: ask only about sexual partners up to 2 weeks before the assault and omit questions about previous pregnancies that have been terminated.

It is exceptional that the identification of an STI assumes evidential importance, as prior acquisition would have to be excluded. Identification of an STI would usually damage rather than help a victim's case, particularly if the STI is not found in the assailant as the courts may make assumptions about the victim's lifestyle. However, if the complainant is a child or someone with learning difficulties who cannot legally consent to sexual intercourse, or an elderly person who has not been sexually active for some years, identification of an STI may be useful evidence.

Criminal injuries compensation

Women and men who have been sexually assaulted can apply for compensation from the Criminal Injuries Compensation Authority. To be eligible for compensation, they must have reported the incident to the police. It is recommended that the forms be available in the clinic. Victim Support will help patients fill out the form. If patients want the clinic to write a letter in support of their claim for compensation, they need to give written permission in their clinical notes. Identification of an STI may positively influence the level of compensation.

REQUESTS FOR AN EXAMINATION

Usually this is initiated by a phone call from either the patient / friend / police or Victim Support. It is advisable to have a clinic protocol to focus telephone assessment and establish the urgency for attendance, depending on the need for:

- Emergency contraception
- Investigation of symptoms suggestive of an STI
- To screen for STIs
- Prophylactic antibiotics
- HIV post exposure prophylaxis
- Hepatitis B vaccination
- Need for emotional support
- Referral to the police

A genital/ oral screen for STIs is ideally carried out at least 10 days after the assault so that incubating infections are not missed, but patients who wish to attend sooner, may do so. It is recommended the patient is offered a choice in the gender of healthcare workers they see, wherever possible. Adequate time needs to be allocated in the clinic.

All referrals of patients aged under 16 or over 60 years need to be discussed with a consultant prior to booking an appointment.

PATIENTS AGED UNDER 16 YEARS

In general, GUM clinics do not take referrals for a child under 16, as these patients would usually be referred to a paediatrician for their care. If a sexually active 14 to 16 year old person walks in to the clinic and discloses sexual assault, it may be appropriate for them to be seen in

the sexual health clinic. It is essential that such cases are discussed with a consultant and advice sought from the paediatrician / child protection team.

Issues of consent and confidentiality are paramount. For patients under 16 it is essential to assess and document the Fraser guidance/ competence, as for all under 16-year olds. (see young persons chapter). If a child protection issue emerges during the consultation process, for example if a young person is in danger themselves, or another child in danger, for example a sibling, then advice will need to be sought from Child Protection Advisers.

ARRIVAL IN THE CLINIC

It is good practice for the patient to see the health adviser before the doctor. This will not be possible if the patient discloses assault when in the clinical room with the doctor, and the course of the consultation is dependant on the experience of the health adviser/ nurse/ doctor available.

When the patient arrives in the department, they may be given the option of waiting in a private room, for example a consulting room, health adviser room but not the main clinic waiting room. They are ideally greeted as soon as possible by a nurse, health adviser or doctor, who will briefly explain the clinic process. Waiting during the process of consultation needs to be minimised, so a 'fast track' system is recommended.

HEALTH ADVISER ASSESSMENT

All identified patients who present having been raped or assaulted will be ideally seen by the health adviser when they first attend the clinic to support the patient through their visit (s). The purpose of their attendance is to screen for STIs, potential pregnancy and check that they have the relevant support in place for example the police, counselling.

It is recommended that the health adviser takes a brief history in order to make an assessment regarding relevance of:

- Whether the person wishes or needs police input or forensic screening. Co-ordinate referral if this is appropriate (it is possible to report the crime, get support/ police protection and not have to press charges)
- Need for emergency contraception/ pregnancy testing (depending on time period since assault/ rape)
- Discuss hepatitis B vaccination and post exposure HIV prophylaxis (PEP). PEP ideally needs to be administered within 72 hours of the assault. Criteria for PEP include: the assailant deemed high risk; the assault involved vaginal or anal intercourse without a condom. (refer to local /national guidance on sexual PEP)
- Assess for symptoms of an STI
- Screen for STIs ideally 10-14 days post assault
- Discuss and offer baseline testing for HIV, syphilis (STS), hepatitis B and C. Encourage the patient to return at 3 months for repeat serology for STS, HIV, hepatitis B and hepatitis C (Where there has been a significant risk of hepatitis C offer repeat serology at 6 months). Offer to recall the person if they do not attend.

- A serum save is recommended as a baseline sample even when all of the blood borne infections have been tested for
- Other medical care
- Check out their support needs and what they have in place and if needed offer follow up/ relevant support (see health adviser specific counselling/ psychological care)
- Explain the tests and examinations and check out the patient's concerns
- Explain the results and follow-up screening
- Check demographic details and offer recall if indicated for example bloods at 3 months post assault. Place on recall system and document in notes re recall
- Offer the patient details of support agencies for example Victim Support, Rape Crisis Centre, and Survivors. Offer an information sheet with phone numbers of support groups (see appendix 1)
- Discuss any other concerns s/he might have. Offer further emotional support as required
- Facilitate application to CICB for criminal injuries compensation and provide the relevant information and forms

It is considered good practice that the health adviser documents the following points in the patient's notes, remembering that these notes may be admissible in court. (see comments on rape/assault documentation):

- Seen by health adviser and health adviser's name
- That they have been raped /assaulted, and write a brief history
- Outcome of the above discussions
- Plan for further follow up
- Information offered
- What support the person has (from health adviser or other agencies)
- Any other additional relevant information
- Document recall as for follow up as above

It is good practice to introduce the patient to their named nurse/ doctor for their visit.

HEALTH ADVISER SPECIFIC COUNSELLING / PSYCHOLOGICAL CARE

It is good practice to assess the patient's support needs at each visit. Psychological trauma and

distress can be common following sexual assault, and early intervention may reduce long-term psychological damage. Please see 'Crisis Intervention' section in chapter 13.

It is good practice that the health adviser carries out a counselling assessment, and where appropriate offer short-term supportive counselling or refer to the relevant local support services. It is recommended that the health adviser also assesses the need for acute psychiatric intervention. Early referral to a clinical psychologist is recommended if the patient does not appear to be coping with the aftermath of the assault.

If appropriate, the doctor may consider giving a short course of night sedation after discussion with the patient. It is not good practice to routinely give night sedation.

It is important to identify the needs of the person who has been assaulted - counselling needs to be offered not imposed. There is no current research evidence to support debriefing of traumatised individuals², the patient therefore needs to choose to disclose what they wish. See the St Mary's centre fact sheet on Rape Trauma Syndrome, 1999 (see appendix 2) which details common reactions, such as denial which may be an important coping mechanism post trauma. Care needs to be taken in not making the patient go through what has happened but the health adviser may offer a sexual health screen and explain there is solely a need to check for infections in the relevant sites and answer any sexual health concerns the individual may have, for example where the patient is concerned there may be permanent physical damage, and is seeking reassurance from an examination.

"Rape victims can suffer a significant degree of physical and emotional trauma during the rape, immediately following the rape, and over a considerable time period after the rape. A study of rape victims has identified a syndrome which is a three-stage process that occurs as a result of rape or attempted rape. This syndrome of behavioural, somatic, and psychological reactions is an acute stress reaction to a life-threatening situation that can last from two years to a lifetime" St Mary's centre fact sheet on Rape Trauma Syndrome, 1999 (see appendix 2).

Patients may attend with negative expectations of a sexual health clinic and of the examination. A traumatic experience in the clinic is likely to compound what has happened to them. It is therefore important to make the consultation and examination as psychologically 'safe' as possible. It is important that the patient is given control and that their account of the assault is believed. It is important to allow the patient some control in the consultation, and making it clear it can stop at any time.

"The risk of rape, sexual harassment, or battering, though high for all women, is approximately doubled for survivors of childhood sexual abuse".³ It is therefore important health advisers are aware patients may have a history of childhood sexual abuse, which may have never been discussed/ disclosed before.

Male rape has only been recognised in British law since the end of 1994. It is important that health advisers consider the issues of male rape/ sexual assault. Only a small percentage of men report male sexual assault.⁴ There are specific issues for men who have been raped, particularly around their masculinity and sexual orientation. It is also important to challenge the myths that men cannot be forced to have non-consensual sex,⁵ only gay men are raped and that only gay men rape men. Heterosexual men may not report sexual assault as they fear being identified as gay.⁶ The majority of men who rape other men identify as heterosexual.⁷

A patient who has been raped may give a highly emotional account, a contradictory account, or disassociated account, which may undermine the credibility of their story. These are normal reactions to such events and care has to be taken in hearing this sensitively.⁸

Health advisers need to keep up-to-date with recent legal, ethical, and psychological developments if working with women or men who have been assaulted. There is also a need to have clinical supervision, to explore issues raised by having sexual assault reported to them.⁹

Appendix 1 gives an example information sheet that may be developed for the clinic for patients. The sheet could be adapted to any clinic to provide local and national contact numbers and brief information on how the person may feel, and information about what is offered in the clinic.

INFORMATION ON THE MEDICAL ASSESSMENT/ HISTORY

The doctor will need to document the history carefully as this could be required in court. Avoid recording any unnecessary detail as any discrepancy with the statement given to the police may be used against the complainant in court.

It is important to record the following information:

- Date of assault (important for incubation period and wound healing)
- Known assailant or stranger
- Type of assault (vaginal, anal and / or oral, attempted or full penetration, penile, digital or other objects). The patient may not spontaneously give a full history, so ask directly
- Ejaculation and use of condoms, if known
- Last sexual intercourse (LSI) - may have had consensual sex with someone else after the assault
- Previous sexual intercourse (PSI) - details of regular/casual partners within last 3 months
- Last menstrual period (LMP) and contraception - remember the possibility of pregnancy

The doctor will record any genital injuries on diagrams, including their size. It is recommended that the injuries are described in the correct forensic terms as bruises (also recording their colour), abrasions (grazes), lacerations (tears) or incised wounds (cuts), even if a forensic examination has been done. NAD (no abnormality detected) is probably not enough – the doctor needs to document that they have specifically examined the vulva, vagina, and cervix.

Examine the mouth in cases of oral sex. A full examination may not be necessary, but the doctor will need to examine any areas the patient says have been injured, and document the injuries found.

It is best practice to label all specimens “sexual assault” not “chain of evidence”, as there is no need to perform a ‘chain of evidence’ or to mark the swabs M/L (medico legal) routinely. The circumstances in which they may be useful are those in which the presence of a sexually acquired infection would provide definitive evidence of assault, for example in a virgin, or in someone elderly with no recent sexual activity. Discuss with a consultant.

FURTHER READING

The Rose Clinic protocol written by Dr Ellie Freedman & Dawn Whittaker

The Roehampton Clinic protocol written by Dr Emma Fox.

Male Rape: Articles from the Professional Medical and Mental Health Journals: Some useful PAPER resources, listed in no particular order: <http://after-words.org/mrape2.htm>

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APPENDIX 1

SAMPLE INFORMATION SHEET FOR PATIENTS

The Department of Sexual Health at xxxxx Hospital aims to provide a supportive, sensitive, respectful and comprehensive sexual health service to women and men who have been sexually assaulted.

What is rape or sexual assault?

Sexual assault is any type of sexual act committed without the consent of one of the parties.

What feelings may I experience following a sexual assault?

We are all different in the way we deal with things that happen in our lives. After being sexually assaulted, some people feel afraid for quite a long time afterwards. Or, they may feel ashamed, anxious and/ or angry. Commonly people feel a lot of guilt and self blame.

For quite a long time you might find it difficult to sleep or eat properly, and your moods will go up and down. You might be irritable and short-tempered, and find it difficult to make decisions. You might also feel tearful at times, and it is possible that you will not feel like being close even to people you are extremely fond of.

It might help you to know that all of these things are usual for someone who has been through a bad experience. Other people in similar circumstances often feel exactly the same. You are not alone. It was not your fault you were assaulted.

Talking to someone who understands all of this may help you to feel better. There are counsellors who are trained to help you sort out your emotions and listen to your problems. Here you can be referred to a health adviser or clinical psychologist. Or you can contact one of the organisations listed below for help.

What happens now that I am here?

You will first see a health adviser who will explain about what services are available, and whether you have any personal concerns. You will be allocated a nurse chaperone who will be with you during your visit today. You will also see a doctor who will take a medical history, and do an examination. The doctor and nurse will explain to you everything that is going to happen, and you can stop the examination at any stage if you want to. Health advisers are also available to provide emotional support.

What tests are offered here?

Tests for all sexually transmitted infections are offered here. These include chlamydia, gonorrhoea, trichomonas, syphilis and hepatitis. These infections do not always have obvious signs or symptoms. You can have an infection without realising it. Some infections can take some time to show up, so we do recommend follow up appointments to exclude them.

What about HIV?

Antibodies to HIV can take up to three months to be detected after any possible risk. However there are more sensitive tests which often detect the presence of HIV much earlier. We can take a sample of your blood to store today so that if you decide to take an HIV test in three months time, we have a sample to compare it to. This can be a difficult time to make a decision about HIV testing. A health adviser will talk to you about it in more detail if you wish.

What about pregnancy?

If there is a chance you might be pregnant as a result of the assault, we can give you emergency contraception up to 5 days after. If it is after this time, we can do a pregnancy test, and if you are pregnant, support you in your decision about what to do (including referring you for a termination).

When do I have to come back?

We recommend a return visit in two weeks time and follow up appointment in three months time.

What if I want to report to the police?

If you want to report to the police what has happened, we can put you in touch with the local station. An assault can be reported at any time, even years after the event. However, forensic evidence needs to be taken within a week of the assault happening. A Health Adviser can talk through the issues with you, as this can be a difficult decision to make.

What about Criminal Injuries Compensation?

Women and men who have been sexually assaulted can apply for compensation from the Criminal Injuries Compensation Authority. To be eligible for compensation, it is necessary that the assault is reported to the police. Forms are available from the health advisers.

Emergency and useful numbers (examples)

| | |
|---|---------|
| Health Advisers, | tel. no |
| Local Police Station | tel. no |
| National Victim Support Line | tel. no |
| Local Victim Support | tel. no |
| Local Rape Crisis Centre | tel. no |
| Survivors (for men) | tel. no |
| Local Rape and Incest Crisis Line | tel. no |
| Rape and Sexual Abuse Support Centre | tel. no |
| Samaritans | tel. no |
| Women's Aid (national number) | tel. No |
| local Women's Aid | tel. no |
| Local Domestic Violence and Racial Harassment Unit | tel. no |
| (24 hour helpline xxxxxxxxx) | |
| Medical Foundation for the Care of Victims of Torture | tel. no |
| Criminal Injuries Compensation Authority | tel. no |
| Rights of Women (legal advice) | tel. no |

APPENDIX 2

INFOSHEET PRODUCED BY THE ST MARY'S CENTRE MANCHESTER

RAPE TRAUMA SYNDROME

Rape victims can suffer a significant degree of physical and emotional trauma during the rape, immediately following the rape, and over a considerable time period after the rape. A study of rape victims has identified a syndrome which is a three-stage process that occurs as a result of rape or attempted rape.¹ This syndrome of behavioural, somatic, and psychological reactions is an acute stress reaction to a life-threatening situation that can last from two years to a lifetime.

PHASE I: ACUTE PHASE – Immediate impact reaction *(Last from one to six weeks)*

Characterised by a disorganisation to lifestyle.

Physical Symptoms

Sleep pattern disturbance: difficulty falling asleep, waking during the night, or other types of insomnia. Nightmares are common
Eating pattern disturbances: marked decrease or increase in appetite, nausea, or stomach pains
Symptoms specific to focus of attack: victims forced to have oral sex may describe irritation to the mouth and throat; victims forced to have vaginal sex may complain of vaginal discharge, itching, burning sensations, etc...
Soreness, aches, pains, etc...

Emotional Reactions

Shock and denial are predominant
Fear is the primary feeling expressed
Two main styles of emotion shown by the victims:
Expressed: characterised by restlessness, tenseness, crying or sobbing, extreme talkativeness, yelling, shaking, etc.
Controlled: characterised by a calm, composed, or subdued effect; feelings are masked or hidden.
A combination of these two styles may be seen
Other common feelings include guilt, blame, shame, embarrassment, anger, anxiety, humiliation, degradation, betrayal, depression.
Thoughts: uncontrolled thoughts, preoccupation, rumination.
Inability to concentrate

Behavioural Reactions

Unable to go out alone and/or with others.
Excessive cleaning/washing.

PHASE II: REORGANISATION PHASE

(Lasts from sixth week to six months or more/lifetime)

A. Readjustment to normal life

1. Changes in lifestyle: changes location of living space, changes job, changes telephone number, turn to support of family/friends, takes self-defence class.
2. Somatization: nausea, headaches, and other physical symptoms; nightmares.
3. Phobias: being alone or in crowds, fear of sex, fear of men, global fears, fears specific to the rape situation, paranoia.
4. Mood swings: anger, depression, flashbacks, rationalization, denial, anxiety.

"All victims in our study experienced disorganisation in their lifestyle following the rape. Various factors affected their coping behaviour regarding the trauma, i.e ego strength, social network support and the way people treated them as victims. This coping and reorganisation process began at different times for individual victims."

"Victims did not all experience the same symptoms in the same sequence. What was consistent was that they did experience an acute phase of disorganisation; many also experience mild to moderate symptoms in the reorganisation process. Very few victims reported no symptoms"
(Burgess and Holstrom 1978)

Studies subsequent to Burgess and Holstrom have shown that the reorganisation phase is affected by the coping skills of the individual and the level of support she can rely on. It would appear that support is a crucial area in terms of an individual's ability to recover from sexual assault.

(See Clark, Lewis 1977; Cohen and Roth 1987; Renner et al 1988)

PHASE III: RESOLUTION/INTEGRATION PHASE

- A. Integration: Rape becomes just another bad event in the victim's life.
- B. Resolution: Victim resolves rape event and effects it has had on her life.

Remember there is no right or 'test book' response to this kind of event. It is inappropriate to judge the nature, severity or even actuality of the event by the way the victim presents.

Remember it is unreasonable to impose expectation on victims. There is no arbitrary length of time after which the victim should be expected to have recovered.

¹Burgess, A.W. and Holstrom, L.L. "Rape: Crisis and recovery. Maryland: Robert J. Brady Co., 1978

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Section D

Legal and professional framework

History of sexual health advising

Law & the sexual health adviser

Ethical issues in sexual health advising

Code of professional conduct

Leading a team of sexual health advisers

History of sexual health advising

HEATHER WILSON

A tradition of philanthropy and social work has co existed with efforts to control sexually transmitted infection. Working within the national clinic system, social workers had contact tracing and health promotion integrated into their role. After World War two, the job of contact tracer gradually became formalised and existed nationwide by the mid 1970's.

The combined tradition of social work and contact tracing has culminated in the sexual health adviser, with their core roles of partner notification, counselling and health promotion.

This chapter is reflects on the circumstances that led to the emergence of a unique profession.

INTRODUCTION

Sexual health and the treatment of sexually transmitted infection is a field of medicine that inspired a holistic approach, with the welfare of those affected being considered alongside the medical, moral and public health ramifications. The origins of the current system emerged from an alliance between the medical profession, moral campaigners and health promoters, which has occurred in the field of sexual health over the last 150 years.¹

THE MORAL - MEDICAL ALLIANCE

The venereal diseases were widely assumed to be associated with prostitution; it was believed that if prostitution could be eradicated, venereal diseases would follow. Indeed the suffragettes maintained that votes for women would see the end of prostitution, when women could pursue other types of work, and with it, the end of venereal disease.² Christian zeal and the ideals of eugenics were the springboard for the first non medical efforts to combat venereal diseases.

Thomas Scott, the assistant chaplain of the London Lock Hospital for Venereal Disease, established in 1792 an Asylum to protect prostitutes who had completed their treatment and wanted to be reformed. They were accommodated for two years and trained to go into service.³ Adler describes how the chaplain of the Middlesex Hospital in 1849 found “more fruit of (his) labours” on the female venereal disease ward than on any other, recommending that syphilitic women were confined to their rooms except for divine service on Sundays.⁴

The Contagious Diseases Acts 1864, 1866 and 1869 were an attempt to deal with the high prevalence of venereal disease amongst the Armed Forces. Modelled on the European system, they were implemented in specified garrison towns and allowed for the enforced medical examination and treatment of women suspected to be prostitutes, men and ‘respectable women’ were seen as inappropriate for genital examination.^{5 6} Known prostitutes could be examined fortnightly and if found to be infected, a woman could be detained for up to six months for treatment.⁷ Hospitals were established for this purpose, and it has been argued that the intention was for a supply of healthy prostitutes for the forces.⁸ The Association for Promoting the Extension of the Contagious Diseases Acts to the Civilian Population was formed. Dominated by the medical profession, it also had members from the Tory party and the clergy. They argued that medics, rather than moralists, had greater authority on social and environmental issues, and claimed great success for the legislation, testifying that people were now behaving in the proper manner and prostitutes were displaying “common decency and self respect”.⁹

This effort to extend the acts provoked the first organised opposition. In 1869 The National Association for the Repeal of the Acts was formed and they asked Josephine Butler to spearhead the campaign. Butler was well known as a campaigner who had published on the subject of the economic plight of women who needed to work. She had set up a home for working class girls and was involved with the Rescue Society, who rescued and reformed ‘fallen women’. The National Association was for men only so Butler and Elizabeth Wolstenholme formed the Ladies National Association to fight this campaign. She was an evangelical Christian, a vicars wife who believed that the repeal campaign was the divine mission that she had been waiting for.¹⁰ With the backing of influential women such as Florence Nightingale, the Association was able to use the language of evangelical religion to influence parliament. They published widely, attacking doctors for using legislation to flout basic moral principles, violate women and destroy civil liberties. Parliament was unable to cope with “the revolt of the women”.¹¹ The campaign was arduous; the women were referred to as “shrieking sisters” and encountered hostility from the public and the medical profession.¹² They were successful however, “despite vociferous protests from the medical establishment, many venereologists, *The Lancet* and the *British Medical Journal*.”¹³

The Liberal politician James Stansfield joined the campaign in 1876 and was able to garner support from other Liberals, he also formed the National Medical Association for doctors who favoured repeal. The House was persuaded that Butlers rescue strategy to deal with prostitution was effective; they became uncomfortable about the state sanctioning immoral behaviour, and paying for it. The Acts were repealed in 1886. Butler was able to use her evidence session in Parliament to emphasise her case for raising the age of consent for girls from 12 to 16. This was eventually successful.¹⁴

EUGENICS AND HEALTH PROMOTION

The state entered a period of inactivity in legislation, both in the regulation of prostitution, although this continued in Europe,¹⁵ and in the area of venereal diseases. Although there was pressure for a government inquiry into the problem, it had proved to be a political quagmire

and parliament preferred to believe that the diseases were in decline, and were anyhow best combated by moral and religious efforts.¹⁶

The Eugenics movement became influential in the early 20th century. Although some of the ideas contravened medical ethics, such as sterilising the unfit, the desire to eliminate ‘racial poison’ such as the venereal diseases, was so persuasive that many prominent doctors were supportive and a new moral medical alliance was forged which became the social hygiene movement. Various organisations were formed out of this including The National Council for Combating Venereal Disease (NCCVD), which consisted of doctors, eugenisists, feminists and moralists.¹⁷

The Royal Commission on Venereal Diseases (1913 – 1916) produced what Oriel describes as “an enlightened document” which became law, the Public Health (Venereal Diseases) Regulations 1916.¹⁸ The recommendations were radical, establishing a free, confidential, nationwide service for the provision of diagnosis and treatment of venereal disease. However, as discussed by Oriel¹⁹ and Adler²⁰, the commissioners were nervous about prevention and prophylaxis. They considered the need for health education and took evidence from schools about “hygiene” lessons and the role of the school as compared to parents.

“...any appeals that may be made to children should be moral appeals. I think you can appeal to them on the ground of morality or on the ground of God, whereas I do not think you will appeal to them very strongly on the ground of the physical risk they run.”²¹

In the end the task was delegated to the NCCVD, which received considerable funds as a result. The commissioners believed that education should be based on spiritual and moral principles, especially given the dilemma of prevention, which may encourage a man to “deliberately fornicate in the knowledge that he would be protected from the consequences of his action?”²²

The NCCVD campaign, which was aimed at troops during the First World War and civilians afterward, was very popular, reaching two and a half million people between 1914 – 1920. It consisted of literature, films and plays, with titles such as “Damaged Goods” These consisted of images of health, athleticism and nature, juxtaposed with sinister images of the city and the amateur prostitute.

This was typical eugenisist propaganda and fostered the belief that venereal diseases were to be caught casually in the urban underworld, public drinking fountains, doorknobs, towels, etc., were all suspected modes of transmission, even by physicians.²³ As Oriel observes, this campaign failed to reach those at actual risk of infection and instead led to “a flow of the worried well to clinics – as was to happen 60 years later after television programmes about AIDS”.²⁴ Nevertheless, the NCCVD remained the only organisation with Government backing but eventually diversified into other areas of health education, becoming the British Social Hygiene council in 1925 and eventually being absorbed into the Health Education Council in 1943. By this time public interest in the subject had faded and there was little demand for the books and pamphlets published about venereal disease.²⁵

CONTACT TRACING AND THE NEW VD CLINICS

Meanwhile the staff at V.D clinics nationwide was carrying out one –to –one counselling and contact tracing. Colonel L. W. Harrison was appointed in 1919 as the first Adviser in Venereal Diseases to the Ministry of Health. He was the medical director of St Thomas’s clinic, which was built according to his design and run according to his rules. These emphasised high

standards of medical care, teaching and research, as well as confidentiality, ease of access and respect for the patients. His systems and clinic design were widely adopted across the country under his guidance as the Ministry Adviser.²⁶

Amongst his considerable achievements as a clinician had been the introduction of contact tracing methods during his military service. In India between 1902 – 1904 Harrison would ask soldiers if they could recognise the source of their infection. Then an identity parade would be held. During the First World War medical officers at the hospital for soldiers with V.D., outside Le Havre in France, were required by Harrison to take a description of the woman concerned as part of the medical history. French plain clothes police would then attempt to find the woman and take her into custody for examination.²⁷ Back in the UK after the War, clinicians were aware of the importance of examining contacts, with Harrison preferring the patients being encouraged to trace their own contacts, which he by then believed to be more effective.²⁸

The first clinic staff to be concerned solely with the social and psychological well being of patients were the almoners. Employed During the 1920's and 1930's, they were medical social workers whose role was primarily to assist with the financial and domestic problems of the patients. However they also undertook to persuade patients to bring their contacts to the clinics.²⁹

DORA 33B AND THE TYNESIDE SCHEME

Formal contact tracing began during the Second World War. The American system of disease control, designed by the epidemiologist Thomas Parran, was being successfully applied to US forces, but the epidemic in England was not being contained. Colonel Harrison planned and implemented the Defence of the Realm Act, Regulation 33b (DORA33B), which required clinic doctors to supply the Medical Officers for Health with names of any sexual contact suspected by two or more of their patients to be the source of an infection. Treatment was then obligatory.

This regulation failed in it's primary objective, due to small numbers of reports, although more success was achieved when unofficial follow ups to single reports were undertaken.³⁰ This regulation was repealed in 1947 but in the meantime "it stimulated and encouraged a considerable surge of activity in the field of contact tracing"³¹

In 1948 the Ministry of health issued instructions to borough medical officers of health and venereal disease specialists entitled "Expiry of Defence Regulation 33b. Suggested Methods of Continuing to trace sources of (Venereal) Infection." All clinics were sent a book of contact information forms. They would send the details of their patients and the contacts to the local authority medical officer for health, who would then ask their VD social worker to approach the contact.³²

Some medical officers used health visitors, who were already employed by them, to do the contact tracing. The benefit of using the health visitors was that they had local knowledge and were known within the community, thus a home visit by a health visitor wouldn't arouse suspicion. The almoners/social workers in this system worked within the clinic, they were regarded as the 'case holders,' while the health visitors were the 'case finders'. The "Tyneside scheme", which started as an experiment in 1943, had followed this approach.³³ In 1944 at a meeting of the MSSVD the social worker was described as an "indispensable member of the staff of the venereal diseases clinic".³⁴ After the success of this scheme, other local authorities followed and most larger clinics employed VD social workers, paid by the borough.

The use of contact tracing methods and their effectiveness is the subject of much of this manual and thus won't be reviewed here. The literature does feature some successes and describes very labour intensive detective work by the VD social workers and health visitors. Detailed contact sheets were developed, which contained descriptions of the person and where they were most likely to be found. Often there was no name and no address but the contacts were found anyway. The workers discuss how frustrating and time consuming this work was "one often has to spend hours on research going from one address to an other".³⁵ All patients with gonorrhoea and syphilis were interviewed, "except selected patients such as innocently infected wives and fiancées"³⁶

It is notable how important to the work the rapport between the worker and the patient is. This is commented on from the perspective of being persuasive and able to extract more information than medical staff from the patients and also to be able to persuade the reluctant contact to attend the clinic. "...I could suggest that they come to talk to me at the clinic and could then fairly easily inveigle them into a consulting room".³⁷

Nevertheless, it is very evident that the workers were conducting supportive interviews with these patients, often expressing concern about their welfare, in particular the ill treatment of prostitutes by their pimps. As Thin comments, these workers were able to: "listen, discuss, offer simple advice, and refer patients to the clinic doctor, to their general practitioner, or to other agencies as required."³⁸

FROM VD SOCIAL WORKER TO HEALTH ADVISER

In 1969, compulsory examination of those suspected to be infected with a venereal disease was considered again by parliament and rejected.³⁹ A report by The Chief Medical Officer in the same year stressed the importance of contact tracing and, in 1971, the Department of Health and Social Security recommended the appointment of contact tracers to every clinic in London. Subsequently, numbers of contact tracers employed in clinics increased nationwide.⁴⁰

With the reorganisation of the health service in 1974, some local authority services and staff, such as health visitors, transferred to the health service. An increase in the recruitment of nurses into the posts of contact tracer/ health adviser has subsequently led to the majority of currently employed health advisers having a nursing qualification. A recent survey put this at 77%.⁴¹

Contact tracing was regarded as a valuable activity: "Effective Contact Tracing and the treatment of carriers of infection requires great tact and perseverance but is an essential element in the control of the diseases".⁴² In 1980 the Health Education Council published "A Handbook on Contact Tracing in sexually transmitted diseases". This was the first textbook on the subject in the world.⁴³ It provides detailed advice and instructions on how to undertake contact tracing. It is a very practical document, advising on the wording of letters, and what to say on phone calls and visits, it even goes to the extent of advising how to dress and behave on a pub or disco visit.⁴⁴

In 1981 five day residential training courses were established for all health advisers, and discussions were held with the DHSS and then NHS Training Authority about developing more comprehensive training.⁴⁵ The developments in health advising practise and expansion of the role in the last two decades are discussed in the Introduction and elsewhere in this manual.

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Law and the sexual health adviser

CHRIS FALDON

The sexual health adviser needs to be aware of the legal framework surrounding their work if they are to practice in a safe and competent manner.

INTRODUCTION

The work of the health adviser is influenced by a number of background legal and ethical factors that are not always readily compatible with one another. An understanding and acceptance of these may greatly assist the health adviser when addressing specific situations and assessing any proposed plans for action.

- **The Law** The law is the base line of all professional activity. To operate outside it runs the risk of instigating legal proceedings or being sued. It is important to have a basic awareness of the legal framework that addresses issues such as slander, defamation, minors and disclosure. It is also necessary to establish what support we can expect from professional organisations and employers
- **The ethos of the workplace** Custom and practice in the place of work can heavily influence professional activity. For example, legally it may be allowable for a health adviser to disclose an HIV positive diagnosis to a patient over the telephone, but the custom and practice of the clinic may say that only the consultant can do this
- **Personal ethics** Somewhere in the middle of the law and workplace ethos lies the ethical stance of the health adviser. Others may pay little attention to this but at times each person may have to confront situations that affect them at their level of conscience. For example; issues of contraception to under-16's; discussing and encouraging sexual practices which one may never engage in personally; withholding the 'truth' from partners

THE LEGAL SYSTEM

Laws emanate from basically two sources;

- Decided cases through the court system. Sometimes known as Case Law, Judge-Made Law or the Common Law
- Legislation. Established by Acts of Parliament (Statutes), directives and regulations. The European Community may in some circumstances be the legislative authority¹

Like most legal systems English law is divided into criminal law and civil law. At the lower levels, different courts administer the two types of law:

- **Criminal Courts:** 95% of criminal cases are dealt with in a Magistrates Court. Magistrates are usually lay people neither paid nor legally qualified and are assisted by the Clerk to the Justices, who is usually a qualified solicitor. The Crown Court deals with the more serious criminal cases and here the accused is tried by a professional judge sitting with a jury
- **Civil Courts:** A civil action can be brought in the County Court, or in the High Court. Higher damages can be awarded by the latter. Many civil cases are settled out of court (about 99% in personal injury cases)

The legal profession is divided into two branches, barristers and solicitors. The public rarely have direct access to barristers, who are called to ‘counsel’, and normally have to go through a solicitor, who briefs counsel. Barristers can argue cases in all higher civil courts and solicitors argue cases in lower courts.² This however is changing and there are moves to make them one profession.³

DECIDED LAW

This forms the basis and backbone of English Law and the English legal system and was developed by the Royal Judges from the Norman conquest to the present day. It is often called the common law because in medieval times it was the law common to the whole realm, as distinct from local customary laws.

The cornerstone of the common law is the doctrine of precedent, which means that once a case has decided a particular point of law, that decision must be followed in all subsequent cases involving that point of law, unless a higher court overrules it. Decisions of the House of Lords, which is the highest domestic court, bind all other courts below it, and decisions of the European Court of Justice can bind even the House of Lords. Health care practice is largely governed by the common law. Consent to treatment is almost entirely a matter for the common law.

LEGISLATIVE LAW

The problem of establishing a precedent is that it becomes rigid and may not reflect new fields of human activity or for that matter be in tune with the political climate of the current age. Under English law Parliament is sovereign, and can make or repeal whatsoever laws it wishes.

Primary legislation describes statutes passed by Parliament and formally approved by the Queen. This can be a lengthy process consisting of a ‘Green Paper’ to outline problems needing addressing, followed by a ‘White Paper’ with proposals for action. A bill is then drafted and introduced to Parliament. Before becoming an Act it must go through a number of hurdles such as a second reading, the Committee stage and the report stage. Once the final text is reached the Bill must be passed by both Houses (Commons & Lords). The process is

meant to generate well thought out legislation. The courts can and do interpret the Statutes (or Acts) which Parliament passes, and what is called the case law thus generated is often crucial in knowing what the law of England is. The 1967 Abortion Act as an example requires a registered medical practitioner to conduct a termination but in the case of *Royal College of Nursing of UK v. DHSS* (1981) it was decided in the House of Lords that the induction/prostaglandin method that requires a high level of nurse involvement, did not offend the requirement. When judge made law and statute law conflict the statute law prevails.

Secondary legislation is the making of regulations by statutory instruments. It is approved by Parliament but prepared by ministers and the details are not debated. They take up less Parliamentary time and can be amended more easily than Statutes. They commonly spell out details of plans more generally put in Statutes. Specific duties, standards and procedures are often the content of regulations. The Abortion Regulations 1991 by way of example can be more instructive to the professional than the Abortion Act 1967.

GUM is very familiar with the 1974 VD regulations and the newer NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 (see Appendix 2).⁴ These impose the same obligations of confidentiality on the members and employees of both NHS trusts and Primary Care Trusts.

THE LEGAL AID SYSTEM

The 1999 'Access to Justice Act' made sweeping changes to the legal aid scheme by establishing a Legal Services Commission to run publicly funded schemes that enable people in need to access legal services. It also paved the way for a more streamlined system dealing with litigation. One outcome was the establishment of a fee system based on the principle of a 'no win, no fee' agreement.⁵

THE LAW AND THE HEALTH ADVISER

The law impinges on health care professionals in the following ways:

Criminal Law. A crime is an offence committed against the State either in the performance of some act that the law forbids or in the omission of some act that the law requires. Laws are generally enforced through prosecutions brought by the Crown Prosecution Service. Other bodies such as the National Society for the Prevention of Cruelty to Children, the Health and Safety Inspectorate and Environmental Health Officers have powers to prosecute in certain circumstances. The outcome of a prosecution is dependant on the ability of establishing a standard of proof beyond reasonable doubt. This leads to a verdict of 'guilty' or 'not guilty' and the penalties vary from fines to imprisonment. The concept of criminal responsibility is important since the state presumes that every person committing an act is sane and is doing so voluntarily unless this is proved otherwise. Legally recognised reasons exist for acts committed which ordinarily would have been criminal such as the use of reasonable force in self-defence. Ignorance of the law is no defence.

Civil Law. Much of the professional's work is written in the framework of the civil law, particularly the part of it known as the law of torts. A tort is a civil wrong or transgression and results in a common law action for damages. Individuals can seek to remedy a civil wrong committed against them by another individual or organisation. Legal action taken by a private individual can result in monetary compensation being awarded though the process can be slow, expensive and cumbersome.

Negligence (duty of care brought into question), trespass to the person (assault and battery) and how legal defences of consent and necessity operate, is of relevance to the health adviser. A further tort of interest is defamation, either as libel (permanent form, usually in writing) or slander (spoken word). A breach of confidence (in England, Wales and Northern Ireland) can lead to a person being sued. The patient can sue the health adviser for defamation. For several reasons this is impractical and unlikely to succeed. First the material has to be of such a nature that the person is lowered in the eyes of 'right thinking' people. In the past allegations of venereal diseases or 'imputation of unchastity in a woman' would have been put into this category. However, a major defence is that the defamatory material is true. This usually prevents successful actions being taken unless the purpose of the breach was to bring the patient into disrepute. A second difficulty is the cost of taking legal action. As defamation cases are not covered by legal aid, this in practice rules out all but the very affluent from taking action.

Public Law. This deals with the relationship between citizens and the state. It concerns the limits of government power, including that of public bodies such as the Department of Health, health authorities, and NHS trusts.

Employment legislation. Codified Acts of Parliament now exist to deal with the increasing complaints of the work situation though much of the law relating to employment has its roots in civil law. Protection of the individual employee and industrial relations regulation are two major themes tackled by employment legislation. If an employer sacks an employee for taking time off for treatment, the employee will have no statutory remedy (a contractual remedy however may be available) unless s/he had been in employment with that employer for at one year or in certain specified situations can be as little as one month.⁶ Health Professionals have an obligation to follow the lawful and reasonable instructions of their employers often set out in policies and protocols. They may be disciplined for failing to follow them and such action has legal backing. Professional judgement may well be exercised to depart from agreed rules and regulations if specific situations merit it and can be clearly argued.⁷

Professional legislation. Professionals are regulated by codes of conduct, which are rules set by their colleagues.⁸ Breaching them constitutes a professional misconduct and can lead to penalties imposed, which in some circumstances can mean being removed from the register.

Since April 2002 the majority of health advisers fall under the jurisdiction of the Nursing & Midwifery Council. Their basic functions are laid down in the Health Act 1999 through detailed statutory instruments. Essentially they determine the rules for professional registration and investigate allegations of misconduct. Codes of professional conduct do not have the status of law but a professional duty is placed on all registered members to work within them. Failure to do so can mean a health adviser be legally prevented from practising thus the law and professional behaviour remain intertwined. The Society of Sexual Health Advisers is in the process of exploring all measures needed to establish and maintain a professional register.

Quasi-Law. The NHS generates circulars, guidance and executive letters instructing how to carry out work. These documents may not be legally binding but may have some legal force if not followed. It is common practice for the Department of Health to use guidance and encouragement rather than compulsion. The 'Guidelines for pre-test discussion on HIV testing' published in March 1996 are such an example. Mrs Gillick objected to a controversial circular in 1985 on contraceptive services for young people. This eventually led to a ruling in the House of Lords, which governs practice.

European Law. Much of this law is concerned with governing that economic activity is based on fair competition. European Community Law is rapidly growing with legislation made or proposed by the European Commission. Treaties, regulations and directives can in some instances have a direct or indirect impact on English law, individuals and authorities such as NHS trusts. A number of directives have been concerned with giving mutual recognition to professionals qualifying from other member states. Doctors and nurses have had their statutes changed to incorporate these directives. The European Court of Justice based in Luxembourg is a further source of European Community law which can examine alleged failures of governments and institutions to meet their legal obligations.

Human Rights Law. International agreements can influence health care law. The European Convention for the Protection of Human Rights and Fundamental Freedoms was originally drawn up by the Council of Europe in 1950 and influenced the European Social Charter of 1961. Until the publication of the Human Rights Act 1998⁹ the UK had no mechanism for the vindication of human rights. Frequent petitions from this country were made to the European Commission of Human Rights. The commission passed on any case to the court if a Convention breach was apparent. The UK Government undertook to agree to any decision made by the European Court of Human Rights.

The 1961 Social Charter makes only brief mention of rights to health and seeks to facilitate the activities of professionals more than limit them. However it does provide for the detention of those judged to be insane or threatening to infect others with disease.

The Human Rights Act 1998 specifically deals with interference by a public authority on the right to respect for private and family life. It is important that the actions of health advisers such as securing the attendance of sexual contacts are legal and backed by sound policies and procedures that clearly articulate their rationale and necessity. Any action taken, even if within policies and procedures, need should be justified for each individual case.

LEGAL ISSUES: SEXUAL HEALTH OF CHILDREN & YOUNG PEOPLE

The health adviser commonly has contact with young people and some attention is given to outlining some of the key legal issues that crop up when dealing with some of the concerns that they bring.

The Civil Law

In general, the consent of the child or young person can be obtained where:

a) The young person is over the age of 16 years. In these circumstances, so long as they are of sound mind, they have a statutory right to give consent under section 8 of the Family Law Reform Act 1969. Parental consent is not required.

or

b) The child or young person is under the age of 16 years, but is deemed capable of giving consent in certain circumstances.

Normally, no medical examination should take place if a child or young person is competent to consent but refuses to do so.

However, those with parental responsibility (e.g. natural or adoptive parents, or the local authority in possession of a care order) can override the refusal in some cases. It is important to take into consideration the refusal of consent from the child before making such a decision.

If consent is not available, doctors can only provide those elements of treatment that are immediately essential to secure the child or young person's welfare.

Fraser Ruling

In the case of *Gillick v West Norfolk and Wisbech Area Health Authority* (1985) 3 All ER 4092, the House of Lords reviewed the issue of consent with regard to young people under 16 years of age. It was held that the test to apply was whether the child had sufficient understanding and intelligence to enable full understanding for any proposed intervention.¹⁰ Parental rights are to yield to the young person's right to make their own decisions.¹¹ This became known as the Fraser Ruling though is still sometimes referred to as an assessment of 'Gillick competency'.

The Criminal Law

See Appendix 1 for summary of sex laws.

▪ *Offences (females)*

In all offences perpetrated by a male upon a female, the Sexual Offences Act 1993 abolished the legal presumption that a boy under the age of 14 was incapable of sexual intercourse. All references to a man, therefore include reference to a boy.

Intercourse with a girl under thirteen It is a serious arrestable offence for a man to have sexual intercourse with a girl under the age of thirteen.

Intercourse with a girl under sixteen It is an offence for a man to have unlawful sexual intercourse with a girl under the age of sixteen in England, Scotland and Wales and under seventeen in Northern Ireland. It is no defence that the girl consented to the sexual intercourse.

It may be an exception to the offence of having intercourse with a girl aged under 16 (but not if she is under 13) if the man is under the age of 24, has not been previously charged with a like offence, and believes the girl to have been the age of sixteen or over, and that he has reasonable grounds for that belief.

▪ *Offences (males)*

Homosexuality Consensual anal sex in private can now occur lawfully when the parties are over the age of sixteen.¹²

Sexual intercourse is deemed not to have taken place in private if more than two men are present, or if it takes place in an area to which the public have access.

Gross Indecency It is an offence for a man (otherwise than in the circumstances below) to commit an act of gross indecency with another man (either in public or private) or to be a party to the commission of such an act or to procure it.

- It is not an offence if the man is under the age of 16 and the other man has attained the age of 16
- No offence is committed if both parties are over the age of 16 and consent and the act takes place in private. In these circumstances there will be no offence of commissioning or procuring

▪ ***Offences (both sexes)***

Rape It is an offence for a man to rape a woman or another man. Rape is committed if a man has sexual intercourse (whether vaginal or anal) with a person who, at the time, does not consent to it, and he either knows that the person does not consent or is reckless as to consent. ('Recklessness' can be defined as indifference to the feelings and wishes of the victim and giving no thought to the possibility she might not be consenting).

Penetration is sufficient to constitute sexual intercourse; ejaculation is not necessary. Consensual sexual intercourse becomes rape if the participating party ceases to consent during intercourse.

The definition of rape was amended by the Criminal Justice and Public Order Act 1994 to include rape by a husband of his wife.

It is also an offence to aid, abet, procure or incite to commit rape.

Indecent Assault It is an offence for any person (man or woman) to make an indecent assault on either a man or woman.

Assault usually includes physical contact and can include acts such as touching or kissing as well as penetration (for example with a finger).

The test for indecency is what a right minded member of the public would consider to be indecent. Factors that should be considered when determining this include the relationship of the accused to the victim, how the accused has come to embark on this conduct, and why they are behaving in that way.

A boy or girl under the age of 16 is unable to consent to an act to prevent it being an indecent assault. Incompetent men and women are also unable to consent, although the accused will only be guilty if they knew the victim was incompetent or had reason to believe that they were.

Buggery Committing buggery with another person or an animal is a serious arrestable offence unless:

1. both parties are over 16 and are in a private place when the act takes place, or;
2. the person who commits buggery is under 16 and the person who it is committed with is over 16 (this ensures protection for minors who may be being abused).

An act will not be committed in private if it takes place in a lavatory which the public have access to, or more than two people take part or are present.

Buggery includes anal sex by a man with either a man or a woman. Less commonly the offence is also committed by either a man or a woman, in any manner, with an animal.

A man who procures another man to commit with a third man an act of buggery which is not an offence (i.e. in the circumstances above) commits an offence. It is also an offence to assault another person with intent to commit buggery.”

Incest It is an offence for a man to have sexual intercourse with a woman whom he knows to be his grand-daughter, daughter, sister or mother. It is immaterial whether the woman consented.

It is an offence for a woman of the age of 16 or over to permit a man whom she knows to be her grandfather, father, brother, or son to have sexual intercourse with her by her consent. A distinction is drawn between permission and submission.

For these purposes “sister” and “brother” include half sisters and brothers. Additionally any relationship imported between two people applies notwithstanding that it cannot be traced through lawful wedlock. The accused must be aware of the relationship existing at the time of the commission of the offence; a mistake of identity may be a defence.

Summary of offences

The law relating to these offences has been overhauled by the Sexual Offences Act 2003. The behaviour described above will still be an offence, but there are a number of new classifications in the Act which could make certain offences more wide-ranging. The Act also includes more protection for children, especially in relation to acts such as incitement to engage in sexual offences and grooming. The Act also contains added protection for those suffering mental disorders, and provides more detail on existing offences. The Act is not yet in force, meaning that the law as stated above still stands, but professionals should be aware that the updated provisions, which offer more avenues of protection and detailed explanation, will come into force in due course.

HEALTH ADVISER IMPLICATIONS

The health adviser owes the employers certain duties;

- To carry out their lawful instructions
- To render them faithful service
- Not to be absent from work without good cause
- Not to disclose confidential information obtained in the course of duty
- To perform duties with reasonable care
- To take reasonable care for the health and safety of others and to co-operate with your employer in this

Being sued for professional negligence is a great fear and can be done for giving either advice or treatment, which an ordinarily competent health adviser would not advise or do. Inexperience is no defence. The following tips should prove helpful:

- Always ensure advice is as accurate as possible
- Do not act beyond the scope of professional competence
- Be willing to take extra trouble in whatever is done
- Always try to maintain good relations with clients
- Keep notes and records which are adequate, legible, signed and dated
- Keep all correspondence and copies of letters sent
- Never admit liability, except on legal advice
- Do not release confidential information until the identity of the recipient has been confirmed (call back other GUM clinics) and clarify the use of this information
- Mark all confidential correspondence as 'Confidential' or 'For Addressee Only'¹³
- Professional indemnity insurance is desirable and most professional associations will provide it though it is unlikely the health adviser will need it because the employing authority is vicariously liable for any negligence committed in the course of employment. In practice it is usually the employer and not the individual worker who is sued

HYPOTHETICAL EXAMPLES

Case Study 1

Fiona, a newly appointed health adviser mentioned to her flat mate that she had seen a well-known footballer with gonorrhoea at the clinic. He was married but had picked up the infection by having oral sex with one of his team-mates. She asked her to keep quiet about it. Some weeks later an article appeared in the local press revealing the explicit details. The source of the information was traced back to her. What are the legal repercussions?

The trust between the patient and professional imposes a duty of care to protect confidentiality.¹⁴ The footballer could sue Fiona's employers for their vicarious liability though this is unlikely as such action could attract adverse publicity. If he had been aware of the intention to print the article prior to its release he would have grounds to take out a court injunction prohibiting publication.

Fiona could face disciplinary proceedings on a number of counts:

- Failing to comply with a term in her employment contract (explicit or implicit) that expects employees to respect the confidential nature of patient information. This may lead to dismissal
- Failing to respect her professional code of conduct. These will vary across professions though all will contain a clause requiring members protect patient confidentiality unless there were legal justifications to breach it

- Failing to comply with the statutory provision of the NHS (Venereal Diseases) Regulations 1974 and the NHS Trusts and PCT's (Sexually Transmitted Diseases) Directions 2000. These prevent the disclosure of any identifying information about a patient examined or treated for a sexually transmitted disease (including HIV and AIDS) other than to a medical practitioner (or to a person employed under the direction of a medical practitioner) in connection with and for the purpose of either the treatment of the patient and/or the prevention of the spread of the disease

Fiona could claim her friend had breached trust between them and could take legal action against her. This may be feasible if the friendship had broken down though may not be advisable if compensation costs would be difficult to recover. Even if this friend had been paid money for her story by the press the judge may not look favourably on Fiona benefiting from these profits.

Acceptable breaches of confidentiality do exist in the following circumstances: ¹⁵

- **Patient consent** Obtaining consent from a patient with a mental illness may not be straightforward due to the question of competency. If the patient is incompetent the presence of another colleague will not make their consent valid. The presence of the extra professional is a matter of good practice to assist in deciding whether the patient is competent. If the conclusion reached is that the patient is competent then their consent is valid. If the patient is incompetent they can be treated in their best interests.
- **Patient best interest** This covers giving information to other professionals. Implied consent is fraught with medico-legal difficulties though in practice it is widespread. It extends beyond the sharing of patient information with professional colleagues into tricky situations where the patient did not refuse consent but equally did not sanction it. For example, supplying verbal information to a GP who rings wanting to know details of his patients clinic visit when he had merely advised he attend without sending a referral letter. Similarly in Case Study 1 it would cover giving information to the Football club doctor if the player did not return to the department for treatment despite several attempts to contact him
- **Court order** If justice is to be served in courts of law, litigation and prosecutions a judge may waive the right of a patient to confidentiality. Before releasing information the health adviser should check with their employers legal department
- **Statutory requirements** Such as the Police & Criminal Evidence Act
- **Public interest** Serious criminal acts warrant disclosure. Suspicion of child abuse should waive any hesitation of protecting confidentiality.^{16 17} The VD regulations make provision to disclose information, against the wishes of the patient, to a relevant health care professional for prevention purposes.¹⁸ Significant harm to an identified individual would need to be demonstrated if the disclosure was not made. For each event a strong case would need to be made to argue that a breach in confidentiality was a legitimate action and proportionate to the seriousness of the concern. This is a complex area and the health adviser should take advice from other colleagues before proceeding further. Clear clinic policies outlining courses of action to be taken in common situations should be available

Case Study 2

Russell attended the GUM clinic as a result of a provider referral for gonorrhoea by contacting him at his place of work. He was a junior doctor working in Accident & Emergency. Epidemiological treatment was given and he took up the offer to have an HIV antibody test. Unexpectedly the result came back positive. The health adviser, Kenny saw him several times over the next few months and although Russell agreed to inform his employer he never seemed to get round to it. Does Kenny have a legal obligation to ensure full disclosure is made?

Health care workers infected with HIV have an ethical and legal duty to take reasonable care to protect the health and safety of their patients. An HIV infected worker must not perform procedures that are clearly described as exposure prone.

*Exposure prone procedures (EPPs) are those where there is a risk that injury to the worker may result in exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.*¹⁹

The General Medical Council as the regulatory body for doctors, places on Russell an obligation to take certain actions.²⁰ These include:

- Promptly seeking and following advice from a suitable qualified colleague. This should cover whom to tell – current, previous and prospective employers. Also what aspects of professional practice may need modification?
- Not to rely on self-assessment of risk to patients
- Arrange appropriate medical supervision
- If he persists in choosing not to follow this guidance he could in the future face disciplinary proceedings and possible dismissal

If Kenny has taken reasonable steps to advise Russell to inform relevant authorities about his status and yet believes that this advice has not been acted on the 'Sexually Transmitted Disease Directions' provide grounds to inform an appropriate person in Russell's employing authority (e.g. an occupational health physician). In practice this is an action likely to be delegated to the GUM Consultant. Russell should be informed that this action is to be taken.

CONCLUSION

This chapter has not intended to cover all eventualities and is merely intended to be a reference guide. Health advisers may need more detailed and specific legal advice on a matter from time to time to clarify issues. An employer has a duty to protect staff and could be approached when an uncertainty arises. Professional bodies or trade union organisations may also be of some assistance. Safe and competent practice will be more assured when the professional appreciates the legal parameters within which to operate.

Having a firm grasp of the legal framework underpinning the work of the health adviser may appear daunting. There are constant demands to respond effectively to patients sexual health needs. The potential for major upset is real. It is important therefore not to ignore legal

implications though at the same time it is worth reflecting on the fact that very few practitioners will fall foul of the law.²¹

USEFUL INTERNET RESOURCES

Brief explanations of the English legal system for non-lawyers.

Nicol N. Barrister & Mediator <http://www.niknicol.co.uk/English/english.html>

Centre for Criminal Justice Studies. UK Law Online <http://www.leeds.ac.uk/law/hamlyn/toc.htm>

Venereal Disease Regulations 2000 <http://www.doh.gov.uk/stdtdirections.htm> The latest version that governs practice within GUM clinics

Nursing & midwifery council. Code of professional conduct <http://www.ukcc.org.uk/cms/content/publications/>
Defines the standards which are required at all times from registered nurses, midwives and health visitors. This is the benchmark against which complaints of misconduct are judged and the source of all the other professional advice and guidance published by the UKCC

The Children Act 1989 http://www.hmsa.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm The Act brings together most private and public law about children, thereby replacing complex and fragmented legislation with a single statute.

Her Majesty's Stationary Office

<http://www.hmsa.gov.uk/legis.htm> UK Legislation since 1988 and Northern Ireland legislation since 1981

Sexual Offences (Amendment) Act 2000 <http://www.legislation.hmsa.gov.uk/acts/acts2000/20000044.htm> An Act to reduce the age at which certain sexual acts are lawful

The Lord Chancellor's Department: Justice - Rights – Constitution. <http://www.lcd.gov.uk/>

APPENDIX 1

Sex Laws at a glance

Heterosexual sex - The legal age of consent in England, Scotland and Wales is 16 years. It is 17 years in Northern Ireland. It is an offence to have sexual intercourse with a girl under 16, even if she consents.

No specific law exists to prevent an older woman having intercourse with a boy under 16. She could be charged with indecent assault. In either case, only the older person is guilty of an offence.

Heterosexual anal sex - The legal age of consent for a man and a woman in England and Wales is 16 years. It is 16 years in Scotland.

Anal sex between two men - The legal age of consent for in the UK is 16 years except Northern Ireland which is 17 years, provided both men consent.

Sex between two women - No specific law exists on the age of consent for lesbians. It may be implied in other laws that both women must consent and be over 16 years, except in Northern Ireland, where they must be over 17 years.

Incest – Sex is outlawed with a close blood relative: father, mother, sister, brother, grandfather and grandmother.

Sex in a public place – This is illegal. Includes toilets, places of entertainment and recreation.

Money for sex - You can't legally solicit or run premises and receive payment for sexual favours/services.

Abuse of trust – The person in the position of trust must be over 18 to commit the offence. The person abused must be under 18. It is a defence if the accused can show that they reasonably believed the other person was 18 or over, or that they were not aware they were in a position of trust with them.

APPENDIX 2

THE NATIONAL HEALTH SERVICE ACT 1977

The NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000

Made - - - - 8th September 2000

Coming into force - - - 15th September 2000

The Secretary of State for Health in exercise of powers conferred by sections 17 and 126(3) of the National Health Service Act 1977(a) and of all other powers enabling him in that behalf, hereby makes the following Directions:

Citation, commencement and extent

1. - These Directions may be cited as the NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 and shall come into force on 1st April 2000.
- (2) These Directions extend to England only.

Confidentiality of information

2. Every NHS trust and Primary Care Trust shall take all necessary steps to secure that any information capable of identifying an individual obtained by any of their members or employees with respect to persons examined or treated for any sexually transmitted disease shall not be disclosed except-

- (a) for the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof, and
- (b) for the purpose of such treatment or prevention.

Revocation

3. The National Health Service Trusts (Venereal Diseases) Directions 1991 are revoked.
8th September 2000

Signed by authority of the Secretary of State for Health

Marcia A Fry

Member of the Senior Civil Service

EXPLANATORY NOTE

(This note is not part of the Directions)

The National Health Service (Venereal Diseases) Regulations 1974 (S.I.1974/29) imposed on health authorities an obligation to secure that information about sexually transmitted diseases obtained by their officers should be treated as confidential. In 1991 Directions were made imposing the same obligations on trustees and employees of a National Health Service trust. These are now revoked in relation to England.

These new Directions, which apply only to England, impose the same obligations of confidentiality on the members and employees of both NHS trusts and Primary Care Trusts.

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- 5 Ibid
- 6 Employment Rights Act 1996 <http://www.hmso.gov.uk/acts/acts1996/1996018.htm> (accessed 30th Oct 2003)
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Ethical issues in sexual health advising

GILL BELL

Ethical considerations are at the heart of all aspects of health advising, including partner notification, counselling and health promotion. This chapter offers a framework for understanding and managing ethical issues.

INTRODUCTION

Almost everything health advisers do has the potential to affect somebody's welfare, and as such may raise ethical issues. Simultaneous duties to the individual patient, their sexual contacts and the community as a whole create numerous dilemmas when the best interests of all cannot be fully accommodated. Choices have to be made about how best to serve a person's interests, or whose interests should receive priority, when there is conflict. Furthermore, the finite nature of resources requires decisions about which individuals, or groups, (if any) should benefit from restricted access sessions, outreach initiatives, or priority appointments.

The aim of this section is to clarify how an ethical issue might be identified and managed. The main ways of approaching an ethical issue are explained, and the key principles are discussed in relation to common dilemmas. There are no objectively right answers in ethics, but there are valid and non-valid arguments for and against a given action. Familiarity with the concepts and language of ethics will enable health advisers to make decisions, and explain them, with greater confidence.

1. APPROACHES TO ETHICS

DEONTOLOGICAL ETHICS: THE IMPORTANCE OF PRINCIPLES

Deontology is the study of duty. Deontological ethics start from the position that there are certain moral principles that we have a binding duty to uphold. Rules of behaviour that serve or enshrine these principles must be followed. Examples of moral obligations include the duty to tell the truth, keep promises, be fair, respect autonomy and treat people as ends rather than means. There are many more.

A situation is an ethical issue, in deontological terms, if potential actions, or inactions, might violate a moral principle. An action is considered to be right if the appropriate principles have been honoured. The consequences of an action are not necessarily relevant to the debate, unless certain outcomes are integral to a principle, such as beneficence (see below).

The concept of rights is an important aspect of deontological ethics. All individuals may be said to have certain fundamental human rights, for example to “life, liberty and estate” ¹ that cannot normally be legitimately transgressed. In addition to these, some people have rights that are the result of particular circumstances where a tacit or explicit contract applies. For example, patients attending genitourinary medicine (GUM) have a right to free and confidential screening and treatment.

Rights are only meaningful if others are obliged to respect them. The rights of a person requiring a sexual health check therefore confer duties on the health care system and on individual health care workers to do whatever is necessary to honour these rights. Sometimes the duty is to do nothing – to refrain from interfering with the person’s right to autonomy.

Debate arises in duty-based ethics when there is conflict between principles, or confusion about the validity, relevance or meaning of a principle.

TELEOLOGICAL ETHICS: THE IMPORTANCE OF CONSEQUENCES

Teleology is the study of consequences. Teleological theories of ethics, such as utilitarianism, regard actions to be right if they produce desirable outcomes. ‘Extreme’² or ‘act’ utilitarians assert that each individual must consider the consequences of all possible actions before choosing the action that produces the best balance of good over harm. Moral rules may be useful as rules of thumb, but they are not sacrosanct, and should be disregarded if they are likely to result in an undesirable outcome in the instance.

By contrast, ‘restricted’³ or ‘rule’ utilitarians place more faith in moral rules than the judgement of the individual, who may lack the necessary knowledge, experience or wisdom to anticipate the full range of consequences. It is postulated that established moral rules have been created, and have survived, because they tend to lead to positive outcomes. Furthermore, rules offer security and protection: the ability to trust that individuals will behave in certain agreed ways is in everyone’s interest. For these reasons, rule-utilitarians believe that the most desirable outcome is more likely to result in the long term if moral rules are followed. The rule-utilitarian commitment to moral principles and rules is based on a perception of their utility, rather than the deontological position that they are intrinsically right.

Debates arise in teleological ethics when there is disagreement about which consequences are desirable, for whom they should be sought, and how they might be calculated reliably.

EXISTENTIALIST ETHICS: THE IMPORTANCE OF MORAL INTEGRITY (AUTHENTICITY)

For the existentialist, the primary moral duty is to be ‘authentic’, or true to oneself. The individual has a fundamental obligation to make a judgement about what is right in a given situation, and to act accordingly. The responsibility to be a conscious moral agent, and make choices, is inescapable: in this sense we are “condemned to freedom”⁴.

Inherited moral rules are not binding, and are of limited use, because they apply to the general, while moral dilemmas are always unique and specific. The individual must also choose which consequences are desirable. An action is right only if the person has acted in 'good faith'⁵: that is, in accordance with his or her own personally constructed values.

The relevance of this doctrine to the ethics of health care is that it "explodes the myth that a professional is somehow different from a non-professional...[A] person should be true to himself in every situation in which he finds himself, and being a professional for a time is just one more situation in which this authenticity is necessary"⁶.

From an existentialist perspective, health care workers should not hide behind their professional role or allow themselves to be guided blindly by professional codes of conduct. There is no escape from the duty to think for oneself: it is a form of moral dereliction, or 'bad faith', to pretend to be are enslaved.⁷

In hierarchical organisations like the health service it is sometimes difficult to avoid bad faith, because there is great pressure to follow the instructions or advice of senior colleagues, regardless of one's own view of what is right.

PROFESSIONAL ETHICS: THE IMPORTANCE OF ROLE

Having considered that, from the existentialist perspective, blind adherence to received rules amounts to an utter failure to be moral, how is it possible to advocate a code of conduct that prescribes professional behaviour? One reason is that subjective individual judgements would be variable, unpredictable and sometimes unacceptable to the majority. They may be guided by self-interest, warped by prejudice or hampered by the difficulty of grasping moral thinking. All professionals have a contract with society to meet certain requirements. The public therefore has a right to be reassured that duties will be performed in full, in an acceptable way, notwithstanding the idiosyncrasies of individual practitioners. Furthermore, practitioners need some guidance: it is unreasonable and unrealistic to expect that we all have the time and capacity to strip down an ethical issue and 'invent' an acceptable response many times each day, without a clear map. Besides, from many ethical perspectives it is part of the nature of morality that we are bound by rules we have not chosen.

Health advisers have particular ethical duties attached to their professional role, outlined in the 'Code of Professional Conduct for Sexual Health Advisers'.⁸ Specifically, they have a duty to:

- Safeguard and promote the interests of patients
- Safeguard and promote the sexual health of those at risk of sexually transmitted infection
- Serve the interests of society
- Justify public trust and confidence

PERSONAL V PROFESSIONAL ETHICS

Personal ethics may conflict with designated professional duties in important ways. For example, it may be difficult to offer supportive and non-judgemental care to a person who is known to be seriously abusive to others; the duty to protect confidentiality may oblige a health adviser to be deceitful, or collude with the deception of others; a possible conviction that

abortion is wrong is at odds with the obligation to offer impartial counselling to a patient who is considering a termination. An individual health adviser may find a team decision on an ethical dilemma to be personally unacceptable – for example, a decision about whether to refer a young person to social services, against their wishes. There may also be occasions where duties attached to other social roles conflict with professional duties.

These conflicts may give rise to debilitating levels of tension and anxiety. It is important for health advisers to have a safe and supportive arena, such as supervision, where these issues can be ventilated and explored.

AN ECLECTIC APPROACH

Even though each of the above approaches to ethics appear to offer a comprehensive, mutually exclusive system, there is much overlap. Some principles, such as beneficence, are consequentialist by nature; consequentialist theories recognise the importance of rules; our professional ethical code⁹ contains both rule and goal based elements; all approaches require individuals to make personal decisions about what is right in a given situation. In practice, an eclectic approach is required. It is not possible to address an ethical issue adequately without considering all elements: *prima facie* principles, consequences, professional obligations and personal integrity.

2. PRINCIPLES OF HEALTH CARE

Beauchamps and Childress¹⁰ propose an ethical framework for health care based on four *prima facie* principles: autonomy, beneficence, non-maleficence and justice.

These are described and discussed in relation to a range of ethical choices encountered by health advisers. The importance of confidentiality will also be considered.

AUTONOMY

Having autonomy means being in control. It also means accepting responsibility for one's choices, actions and welfare. An autonomous person is a rational being who is free to make decisions and act, or permit actions on his/her behalf, accordingly. Autonomy is of central importance to most schools of ethical thought. For some deontologists, such as Kant and Sartre, it is a requirement of moral agency, and therefore intrinsic to the core value of persons. "Moral value is something that springs into being only when there is an actual moral agent deciding what to do, and doing it".¹¹ In other words, one of the qualities that make persons valuable is the ability to make moral choices. A person who lacks autonomy therefore potentially has less status as a human being. For this reason, it cannot be violated or surrendered: autonomy is both a right and a duty. Utilitarians have also stressed the importance of autonomy because it enables individuals to pursue their own goals. The assumption here is that the individual is the best judge of what will maximise his or her well-being.

The following table summarises the ways in which health advisers might facilitate, respect or promote autonomy.

Table 23.1

| <i>Respect for autonomy means that:</i> |
|---|
| Truthful, accurate information needed to make informed choices about care is given promptly, in a way that can be readily understood |
| Informed consent, freely given, is sought prior to any action that carries a risk for the patient (Examples include partner notification; HIV or hepatitis testing; sharing of information with others) |
| Patients are empowered to make and sustain positive behaviour/lifestyle changes of their choice (for example, through risk-reduction interventions) |
| Health is restored where possible, thereby removing physical and psychological barriers to independence |
| Confidentiality is maintained. The patient understands the limits of confidentiality, and is warned of necessary disclosures |
| Choices are respected |
| Persons are treated as ends in themselves, not means to an end |

Ethical dilemmas in relation to autonomy

Difficulties arise in relation to autonomy when:

- **There is conflict between the autonomy of one person and the welfare, rights or autonomy of another**
This conflict would arise if, for example, a woman with chlamydia did not want her ex-partner to be notified. There would be some duty to encourage her to change her mind, even though this challenges her autonomy, because he is entitled to information that will allow him to protect his health, and that of future partners.
- **The person wishes to surrender autonomy**
For example, a patient who is having difficulty deciding whether to have an HIV test might ask the health adviser to decide for him (“What would you do?”). The health adviser might be tempted to ‘help’ the patient make the ‘right’ choice. However, such paternalism (see *Paternalism*, below) would weaken his autonomy by allowing him to avoid responsibility for the decision.
- **The decision appears to be against the person’s interests**
Legally competent patients cannot be obliged to undergo interventions against their wishes, regardless of the potential benefits for themselves. However, situations arise where a patient makes a fully informed choice that appears to be against his or her interests. Take the example of an HIV contact whom refuses testing to protect his partner from guilt, should the test be positive. The dilemma for the health adviser is whether to accept the patient’s choice without comment, or to challenge the decision. Any attempt to encourage, persuade, cajole or pressurise a person into making a particular choice violates autonomy to some degree.

- **The person's stated wishes are not autonomous**

This may be because the capacity for reason or understanding is impaired, or under-developed. For example, an intravenous heroin user might request a test for hepatitis C while heavily sedated by drugs and/or alcohol. In this condition, s/he would not be able to make an autonomous decision because the capacity to reason would be temporarily impaired, and consent would not be valid.

B E N E F I C E N C E

Beneficence means doing good. The assertion that an action is right if the consequences are beneficial is central to utilitarian ethics. As health advisers we have a professional duty to seek certain benefits for certain people. Primarily, there is a duty to promote the sexual health of the patient, the control of infection and the wider community. Regarding patients, there is an additional duty to safeguard and promote broader aspects of health and well-being.

N O N - M A L E F I C E N C E

Non-maleficence means not causing harm. As health advisers we have a duty to minimise the damage we do to patients, contacts or the community in the process of trying to do good, given that "whenever we try to help others we inevitably risk harming them".¹² There is also a wider duty to avoid harming other people, even if we do not have a professional duty to create benefits for them.

Table 23.2

| <i>Beneficence/non-maleficence depends upon:</i> |
|---|
| Concern for the welfare of the patient/contact/client/community |
| Respect for dignity and privacy |
| Respect for autonomy |
| Professional competence |
| A safe environment |
| Disclosure of unsafe practice |
| Evidence-based practice, informed by research findings and local audits |
| Adherence to agreed protocols |
| Clinical and counselling supervision |
| Effective liaison with other members of the care team |
| Awareness of services that may be helpful to patients |

Ethical dilemmas in relation to beneficence/non-maleficence
Difficulties regarding beneficence/non-maleficence arises when:

- **Doing the most good and/or least harm for a patient requires their autonomy to be violated**

Sometimes health care workers believe they are better able to decide what is in the patient's interests than the patient. Such views are paternalistic.

Paternalism involves denying a person autonomous control in order to protect them from harm. In health care this may take the form of giving only selective information, or overriding stated wishes, or doing things for the patient that they ought to do for themselves.

The implication behind paternalism in the context of health care is that ultimate responsibility for the patient's health rests with the professional rather than the patient. Paternalism is problematic because it violates one fundamental principle of health care – autonomy – to fulfil another – beneficence.

The justification for paternalistic acts is that they serve the best interests of the person by protecting them from harms that are more damaging than the temporary loss of autonomy. The danger of paternalism is that it may erode a sense of personal control and responsibility for health. This may discourage health-seeking behaviour in future and/or diminish a person's ability to avoid risk. The damage to the person is compounded by the subtle loss of status that accompanies loss of autonomy.

However the capacity to act autonomously and take due care of physical health can be compromised by many factors, including addiction, sickness, depression, distress, limited understanding or a chaotic lifestyle. In such circumstances the patient may not be able to fully protect him or herself, and require assistance.

Consider the following example of a 16-year-old girl with untreated chlamydia: she has been informed that she needs medication; that her abdominal pains could be the result of her infection, and that failure to get treatment as soon as possible may result in more serious illness, or infertility. She promises to attend the next day, but fails to do so. Should the health adviser keep contacting her until she finally attends, or should the girl be left to take responsibility for herself, given that she has been fully informed? Is it harassment, a violation of autonomy, to keep pursuing her? Or is it more injurious to her autonomy in the long run to abandon her to the risk of infertility, which will restrict her life choices in the future?

- **Bringing benefits to some might harm others**

There is often a conflict of interests between parties in partner notification. A typical scenario might involve an HIV positive patient who is reluctant to inform a partner of his status because he fears the relationship may break down; there is reason to believe the partner, whose identity is known, is at ongoing risk.

If the partner were to be informed of his risk by the clinic (against the patient's wishes) he could protect himself from future exposure, or gain access to medication if already infected. The patient, on the other hand, may suffer as a result of damaged relationships with the partner and the clinic.

- **The balance of benefits and harms is difficult to estimate**

Many actions result in a ripple of far reaching consequences. The variety of short and long term benefits and harms for all interested parties can be difficult to calculate. Research findings may provide clues (this is the main rationale for research) but there may be a lack

of research in a particular area, or findings from one study in one time and place may not be transferable. In the absence of reliable guidance, a crude calculation of harms and benefits has to be attempted.

Consider the question of whether antibiotics should be delivered to the home of a sex worker who has failed to return for treatment for gonorrhoea, despite having been informed. There is reason to suspect that she sometimes has unprotected sex with clients. In the short term the consequences would be favourable: the risks of complications and onward transmission could be halted. In the long term the net benefits might not be so clear: the woman may be discouraged from taking responsibility for her own health in future; she might expect that treatment will be brought to her on all future occasions, putting a strain on resources, and leading to delayed treatment if staff cannot be released; other sex workers may expect the same service, or feel unfairly treated if they do not get it.

JUSTICE

Justice, in this context, means fairness. The difficulty of treating everyone fairly rests on the paradox that individuals are at once equal and unequal. On the one hand, all people have equal fundamental value as human beings, and are entitled to be treated with the same degree of consideration and respect. On the other hand there are many inequalities that put some individuals at an unfair disadvantage. Sexual health can be adversely affected by many factors, including young age, female gender, social deprivation, black ethnicity and ^{13 14} homosexuality.¹⁵ In view of these inequalities, “people can be treated unjustly if they are treated equally”.¹⁶ Being fair may mean attempting to make individuals more equal, by favouring the disadvantaged. For this reason, justice requires us to “treat equals equally and unequals unequally”.¹⁷

The three concepts of justice below¹⁸ all influence the ways in which people gain access to GUM services.

- **Justice as ‘to each according to his rights’**

All service users share basic rights that ensure the same minimal standard of care for everyone. The open access ethos of GUM services rests on the principle that all individuals have an equal right to request a sexual health check. There is no obligation to demonstrate need: a person does not have to be symptomatic, or to be a known contact of infection, in order to book an appointment. Other rights include the right to be seen within half an hour of the appointment time¹⁹ the right to free treatment and the right to confidentiality.²⁰

- **Justice as ‘to each according to his need’**

This concept of fairness aims to redress existing inequalities. It usually underpins the allocation of health care resources.²¹ An example in GUM is the triage system, whereby patients in need of urgent medical attention can be seen without delay. Others may be given preferential access if they are disadvantaged by the appointment system because, for example, they cannot predict when discreet absence from home, work or school will be possible.

- **Justice as ‘to each according to what he deserves’**

The idea that health care might be allocated as a reward for good behaviour, or compensation for an injury, does not immediately appear fair at all. However, there are occasions when patients may be given preferential access to the service for this reason.

Take the example of a young gay man who calls in without an appointment because he happens to be passing and his hepatitis B vaccine is due. He does not have a need or a right to be seen urgently. However, this man was extremely co-operative with partner notification a couple of months earlier, when he presented with primary syphilis. He went to a great deal of trouble to track down casual partners, and to bring identifying details for the health adviser to locate others. He also used his influence with local gay saunas to allow health promotion materials to be displayed. There is a sense in which this man deserves a reciprocal favour as a reward for all his help, which may have averted a local outbreak of syphilis.

Table 23.3

| Justice depends upon: |
|---|
| Adherence to agreed protocols |
| Equal respect for persons, with consideration for the balance of benefits and harms for all affected individuals |
| Equal access for equal need |
| Non-discrimination on the grounds of personal characteristics that do not relate to need, such as age, ethnicity, class, status, sexuality, values, beliefs |
| Respect for rights (human, contractual, legal) |
| Priority access given on the basis of need |
| Targeting prioritised on the basis of need |
| Information given on the basis of need |

Ethical dilemmas in relation to justice

Difficulties arise in relation to justice when:

- There is conflict between competing claims for justice**

The finite nature of health care resources inevitably leads to competition between interested parties: the rights or needs of one individual, or group, may be met at the expense of others. Special arrangements may be made to give more equal access to those who may otherwise be deterred from using the service. Examples include restricted access sessions that are only available to certain groups, such as teenagers, or sex workers, or gay men. Similarly, there may be fast-tracking arrangements for certain patients. The difficulty here is that others may have their access restricted, or waiting times increased, as a result.
- There is conflict between the principle of justice and other principles of health care**

The concepts of justice considered here are protective of the individual, rather than the community.²² Health advisers have a professional duty to protect the sexual health of the community as well as of individuals: they would therefore need to consider justice in the context of other principles, such as beneficence.

Consider the ethics of a pilot scheme that offered financial incentives (£10 travel expenses) to street-workers who were playing a significant role in the local transmission of

gonorrhoea, but whose uptake of clinic services was poor due to the overriding demands of drug addiction that made sexual health a low priority for the women.²³ Objections to the policy might be that it is unjust to offer financial rewards to some patients and not others. It may also have violated the women's autonomy by exploiting their desperate need for money. Furthermore, it might be seen to support, or collude with, illegal drug use by financing the purchase of heroin. On the other hand, the initiative resulted in sexual health benefits for the women and the community. Previously undiagnosed sexually transmitted infections (STIs) were treated in 5/27 (19%), preventing further complications or onward transmission.

CONFIDENTIALITY

Confidentiality is central to all the above principles of health care. Moreover, it is of fundamental ethical importance to sexual health services because of the particularly private nature of sexual behaviour, the stigma that accompanies sexual disease, and the damage to relationships if infidelities are exposed. Without a promise of confidentiality, people may be less likely to seek treatment for infections, or co-operate with partner notification. The sexual health of the community would suffer as a result.

Table 23.4

| <i>Management of confidentiality requires:</i> |
|--|
| Protection of patient privacy within the clinical area. Discussions or examinations would not be overheard or observed by anyone who is not involved in the delivery of care, unless the patient has given prior consent |
| Protection of patient records (paper or electronic). These would only be available to staff involved in the delivery of care. They would be stored in locked cabinets when the clinic is closed |
| Protection of the identity of service users. Appointment lists would not be visible to other service users. Enquirers would not be told whether an individual has an appointment, or is attending |
| Protection of data or photographs capable of identifying an individual patient. These would not be used for teaching, research, epidemiological surveillance or publications, without consent |
| Protection of patient information. Details of a named patient's sexual history, diagnosis or care would not be shared with a third party outside the care team unless requested by the patient, or required by law |
| Patients to understand the limits to confidentiality |
| Negotiation of an acceptable means of contacting each patient, should the need arise |
| Discretion when encountering a third party in the process of partner notification or patient recall |

Ethical dilemmas in relation to confidentiality
Difficulties arise in relation to confidentiality when:

- **Confidentiality is against the patient's interests**

Breaches of confidentiality might be justified if this is necessary in order to protect a patient from harm. For example, if a patient with an untreated STI fails to return for treatment and cannot be located, it may be appropriate to inform the GP, who might see the patient in future and give the antibiotics. This would only be justified if the benefits of receiving treatment outweighed the potential harms incurred, such as the perceived damage to the GP/patient relationship.

- **Patient confidentiality is harmful to others**

Health advisers sometimes have to choose between protecting a patient's confidentiality and protecting others from harm. An acute dilemma of this kind might involve an HIV positive patient who does not intend to inform his regular partner of his diagnosis, but who continues to have unprotected sex with that partner.

Arguments for warning the partner might be that she has a right to know so she can protect herself, and that the health adviser has a professional duty to prevent the transmission of infection, where possible. An alternative view might be it is ultimately the duty of the patient, not the health adviser, to inform the partner.

Breaching confidentiality could be very damaging to the patient, who may lose his relationship with the partner as a consequence. He could also find it hard to access health services in the future if trust has been destroyed. The duty of care to a patient makes it very difficult to take a course of action that inflicts harm. Some would therefore argue that the health adviser has a greater duty to protect the interests of patients than of other citizens.

There is also the consideration that breaching confidentiality may be detrimental to sexual health in the long term if infected individuals were discouraged from seeking care or giving any information about partners.

- **Confidentiality requires other moral principles to be breached**

In some situations confidentiality cannot be fully protected unless the health adviser is prepared to lie, or collude with lies told by patients. For example, a health adviser may consider posing as a friend or work colleague to allay the suspicion of a third party encountered during provider referral.

The justification for this lie might be that it protects the patient and honours the trust placed in the service, without appearing to harm anyone else. This overriding commitment to confidentiality may benefit the sexual health of the wider community by making services more accessible.

On the other hand it could be regarded as unprofessional to tell lies - a breach of public trust that health care workers will tell the truth. This may undermine confidence in services and jeopardise the public standing of health professionals.

Table 23.5

| <i>Guidelines for managing an ethical dilemma</i> |
|---|
| Identify all possible courses of action |
| Identify the moral principles at stake, for each action. These will include the rights of all affected individuals |
| Clarify your particular professional duties in the situation |
| Consider the potential consequences of each action, for all individuals that might be affected. This might include the patient, a contact, the community or a health care worker |
| Clarify any facts that might influence the decision |
| Discuss with other health advisers. Ensure you have the professional support of at least one other health adviser before committing to a course of action |
| Discuss with other members of the multidisciplinary team. Seek a consensus of support for any action |
| Work within all relevant codes of professional conduct. An individual health adviser may be bound by the Nursing and Midwifery Council Code of Professional Conduct for Nurses, or the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice in Counselling and Psychotherapy, in addition to the Code of Professional Conduct for Sexual Health Advisers (See Ch. 24) |
| Avoid actions that breach the law. Seek a legal opinion if you, or the law, are not clear. Legal advice may be available from the trust solicitor. Alternatively, a medical colleague may approach the Medical Defence Union, or the Medical Protection Society |
| Document key points of the discussion, personnel involved and the decision reached in the patient's notes |

CONCLUSION

Health advisers face many ethical dilemmas in the course of their work. The principles of *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* can guide reasoned moral choices. It is good practice to discuss ethical difficulties with colleagues, and to document such discussions.

Further examples of ethical issues are discussed elsewhere in the manual:

- Ethical issues in partner notification, Ch. 5
- Ethical issues in pre and post-test discussion, Ch. 15
- Ethical issues in patient recall, Ch. 10
- Ethical issues in outreach work, Ch. 28
- Ethical issues in health promotion Ch. 30

■ Ethical issues in triage, Ch. 12

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Code of professional conduct

THE SOCIETY OF SEXUAL HEALTH ADVISERS

The purpose of the *Code of Professional Conduct for Sexual Health Advisers* is to clarify the professional and ethical standards of conduct required of sexual health advisers.

1. THE ROLE OF THE SEXUAL HEALTH ADVISER

There are three core aspects to the role:

- 1.1 To ensure, wherever possible that contacts of sexually transmitted infections (STIs), including HIV, are offered medical services through partner notification.
- 1.2 To reduce the transmission of STIs, including HIV, through health promotion initiatives.
- 1.3 To support individuals affected by STIs, including HIV.

2. SEXUAL HEALTH ADVISERS HAVE A DUTY TO:

- 2.1 Safeguard and promote the well-being of individual patients/clients.
- 2.2 Safeguard and promote the sexual health of the wider community.
- 2.3 Serve the interests of society.
- 2.4 Justify public trust and confidence.
- 2.5 Uphold and enhance the reputation of the profession.
- 2.6 Adhere to the law.

To achieve these aims, sexual health advisers will:

3. RESPECT THE INDIVIDUALITY OF PATIENTS/CLIENTS

- 3.1 Sexual health advisers will safeguard and promote the interests of all patients and clients irrespective of age, gender, ethnicity, sexuality, ability, lifestyle, socio-economic status, culture, religion, values and beliefs.
- 3.2 Sexual health advisers will ensure:
 - 3.2.1 Interventions are tailored to meet the needs of the individual.
 - 3.2.2 Communications are as clear and effective as possible.
 - 3.2.3 Personal beliefs and values that may adversely affect the quality of care are addressed in supervision.

4. RESPECT THE AUTONOMY OF PATIENTS/CLIENTS

- 4.1 Individuals have the right to be informed and make choices about their health and care. Sexual health advisers will ensure:
 - 4.1.2 Patients are offered as much information as they may require about their current health, treatments, choices, prognosis and services available.
 - 4.1.3 Information given is accurate, truthful and clear.
 - 4.1.4 Valid consent is obtained for all procedures or communications that carry a risk for the patient.
 - 4.1.5 Valid consent would be:
 - Informed
 - Freely given
 - Given by a legally competent person, capable of sufficient understanding to make an informed choice.
 - 4.1.6 If valid consent cannot be obtained, the multidisciplinary team will decide how to serve the patient's best interests. This may involve wider consultation with the patient's significant others and/or professional bodies.
 - 4.1.7 If a legally competent person refuses consent, this will be respected, unless a third party is thereby placed at avoidable risk of significant harm. Such situations will be discussed with the multidisciplinary team.

5 . P R O T E C T C O N F I D E N T I A L I T Y

- 5.1 Information obtained in a professional capacity will not be disclosed beyond the multidisciplinary care team except:
 - 5.1.1 To another medical practitioner or person working under the direction of a medical practitioner for the purposes of treatment and/or prevention of an STI. (VD Regulations 1974).
 - 5.1.2 With valid consent.
 - 5.1.3 By law or court order.
 - 5.1.4 To protect the individual, or another, from the risk of significant harm.
- 5.2 Sexual health advisers will take all reasonable steps to ensure that:
 - 5.2.1 Individuals are aware of the limits of confidentiality.
 - 5.2.3 Personal information is protected from unauthorised access.
 - 5.24 Consent for disclosures is always sought.
 - 5.2.5 Disclosures are limited to the amount of information that is necessary to achieve the legitimate purpose.

6 . E N S U R E F I T N E S S T O P R A C T I S E

- 6.1 Sexual health advisers will:
 - 6.1.1 Ensure they have the knowledge and skills to perform all aspects of the role safely and effectively, based upon current evidence.
 - 6.1.2 Demonstrate commitment to ongoing professional development.
 - 6.1.3 Adhere to professional guidelines from The Society for Sexual Health Advisers.
 - 6.1.4 Be guided by all relevant government directives.
 - 6.1.5 Work within the limits of their professional ability. Where the practitioner lacks confidence, experience or appropriate training, the support and guidance of competent colleagues will be sought. The direct line manager will be informed of the need for additional training or support.
 - 6.1.6 Seek regular managerial and clinical supervision.
 - 6.1.7 Ensure their workload is manageable. The direct line manager will be informed if an excessive workload jeopardises professional standards or places an unreasonable strain on practitioners.

- 6.1.8 Ensure they are physically, psychologically and emotionally able to undertake duties without risking harm to themselves or patients/clients/contacts. Concerns will be brought to the attention of the direct line manager.

7. WORK CONSTRUCTIVELY WITH OTHER MEMBERS OF THE CARE TEAM

- 7.1. Sexual health advisers will:
 - 7.1.2 Recognise, respect and support the contribution of others to the care of the patient. This may include medical and nursing colleagues, social workers, psychologists, counsellors, physiotherapists, occupational therapists, dieticians, pharmacists, youth workers and voluntary agencies, as well as partners, relatives and friends.
 - 7.1.3 Ensure the patient is offered access to any professional or non-statutory services that may be beneficial.
 - 7.1.4 Endeavour to communicate effectively with those involved in the patient's care. Information that allows others to do their best for the patient will be shared promptly, subject to patient consent. Sexual health advisers will take all reasonable steps to ensure that they, or a delegated colleague, can be contacted for case discussion. A record of care given and discussions with other carers will be recorded promptly in the case notes.
 - 7.1.5 Support the professional development of colleagues by sharing knowledge and skills appropriately.
 - 7.1.6 Ensure other carers understand the role of the sexual health adviser.
 - 7.1.7 Work within their specified role.

8. PROTECT PATIENTS/CLIENTS/CONTACTS FROM HARM

- 8.1 In addition to the above measures, sexual health advisers will:
 - 8.1.2 Remove or report hazards in the physical environment.
 - 8.1.3 Protect patient dignity and privacy.
 - 8.1.4 Report concerns that a colleague may be unfit to practise, due to incompetence, poor health, or inappropriate behaviour.
 - 8.1.5 Advocate on behalf of patients, clients, contacts and the wider community to ensure that all have fair access to care.
 - 8.1.6 Establish clear professional boundaries with patients or clients to minimise the risk of abuse or exploitation. All aspects of the relationship should focus exclusively on the needs of the patient or client, and must not be detrimental to

their welfare in any way. Embarking upon a sexual relationship with a patient is forbidden.

- 8.1.7 Refuse offers of gifts, favours or hospitality that may be perceived as an attempt to secure preferential treatment or build an inappropriate relationship.
- 8.1.8 Never ask for, or accept, a loan from patients, clients or their associates.
- 8.1.9 Document sign and date all aspects of care in the patient record.
- 8.1.10 Take all reasonable steps to ensure that the patient has access to alternative support at times when the sexual health adviser is not available.
- 8.1.11 Declare any interests or conscientious objections that may prejudice advice or treatment.

Leading a team of sexual health advisers

DORINDA THIRLBY

A forward planning team can greatly benefit from using specific evaluative tools to make strategic advances. These are presented.

If the core roles of the health adviser are to be strengthened then good relationships are needed with the wider clinic team members.

Annual formal individual performance appraisals can be viewed negatively by some staff. They can however, along with more regular management supervision, enhance the contribution an individual makes to team objectives as well as promote professional development.

INTRODUCTION

Management courses are often available to managers in the NHS by NHS Trust training departments, for example on performance review and on leadership styles, which would complement this chapter. Management is concerned with looking beyond oneself and "exercising formal authority over the activities and performance of other people" ¹

Many health advisers may be managed by a senior health adviser who has health advising experience themselves. Others in smaller teams may be managed by a senior nurse/ matron or an operational manager, but all need to be managed so as to have direction in their work and role. This chapter will look at managing a health adviser team through business planning and setting objectives for the team, and how these are translated into individual performance reviews. This links in with Trusts' clinical governance frameworks, to ensure competence in practice.

It is often difficult for health advisers in a team to see beyond being 'on call' or 'covering' the clinical work, and at the mention of business planning many will fear being given additional work to do. The manager's role will encompass influencing the morale of the team, and the individuals' motivation, job satisfaction and performance. It is important to take into account

the expectation of colleagues such as consultants, nurses and managers within the GUM /HIV setting and keep them informed of the work being planned by the team.

Many of the systems within the NHS and GUM are based on historical systems, which have developed alongside the speciality. Business management is about forward planning, it is important to look at the health adviser role, and look at whether there is a need to change and how the role may be best developed. There needs to be some foresight of change in the role the profession and responsiveness to change. It is important to take stock of how the team is working, day-to-day and look at whether change (within financial constraints) can be made.

When looking at the development or planning for the team it is also important to review the need for change in the core prescribed roles as well as looking at both the internal and external pressures on the team and their role.

This chapter will look at:

- Considering the core roles of the health adviser team
- Predicting what a team may need to consider in the next five years by identifying potential pressures on a health adviser team through the uses of a Political, Economic, Social-cultural and Technological changes tool (PEST)
- Developing a team “Strengths, Weaknesses, Opportunities and Threats” (SWOT) analysis to enable the team to come up with team objectives for the next 5 years and for the next year
- Delegating the objectives to an individual health adviser
- Individual performance reviews/ plans
- Guidance for management supervision including reviewing the health adviser’s objectives

CORE ROLES OF THE HEALTH ADVISER TEAM

Prior to setting aims or objectives it is important for the senior health adviser/ manager to look internally at the needs of the team and define the health adviser team goals or 'core' roles of the team. These are the areas of work where the team are clinical experts, and therefore can lead local discussions and developments: in the clinic / hospital/ community / nationally.

The following headings show the possibilities for the team and serve as a checklist, although this will vary from service to service. The senior health adviser/ manager will influence in which direction the team works and it is therefore important to ask what a progressive health adviser team needs to be undertaking/ developing.

These suggestions are examples, and are therefore not exhaustive but may be used to focus on the team’s issues:

a) Leading partner notification. It is recommended all health adviser teams take a clinic and local lead in developing partner notification:

in the team - consider:

- Looking at the recommendations standards from this manual
- What could the team be doing to improve partner notification?

in the clinic - consider:

- What facilitates partner notification
- Do the receptionists need training? For example what to do with a contact slip, how are they attached to the notes? how are the notes then cross referenced?
- What would facilitate the health adviser's role?

out of the clinic - consider:

- How can partner notification be facilitated for contacts of STIs? For example women with PID in the gynaecology department?
- How can the team facilitate partner notification in primary care settings? Will this require more staffing?
- Funding issues. What low cost suggestions are there? For example phone advice for patients with an STI

b) Lead HIV testing. It is recommended all health adviser teams take a clinic and local lead in HIV testing:

in the team - consider:

- How does the on call system work? Could it be improved?
- What is good documentation?

in the clinic-consider:

- How does HIV testing get offered in the clinic?
- Who gets referred to the health adviser? Is there a protocol?
- How does the team measure uptake?
- Could uptake and testing access be standardised?
- What training/ facilitation is required?
- Do clinical notes prompts need to be updated?

out of the clinic - consider:

- What testing is happening in the rest of the hospital and the community?
- Is there a clear guidance or evidence based protocol?

- Is there a training need?

c) Lead sexual health promotion. It is recommended all health adviser teams take a clinic and local lead in sexual health promotion undertaken:

in the team - consider:

- How are people referred for work re risk reduction?
- What models of working do the health advisers each use?
- Are there experts in the team for internal referral or informal supervision?
- How can documentation be improved in the clinic notes?

in the clinic - consider:

- What clinic resources are there?
- The team needs to be taking a lead in the health promotion being undertaken in the clinic, for example does the team take an active role in assessing relevant leaflets for patients attending the clinic?
- Could sexual health promotion discussions be improved?
- Is there a need for a multidisciplinary team meeting on health promotion messages/ resources being used in the clinic? For example access to condoms and information about correct usage

out of the clinic – consider:

- Health adviser involvement in the local sexual health strategy and teenage pregnancy planning meetings
- Look at the possibility of developing the MSSVD STIF courses for local GPs/ practitioners.

d) Manage recall / results management. It is recommended all health adviser teams take a clinic and local lead in the management of infection recall.

in the team - consider:

- Does the recall protocol need to be improved and are there any gaps?
- Are there fail-safe systems in place and is this audited?
- How can documentation be improved in the clinic notes?

in the clinic - consider:

- Are the rest of the clinic aware of the protocols and are they circulated?

- Could an audit be undertaken which could be presented to the clinic, giving examples of cases so that people understand the complexities of recall?

out of the clinic - consider:

- What sexually transmitted infection recall is happening in the hospital and community?
- Is there a clear guidance or evidence based protocol?
- Is there a training need?

e) Counselling and access to other psychological services. It is recommended all health adviser teams take a lead in counselling undertaken in the clinic.

in the team - consider:

- What is the skill mix of the team?
- What counselling training do health advisers have?
- Is counselling supervision in place?
- What appropriate counselling work could be undertaken by the team?
- Could this be expanded/ or cut back?
- How are people referred for counselling?
- What models of working do the health advisers each use?
- Are there experts in the team for internal referral or informal supervision?
- How can documentation be improved in the clinic notes?
- What is the health adviser's role with patient advocacy?
- Do they take a lead in representing the patient's needs?
- Health advisers have an important role in maintaining patient perspective in decisions about clinic protocols and practice, for example maintaining access, improving waiting times, assessment and fast tracking 'at risk' patients
- Helping to ensure that there is a system for patients to make comments about the service (positive and negative)

in the clinic - consider

- Are there ways to make the professional counselling work of the team more visible to the rest of the clinic? For example documentation or presenting cases/ models at the clinic meetings.
- Would it be a good idea to write a protocol? For example for urgent assessments

- Who can the team refer onto? is this explicit to the team?

f) Teaching. It is recommended all health adviser teams take a clinic and local lead in teaching.

in the clinic - consider:

- What are the team be doing in terms of teaching?
- Are the health advisers involved in the teaching programmes?

out of the clinic - consider:

- Medical/ nursing schools, schools teaching?

g) Visibility of the role. It is recommended that health advisers consider the visibility of their role.

in the team - consider:

- Is the role visible or explicit and does work need to be done to make it more explicit?
- Is the role understood- i.e. why people are referred?
- Is it clear who is on call?
- Are they in the clinical area?
- The importance of documentation, does documentation need to be improved?
- Is the team's documentation standardised or consistent?
- Is it clear from the documentation what the patient gained from seeing a health adviser?
- Does documentation facilitate additional work? For example when seen again by another health adviser, or referred onto a psychologist who sees the patient for a similar issue.

in the clinic - consider:

- Is the role understood? i.e. why people are referred?
- Nurses/ doctors sit in to understand the role better?
- Are there clear referral protocols?
- Is there representation at the relevant departmental meetings?
- Can the team be more accessible without compromising quality?

- Look at how the team's activity is recorded and how the work is measured. Many GUM software systems have simply inserted look up trees where the team can record the work and time taken. For example see appendix 1

h) Audit/ Clinical governance. The team needs to ensure that the health advisers' work is evaluated and that national standards are met where they apply.

in the team - consider:

- What audits need to be undertaken?
- Representation at clinical governance meetings
- Development of the appropriate protocols

POLITICAL, ECONOMIC, SOCIAL-CULTURAL AND
TECHNOLOGICAL (PEST)

A team of health advisers do not work in isolation, and the role is influenced by a number of external pressures. It is therefore useful to consider with the team what the clinic, trust, local, regional and national pressures are by brainstorming the political, economic, social-cultural and technological influences. A P.E.S.T. analysis helps the team to look externally and examine future opportunities and challenges to try to predict potential changes that could impact on the role.²

Ideally the manager needs to undertake the PEST exercise with the health adviser team as a warm up to doing the objectives planning. If time is limited then the senior/ manager may undertake the exercise and circulate their thoughts for comment. It may be undertaken with a flip chart. Set an hour aside with the team (or as many as can be there- missing team members can be circulated with a copy to add their thoughts, so that they are included in the team process.) Looking at these areas will help the manager and team think conceptually.

Simply using individual flip charts or headings on a computer projector ask the team the following questions about potential changes (These suggestions are examples, and are therefore not exhaustive but may be used to focus on the team's issues)

The political future. There needs to be team foresight into possible political influences on the organisation and team. It may help to focus on:

- What is happening nationally For example change of government, proposed closure or development of the service- how will this impact on the health adviser service? Will the team be expected to work differently?
- Any new legislation proposed which may have an impact on the health adviser service?
- Local- how the sexual health strategy will be developed locally- who will take the lead: the PCT, family planning, GUM or health advisers. What will health advisers be expected to do? For example involvement in partner notification for chlamydia in primary care.

- What about clinic politics (negative or positive)?- and look at the impact on the team?

The economic future. Explore what may be about to change (negative and positive) in the next few years which may affect the team. NHS funding is often undergoing change, and HIV/ GUM funding has undergone significant changes in the past few years, how could this affect the role:

- Changes to funding formulae. For example what is the current belief on the HIV / GUM funding For example what are plans locally re HIV prevention monies? How is the team funded? Will there be changes in funding as a result of sexual health strategy/ teenage pregnancy initiatives?
- What is happening with local PCT funding, what are the financial links with GUM?
- It is important to know how the Trust is planning to achieve its cost pressures (or spend its underspend). The senior needs to be aware of the meetings/ forums where finance is discussed so that the health advisers are represented
- Are there local investment or development plans that are relevant?
- Are there any development monies that could be bid for?
- What budget lines do the health advisers oversee? Could there be any change to these?

The social-cultural future. It is important to focus on social or cultural changes and what the implications there are for the health adviser team:

- Are different cultural groups beginning to access the service? How does the health adviser need to respond to this change in the service For example to facilitate access to care and treatment for 'at risk groups'?
- Implications of changes in lifestyle identified in reports, that may affect the way the team works
- How to manage an increasing workload of patients and how to prioritise the workload
- What are the health and education needs of the attendees?

The technological future. There needs to be foresight into possible technological changes on the organisation and team. It may help to focus on:

- What will the impact of new screening tests be? For example, changing to more sensitive chlamydia screening tests so that more patients with chlamydia are diagnosed. How will the clinic cope with the increase in work and referrals or requests for advice from the community?
- How will information technology (IT) impact on the clinic and the team? It is important to meet with the IT department who will be able to give insight into proposed developments to the system, and what it will be possible to develop, for

example using computers for all recall management, letter generation or for managing partner notification

- Possible research findings and impact, for example moving to regular resistance assays

The P.E.S.T analysis helps the health adviser/ manager (and the team) think about the future and look at potential changes and formulate a picture of what the team needs to be working on.

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Using a team “Strengths, Weaknesses, Opportunities and Threats” brainstorming exercise to enable the team to come up with team objectives for the next year/ 5 years.

The SWOT is a tool to help the team and manager focus on the strengths, weaknesses, opportunities and threats for the team which informs the strategic change³, or what the team are planning to do in the next one to five years. The senior s be mindful of the team’s core roles (partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work) and introduce them as prompts under each of the SWOT headings. The senior must be mindful not to censor people’s responses and write all of the suggestions down. Let the team think laterally, and say what they think. The senior can also introduce their ideas (without it meaning that everyone has to do what the senior thinks). The SWOT does not need to be circulated beyond the team, only the final objectives.

Again this exercise can be done in an hour (but may be better in two). If time is limited to an hour, circulate the PEST to get the team in the mood again. Then divide the time to 10 minutes on each SWOT, 10 minutes on 5 year plan, 10 minutes on what the team needs to do this year, and then open up the discussion for ten minutes on who might lead on each of the objectives.

Using individual flip charts or headings on a computer projector ask the team the following questions.

Strengths:

- What are the team’s distinct strengths, attributes or competencies?
- ‘What does the health adviser team do well?’
- ‘What are the health advisers respected for in the clinic? And in the community?’
- ‘What would fall apart if the health advisers were not here?’
- ‘What does nobody else do as well as health advisers? (in the clinic and out of the clinic)’
- Consider the strengths in partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work.

Weaknesses:

- This is looking at the negative aspects or deficiencies of the team, including resources, image
- ‘What are the health advisers not doing? (or could improve on)’
- ‘What are the health advisers failing at?’ for example recording activity, returning contact slips
- Consider weaknesses in partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work

Opportunities:

- What is favourable for the team?
- ‘What would the team love to do given the time and money?’
- ‘What could the team be doing much better? For example triage, outreach and schools work’
- Consider the opportunities in partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work

Threats:

- This is the opposite of opportunities; it is unfavourable situations which may arise from environmental conditions.
- ‘Who might take a part of the role on?’
- ‘Is there an individual who is seen as a threat?’
- Consider the threats in partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work

A 5-year plan. At the end of this exercise another sheet of paper can be used entitled ‘a 5 year plan’ and the team asked to brainstorm the next 5 years. Introduce the brainstorming session as ‘What would the team ideally like to do in the next five years’

List the core team roles and brainstorm what the team’s aims are, making sure partner notification, HIV testing, health promotion, counselling, recall/ results management, teaching, MDT team work are all covered.

Questions such as ‘What could the team improve on in each of these areas in the next five years?’ and ‘What does the team need to improve on?’

The next year? It is important to focus the 5 year work plan into what could ideally be achieved in this coming year. Using the 5 year list ask the team to come up with the ten (5-20 dependant on the size of the tasks and the size of the team) things the team need to do.

Setting objectives. Objectives are about what the team is striving to accomplish. Once the goals are identified, this gives a focus for the team. The objectives are best written after writing the PEST and considering the team's core roles.

The objectives: ⁴

- Standardise the performance of the health advisers
- A structure for producing the teams goals for planning and management control
- Allows the team to move forward with their visions
- Gives guidance for decision making (and a defence against criticism)
- Documents a clear focus for purposeful behaviour (in work that can be a bit 'jack of all trades- where the team can define what the trade is)
- May influence the structure and the working of the team
- Provide a motivation and reward
- Show what the team is really trying to provide (makes the work explicit)

It is the senior's/ manager's responsibility to clarify the goals especially where there are conflicting view points. The manager needs to integrate the organisational or team goals with personal goals of the individual health adviser.

- As a senior health adviser/ manager it is important to look at the following expectations:
- What does the senior wish the team to achieve?
- What does the organisation want the team to achieve?
- The PEST may raise most of these issues, but it is important to know what the consultants, doctors, nurses and managers want from the team
- What does each individual health adviser want to do?
- What courses are health advisers going to do, and how does their learning fit into the role?
- What are the core roles of the team?
- Are the objectives SMART enough?

SMART is about making sure that the objectives are achievable. Are they:

- **Specific?** Are they quantifiable and testable? Is it possible to measure whether the objective has been achieved?
- **Manageable?** Are they genuinely within the health adviser's control or influence?

- **Attainable?** Are they realistic about the scale of what can be achieved? Is it within their remit to do the objective or does it rely on others?
- **Resourced?** Is it possible within manpower and financial constraints?
- **Time-bounded?** When do they have to be done by? Is it achievable in the year?

DELEGATING THE OBJECTIVES

This can be discussed in the meeting and staff may offer to work on an objective they are interested in. These discussions can also continue out of the meeting.

The objectives need to be delegated to all members of the team including the senior. It is also important for the manager to look at what support/ training needs/ appropriate supervision and support will need to be given to the health adviser so that they can do their task.

It is important to:

- Write up the exercise promptly and circulate to the team (see example fig.1)
- Identify who will be doing each objective and agree this with the individuals concerned
- It may be appropriate to discuss the SWOT with the clinic manager/ the senior health adviser's manager. This will help inform the manager of the teams plans for development and may improve the visibility around the health adviser's role. It may be a good way of selling the potential of the team, their good ideas, and it helps managers understand what the team is trying to achieve. There may need to be some censorship if there are people named in the SWOT
- Produce the list of 5-year objectives. 1-year objectives (priorities) and who is doing what within a few days. (Check that they are SMART enough-see below) see (example 1)
- The objectives need to be discussed with other senior members of the clinical team so there is cohesion for the clinic's overall objectives and strategic direction

Obstacles to achieving the objectives. Objective setting needs to be an annual process so it is important that the senior health adviser/ manager looks at ways that the process could be sabotaged by the team or themselves:

- **Sabotage:** Individuals may try to sabotage the process. It is important to think about what's going on in the team. Consider speaking to anyone who is likely to sabotage the process to minimise any possible disruption
- **Negativity:** It is important that the senior leads this process, is not too negative, is enthusiastic and thinks about how the session will be run. This process is about developing the team year upon year. It is a continually evolving process
- **Time:** It is important the team have protected time. Give plenty of warning of when the SWOT will be, expect all of the team to attend and make this explicit to them, for

example they need to be there unless there is a personal disaster/ ill health so no double booking. Lay the boundaries down. The meeting has to start on time and the senior makes sure that the health advisers are reminded

- Creativity: It is important to think laterally. It is important that the senior/ manager avoids being dictatorial and motivates the team to develop their ideas

Table 25.1

| Example of an agreed team objectives: (based on 1 Fulltime HA (HA1) and 2 part time: HA2/3) | | |
|--|--------------------------------------|-------|
| <u>Annual HA team objectives & who to take lead</u> | | |
| <u>HIV</u> | | |
| | Adherence work/ HA assessment audit: | HA1 |
| | PN | SHA |
| <u>PN</u> | | |
| | HIV PN* | SHA |
| | GC/CT PN | HA1 |
| | Telephone HA | SHA |
| <u>Counselling</u> | | |
| | Review and develop protocols: | |
| | HA counselling/ referral/ assessment | Team |
| | Protocols | |
| | women sex dysfunction | HA2 |
| | Triage | HA1 |
| | Hep C | SHA |
| | Counselling/ referral | HA2 |
| | Condom | SHA |
| | Telephone HA | SHA |
| | Web protocol | Team |
| | Rape/sexual assault | HA2 |
| | ?counselling leaflet | Team |
| <u>Sexual Health promotion/HIV prevention</u> | | |
| | Who will take the lead/ represent: | |
| | Young people | HA3 |
| | Gay men | SHA |
| | African | SHA |
| | Sex workers | HA2 |
| | IVDU | SHA |
| | Boards/ leaflets | HA1/3 |
| | Library (web protocol) | HA1 |
| <u>Promoting HA role</u> | | |
| | Audit | |
| | HSV audit | HA3 |
| | PN audit | HA1 |
| | Counselling audit | HA2 |
| | ↑Community links +PN (C4a | Team |

INDIVIDUAL PERFORMANCE REVIEWS/ PLANS

From the team objectives- it is important to look at who is best suited to lead on an objective, based on the particular skills of the health adviser, what the individual health adviser wants to do, and what is best for the team and the service.

Most NHS Trusts will have guidance on performance review. Most managers will be expected to attend a study day on performance reviews and there are often corporate forms to be used and interview assessment tools.

Often performance reviews are viewed negatively by staff and may even be seen as a threat. It is important to address people's concerns about their purpose, and should be much more about keeping track of someone's performance, and can be used to celebrate the health adviser's success/ hard work.

The person's individual objectives are used as a focus of the individual's work performance. It is the Senior health advisers task to annually set them carefully making sure they are SMART and to review them through the year in supervision to detect problems. For example with lack of time or support, early on rather than discovering the tasks have never been started (see management supervision session). Once the individual performance plan has been set and agreed then it needs to be reviewed regularly as part of the health adviser's supervision.

Setting individual objectives may be facilitated by an individual appraisal (see Appendix 2, an example of a health adviser questionnaire/ interview tool).

Using the tool set out before or a Trust questionnaire, this may need slight modification so it is relevant to the role.

Some health advisers may be part of a performance related pay structure. The questionnaire is a start point, a clarification or review tool for the health adviser, which asks the health adviser what targets or objectives they would suggest for themselves (see question 11). The health adviser can be helped to make SMART objectives from their team objective. (See appendix 3, an example of a health advisers annual objectives developed from the team objectives, appendix 2)

Time needs to be set aside for the health adviser to go through the questionnaire, ideally before meeting the senior/ manager. This can be completed directly onto a computer template. If there is some resistance then meet with the individual and go through the questions with them making a note of the answers.

Meet and talk through the questions and discuss what issues they raise. Going through the questionnaire and discussing possible objectives may take 60-90 minutes. If the session goes on longer it is best to rebook the finalising of the objectives. After the session the health adviser will need time to update their questions and develop their objectives. A further meeting can be arranged to set and agree the objectives.

GUIDANCE FOR MANAGEMENT SUPERVISION

This is to include reviewing the health adviser's objectives (it is not counselling or clinical supervision)

- Find protected time/space for 60 minutes (although may only be 30-40 minutes depending on need). Do not cancel the sessions, and do not let people interrupt the session, the time needs to be respected
- It is important to meet regularly and have fixed meetings, ideally every month – to six weeks, (more often if there are performance/ support/ training issues)
- The senior/ manager needs to prepare before meeting and think about any thoughts or comments that need to be made. Review objectives prior to the meeting

- The senior/ manager needs to have the relevant leave forms/ rotas at hand to look at annual or study leave requests
- The senior/ manager needs to have the relevant paperwork, for example their objectives to hand

Checklist

- **How are things?** What does the health adviser want to say? Are there any specific problems? 'How is it all going?'. Does the senior/ manager have any concerns about the health adviser's work or performance in the team, for example lateness. If there is an issue the senior/ manager needs to give clear guidance/ boundaries on what their concern is and what is expected to change and why
- **Any concerns in the health adviser team or clinic team?** Similarly are there any concerns for the health adviser or their manager? If there are it is important to make it clear what the managers perspective is, giving guidance/ boundaries of what is acceptable and what is not. Decide on any action that needs to be taken and if so make it explicit what needs to be done by the health adviser to achieve the action
- **Discuss their patients.** Review the individual's patient workload, for example how many ongoing patients and how many sessions, whether the cases are being supervised and whether there are any management issues that the manager needs to be aware of. It is important to be clear about the differing roles and boundaries between the role of the clinical supervisor and that of the manager, for example the management session need not spend time focusing on a patient. If there are specific patient management issues, for example when the clinical supervisor has suggested that the health adviser discuss an ethical dilemma with the manager to get their viewpoint, then it is important to arrange a separate time to focus on the issue
- **Leave.** Review annual leave/ study leave and where time owing is allowed that this is reviewed and managed
- **Study leave.** Chance to raise review development. Review an individual's development portfolio
- **Reviewing annually set objectives.** Revisit and review objectives, going through each objective and look at how the work is progressing. Identify if there are any difficulties in achieving the objective. If it is not being achieved- is this reasonable- how can they get back on track. Giving clear guidance about what is expected
- **Anything else**
- **Set the next date**

APPENDIX 1

Measuring health adviser activity An example of the Roehampton Clinic FMI computer software look up tree, where the team can record the work and time taken, as they see the patients.

1. Interview Reason look up Maintenance

- **HIV pre test counselling – health adviser**
 - Pre test disc – test performed
 - Pre test disc – test declined/deferred
 - Pre test disc – information only
- **HIV post test counselling – health adviser**
 - Post test disc – negative result
 - Post test disc – equivocal result
 - Post test disc – positive result
- **STD advice**
 - Std Advice – gonorrhoea
 - Std Advice - Hepatitis B
 - Std Advice - Hepatitis C
 - Std Advice - Herpes
 - Std Advice - NSU/chlamydia, PID
 - Std Advice - Other
 - Std Advice - Syphilis
 - Std Advice - warts
- **Other counselling**
 - Abuse counselling
 - Bereavement counselling
 - Dealing with complaint
 - Condoms supplied / discussion
 - Contraception discussion
 - Cervical cytology & colposcopy disc
 - General counselling
 - Pregnancy
 - Top counselling
 - Psychosexual counselling
 - Rape / serious sexual assault
 - Triage of patient
 - Worried well
 - Triage RUSH/ under 16 (young persons clinic)
- **HIV**
 - HIV positive on-going counselling
 - Introduction of HA
 - HIV one off
 - Discussion with relative/ significant other
- **Telephone discussion**
 - Abuse
 - Contraception
 - NSU, Chlamydia & PID
 - Gonorrhoea
 - General information
 - Hepatitis B
 - Hepatitis C
 - Herpes
 - Discussion with HIV + patient
 - HIV information
 - Other telephone discussion
 - Pregnancy
 - TOP counselling
 - Rape / serious sexual assault counselling
 - General STD discussion
 - Syphilis
 - Warts & HPV
 - Cervical cytology & colposcopy

- **Liaison performed by health adviser**
 - Liaison with counsellor
 - Liaison with Dietician
 - Liaison with Other independent agency
 - Liaison with Psychiatry
 - Liaison with Psychologist
 - Liaison with HA / Sexual medicine
 - Liaison with Social worker
 - Visit to patient by health adviser
 - Ward visit by health adviser

APPENDIX 2

An example of a HA questionnaire/ interview tool

Name:

Date of discussion:

1. Does your job description accurately describe your main duties and responsibilities? If no, explain why? Has your job changed in the last twelve months? If so, how?
2. Which aspects of your present job give you the greatest satisfaction and why? What tasks do you feel you perform particularly well and why?
3. Did you achieve all last years objectives? Which did you find most rewarding? Most difficult? What constraints were there? (This section may not be applicable for the first review of performance)
4. What are your key job skills and areas of strength?
5. Do you feel your knowledge, abilities, and skills are being fully used in your present job? If not, why?
6. How well does your present job fit in with your immediate and longer term career plans? Have you made any plans? Should you be making plans?
7. What extra help or guidance do you feel you need to do the present job more effectively or prepare for future development?
8. Have you attended, or given any training courses this year? What did you gain from them?
9. Do you feel the need for any further training in any particular area? Think not only of your present job but what would you like to be doing over the next five years.
10. Which work-related tasks interest you the least or seem particularly difficult? Why?
11. Can you suggest any improvements in work systems, staff deployment etc, which could assist to make the service more efficient?
12. What targets or objectives would you suggest for yourself for your own development this coming year? Which ones would be most rewarding? Most difficult? What constraints may there be?
13. Do you wish to mention any other things, personal problems, anxieties or achievements to your manager?

APPENDIX 3

An example of a health adviser's annual objectives, a real example (taken from the team objectives) and all of the objectives were achieved

| Key objectives for review period | Action required |
|---|--|
| 1. Would like to manage the gonorrhoea and chlamydia PN audit work | <ul style="list-style-type: none"> (a) Update the PN sheet for use in RC notes (May) (b) Define what should be documented on the notes(May) (c) Define what should be documented on the computer(October) (d) Get list once a month of GC/ CT +ve results(May) (e) Give notes to relevant HA for PN review (monthly) (f) Produce summary of info on contacts (September/December/ March) (g) Review PN sheet design based on December audits findings(Jan) (h) Present to clinic at clinic meeting (Jan) |
| 2. Update the recall policy | <ul style="list-style-type: none"> (a) Update old policy to include new computer codes (June) (b) Get 'X's completed work on sending out letters, visits and put in document (June) (c) Circulate policy to other HA's and get comments(July) (d) Update (July) (e) Circulate to nurse 'xx' & Drs 'xx' in clinic for their comments(August) (f) Send copy to 'x' (Senior HA in same Trust) for comments(Sept) (g) Submit for clinical governance to whole of GUM in Trust (2 clinics)(Oct) |
| 3. To be clinic 'Patient information/ resources manager' | <ul style="list-style-type: none"> (a) Sort out the patient library (June) (b) Update patient information files(June) (c) Put relevant up to date literature out in the patient waiting room for HIV clinics (every two months review what is being put out) (d) Remove medical books/ magazines to specialist registrars room(June) (e) 'X' to do teaching on Publisher(July) (f) 'X' Teaching on using the scanner(August) (g) Look at producing specialist displays For example BV(September) (h) Change display boards every 6 weeks |
| 4. Revisit the health adviser policies for clinical governance | <ul style="list-style-type: none"> (a) Review the health adviser policies and decide with HA team which ones we will each review For example provisionally 'x' to do B1,C4a, Triage (meeting in June) (b) Get relevant 'x' Trust (other clinic in Trust's) policies(August) (c) Rewrite/ update policies(September) (d) Meet regularly with rest of HA team and present these policies(Feb) (e) Submit for clinical governance to whole of GUM in Trust (2 clinics)(March) |
| 5. Look at applying to do xx MSc next year | <ul style="list-style-type: none"> (a) Re discuss with supervisor (b) Approach x, x and x organisation to find out relevant courses (c) Discuss with 'x' at supervision in September (or in 2 weeks if decide to go for this academic year) (d) Look at applying and getting study leave funding/ support by completing Trust forms (October) |

REFERENCES

- 1 Mullins, I.J. Management and organisational behaviour, 5th Edition, Financial Times Pitman Publishing. 1999, p.166.
- 2 Ibid,p.101
- 3 Ibid,p.132
- 4 Ibid,p.117

Section E

Community settings

Community health advising

Outreach work

Ethical issues in outreach work

Working in prisons

Community health advising

TINA SHARP

This chapter aims to examine the role of the health adviser in a community setting and draws from the experiences of a Chlamydia Co-ordinator covering two inner city primary care trusts. Defining the term community and examining the aspects of health advising which have been found to be useful in this setting may allow a clearer idea of the benefits of extending genitourinary medicine GUM services.

INTRODUCTION

The term 'Community' is frequently used to describe general practice and contraceptive services. However, screening is commonly offered for treatable sexually transmitted infections (STIs) within termination of pregnancy (TOP) services, Accident & Emergency departments and Gynaecology and Obstetric units. These include charitable or private organisations. The role of the community health adviser may be best described as offering support in the facilitation of screening for STIs and partner notification in all areas outside of the clinical GUM setting.

So far the main focus of community health advising has been on *Chlamydia trachomatis* as it is the most common treatable STI in the UK. It has been well established that this infection is most prevalent in sexually active young people, usually without symptoms. However it can cause serious complications, particularly for women, if left untreated, inadequately treated or if re-infection occurs.¹

The aim of extending the health adviser's role outside of GUM services has been to improve and standardise the care offered to clients testing for STIs in a community setting, and to allow them the opportunity to receive the same level of care as an individual testing within the GUM service. The health advising skills most valuable in this setting are the provision of sexual health education for the professionals and their patients, and of sharing the management and follow-up of those diagnosed with an infection to ensure the best possible outcomes.

Where chlamydia testing is taking place, the recommended care prior to testing includes gaining informed consent from the patient and establishing how they will receive their results. If the result is chlamydia positive, care ought to include:

- Giving diagnosis and correct information regarding this
- Giving correct treatment
- Offering testing for other STIs
- Giving advice regarding re-infection within this episode
- Discussing partner notification (see chapter on partner notification)
- Sexual health education
- Arranging follow-up at the end of treatment²

In the GUM setting, the aim is for all clients to be referred to a health adviser to discuss partner notification and for a minimum of 70% of patients diagnosed with chlamydia to have at least one contact attending for screening and/or treatment.³

One may say that within any of these areas surely the health professionals could carry out the recommended care listed above. However, in some areas there may be a lack of experience and discomfort in discussing STIs with a patient, particularly where partner notification and recent sexual history are concerned. Furthermore, there may not be a sufficient knowledge base or the training to support staff in discussing an STI diagnosis or arranging follow-up, especially if positive results are infrequent in that area. The role of the health adviser is to discuss these issues. Where there is a liaison system in place the health adviser can take responsibility for monitoring cases to ensure that the patient is made aware of the result, receives treatment, discussion of partner notification, and receives appropriate follow-up.

In order to ascertain where health advising input may be advantageous, it is first necessary to establish either where testing is already taking place/ could usefully be taking place or where a health adviser could be placed in an advisory capacity to benefit individuals attending a non-screening service (such as a young persons project). Microbiology departments can usually provide very helpful information about the former. Regarding the latter, the Royal College of Obstetricians and Gynaecologists⁴ advocate all women having a TOP, or that women aged under 36 years having any form of uterine instrumentation (including insertion of IUD) ought to be routinely screened or treated prophylactically for chlamydia, gonorrhoea and other anaerobes. Therefore TOP services and IUD clinics (including GPs who undertake these procedures) would be appropriate targets for both screening and health adviser intervention.

Having established which areas are testing for STIs and which areas could be testing for STIs, links between these areas and health adviser services can begin to be developed. In order to do this successfully the following must be examined:

- The protocol for the area
- The patient group and criteria for testing
- The present system of dealing with a positive STI result
- The structure of the staffing within that service

Whilst examining these aspects of any service, it is important to assess the experience of staff with a view to potential training needs.

THE PROTOCOL FOR THE AREA

An established and effective protocol for the management of STIs will often create an easier pathway to developing sensible dialogue between health advisers and a service. It will usually mean that there is someone with an interest in the standards of testing and management, so identifying that person is crucial to the development of any referral system. However it must not be assumed that having a protocol means that it is being followed. Encouragement of an audit can be very useful in establishing not only if the protocol is being used but also how effective it is.

If there is no protocol in place, the following aspects are essential groundwork for development of a care pathway.

THE CLIENT GROUP AND CRITERIA FOR TESTING

Services already screening for STIs will have their own criteria for testing. For example, Accident & Emergency Departments may initiate testing individuals attending with signs and symptoms suggestive of an STI outside of GUM hours. The criteria and specific client group should give an indication of how much testing ought to be taking place. So an Accident & Emergency Department, who see mixed clientele with varied problems, will test far fewer clients than a TOP service, who by their nature should normally test most of their clientele. No criteria or poorly adhered to guidelines might indicate a service in need of education and training. This is a role well suited to the health adviser.

Services have varied responses to positive STI results and treatment. Those attending for a procedure involving uterine instrumentation following Royal College of Obstetrics and Gynaecology (RCOG) recommendations will usually have had treatment. This will be either from a known positive result or prophylactically in the absence of a result before the procedure takes place.⁵

This can have a direct effect on the work of the health adviser. Those who have already had both treatment and procedure may be less likely to attend a GUM clinic for partner notification and follow-up. Patients who have an untreated infection may be more likely to attend a GUM clinic for their treatment and therefore see a health adviser. This appears to be the case in a comparison of unpublished audits of a liaison system between the Accident & Emergency Department, Gynaecology and TOP services in an inner city hospital, and a key worker based within the health adviser team in the local GUM service.⁶ Similarly, in the contraceptive services within two inner city primary care trusts, of women referred to three GUM clinics with mostly untreated chlamydia infection, the vast majority attended. In the latter case it was noted that use of a “suitably skilled individual” with health advising skills had “demonstrated better outcomes than previously reported”.⁷

For patients who have already received treatment the rationale for referral is to ensure that partner notification and follow-up take place. When it is unlikely that there will be a need for a test of cure, and if the patient does not wish to have further tests for other STIs, this may be something that can be discussed with the patient by telephone at a mutually convenient time.

There is evidence to suggest that the younger the person, the less likely they are to attend for follow-up at a GUM clinic⁸ and the greater the delay in accessing treatment.⁹ In some areas, the criteria for testing is likely to reveal a high prevalence of infection. For example, the screening of asymptomatic women aged under 25 years in a dedicated young person’s service.

If the patients seem less inclined to attend a GUM clinic and are able to access treatment from the dedicated service, having a sessional health adviser available in that service can enable successful partner notification and follow-up to take place.⁸ This is only likely to be an economical use of the health adviser's time if there are enough clients in need of sexual health advice or partner notification (PN).

THE PRESENT SYSTEM OF DEALING WITH A POSITIVE STI RESULT

Examining the systems already in place can reveal a great deal about what a health adviser could offer that area. Specifically; the management of results, the treatment and advice given to patients diagnosed with an infection, the documentation and success of PN, and relevant follow-up.

It may be that patients are not being referred to GUM services because staff are unaware of the importance of discussing PN or the facilities are not in place to follow-up clients promptly. In such circumstances there may be the need to educate and train the health professionals involved. In other settings the health professionals may understand the importance of PN and follow-up and will routinely refer clients diagnosed with an STI to a GUM clinic. Here the emphasis will be on the effectiveness of the referral system. Simple measures, such as ensuring that the correct information about a GUM clinic is available to patients and staff can help ensure successful referral.

THE STRUCTURE OF THE STAFFING WITHIN THE SERVICE AREA

When developing a standardised method of referral, it is important to take into account staffing levels and turnover, continuity, and how many are full-time or part-time. All members of the multidisciplinary team have an important role in providing a smooth running and functional care pathway.

In areas where staffing levels are high and frequently changing, it may be useful to identify a small number of people willing to support a protocol or care pathway. They ought to take responsibility for managing positive results, ensuring that a patient is informed of their diagnosis, treatment is accessed, and a referral for PN and follow-up is made.

In hospital-based services (TOP, Obstetrics & Gynaecology, A&E) the staff most likely to have the greatest amount of contact with patients are the nurses and midwives. Generally there is a change of junior medical staff every six months and it is important to remember that they may have little or no experience of testing and managing STIs. Having a regular teaching slot in an induction programme can be useful. In addition, a more efficient process can be achieved if two or three nurses/midwives can be identified who are willing to take part in a liaison system, taking over the notification of patients with positive results and referring them to GUM.

Contraceptive services are often part-time services spread across a district employing many sessional staff. In this situation it may be helpful to identify the most full-time clinic and then approach the full-time members of staff within that particular clinic.

Presenting at meetings aimed at GPs can be one way of providing education and clarification regarding testing and management of STIs to a primary care audience. When setting up a

referral system it may be beneficial to approach individual group practices to ensure that as many practitioners as possible are aware of any agreed method of referral. However, because the current number of investigations for STIs are relatively small per individual practice, the person who takes note of a positive result may not remember that there is a specific referral system in place. It can be worthwhile trying to identify which clinicians are most likely to do the testing or take responsibility for notifying a patient of a positive result.

A very useful tool to aid adequate management and referral is for Microbiology to provide a regular list of positive results to a key health adviser / co-ordinator in the GUM service. In areas with large numbers of staff such as the Obstetrics, Gynaecology and A&E Departments, these results may be co-ordinated by a nominated person. For the key health adviser / co-ordinator it can highlight when a patient is not referred to GUM. This allows the opportunity of contacting the site of testing and acts as a safety net, ensuring that they are aware of the positive result and that action has been taken. It is also important to remind staff of the agreed referral system. If the patient refuses even telephone contact with a health adviser then this is an opportunity to offer support to the staff in doing partner notification and follow-up.

PROCESS OF OFFERING A TEST FOR AN STI

Being aware of how the test is offered and discussed can be very helpful in facilitating recall for treatment and follow-up. Informed consent ought to always be sought when taking a test for an STI. It is worth highlighting that when testing for an STI outside of the GUM setting, the idea that an STI could be present may be completely unexpected for the patient. Or in the case of routine screening, such as prior to insertion of an IUD, the idea of the result being positive may seem very unlikely sometimes to both patient and clinician.

Therefore, having ensured that the patient is aware of what they are being tested for, it is crucial to have a clear indication as to how they would like to receive their result. It may not be appropriate to send it to the usual home address or the patient may prefer to be contacted by a specific phone number. This is particularly important to consider when testing young people. For this group, mutually agreed contact methods may even be by telephoning a named friend or via the school nurse.¹⁰ Absence of informed consent can make the giving of a positive result very difficult for the health professional, and be very shocking for the patient, with the added possibility of compromising the patient's confidentiality.

HIV TESTING IN THE COMMUNITY

As a health adviser it is important to identify where HIV testing is currently taking place and what the existing practices are. This may help establish any training needs or gaps in service provision. It may be appropriate to set up a health adviser lead testing session in primary care in areas where there is potential for high prevalence. With adequate training and support all primary care settings may feel equipped to offer HIV testing if resources and patient demand allows. The role of the health adviser is to support and evaluate practice and work within the community team to provide safe and quality care.

These straightforward issues, if addressed pro-actively, can lead to the achievement of a more functional and streamlined sexual health service. The role of the health adviser in the community is to be flexible within existing services, to support the development of sexual health, and to encourage good practice. It is important to maintain strong links with GUM and encourage community practitioners to draw on this expertise. The health adviser can be

an important link between these services and work towards fostering best practice in the management of STIs outside the GUM setting.

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Outreach work

GILL BELL

At-risk populations may find services difficult to access. This chapter explains how outreach work can be used to deliver health promotion and/or sexual health services to those most in need.

INTRODUCTION

Outreach work involves making contact with at risk individuals or groups on their own territory. People at high risk of sexually transmitted infections (STIs) often make poor use of genitourinary medicine (GUM) services^{1 2} where screening, treatment, hepatitis B vaccinations, condoms and risk-reduction counselling are available to protect them. Lifestyle factors such as homelessness,³ transience^{4 5} and casual or anonymous sexual partners^{6 7 8} also make it difficult to notify those exposed to infection. For these reasons health advisers may undertake targeted community-based initiatives to ensure sexual health care reaches the people who need it most, and transmission of STI is minimised.

Health advisers may use outreach methods to promote safer sex^{9 10} and to deliver services directly.^{11 12 13 14 15 16 17 18} They also can be used to encourage the uptake of existing services^{19 20 21} and assist with partner notification.^{22 23 24 25}

MODELS OF HEALTH PROMOTION

Rhodes, Holland and Hartnell described four models of health promotion.²⁶ Each is based upon different assumptions about the causes of health-related behaviour, and each determines different approaches to outreach work.

Information giving models emphasise the importance of having the appropriate knowledge to avoid ill health and use services effectively. The relationship between knowledge and behaviour may be more complex than this model suggests,²⁷ but the need remains for health advisers to give accurate information about STIs, services and prevention methods during outreach.

Self-empowerment models emphasise the sense in which ill health is related to lack of personal control. Relevant aims for a health adviser would be to enable individuals to practise safer sex by offering suitable condoms, demonstrating their use and helping the person to develop assertiveness and negotiation skills. Potential patients might be empowered to use the

GUM service if, for example, they can negotiate a manageable time and be supported by the outreach health adviser on arrival.

Community action models emphasise the influence of group norms and values upon individual behaviour. Through outreach work health advisers can use the ‘see and be seen’ ethnographic approach to health promotion and contact tracing.^{28 29}

‘Seeing’ people (and listening to them) in their own milieu gives important insights into social and sexual connections between individuals, dominant attitudes to sexual health and service use, and normative expectations that surround sexual contact. As a result, health advisers are better able to ask the right questions during partner notification interview, construct effective health promotion messages, and identify opinion leaders who are best placed to deliver them.³⁰

‘Being seen’ raises the profile of sexual health and helps to build bridges with the GUM service. In these ways health advisers can use ethnographic methods to understand and influence the cultural norms that underpin partner selection, condom use, service use and partner referral. Potterat, Muth and Bethea give a definitive account of contact tracing through outreach work.³¹

Radical political models focus on challenging the structural social, economic and politico-legal determinants of ill-health. For example, it has been argued that laws introduced in the 19th century to control prostitution have stigmatised and marginalized women selling sex, making it more difficult for them to access services.³² Law enforcement policies have also, in the past, discouraged prostitutes from carrying condoms because the possession of condoms could be used as evidence against them in court. Outreach workers have been instrumental in persuading police to refrain from using this as evidence, thereby making it easier for women to protect themselves. On a micro level, existing services may be persuaded to offer a wider range of opening hours, exclusive sessions for certain groups or fast tracking arrangements to make them more accessible to vulnerable individuals.

TYPES OF OUTREACH WORK

Detached work is undertaken directly with individuals, or groups of individuals, outside of an agency setting, such as the street, pubs, saunas or drug houses.

Peripatetic work is undertaken with, or through, organisations such as schools, residential care units, prisons or hostels.

Detached outreach

Aims and objectives may include:

1. To reduce individual risk of acquiring an STI by

- Offering information on transmission routes
- Providing condoms, lubricant and clean injecting equipment
- Promoting vaccinations for hepatitis B

- Enquiring about the factors that influence risk for that group, and tailoring health promotion messages accordingly. The closer working relationship that outreach allows may encourage risk disclosure ³³
- Offering risk-reduction counselling/ safe sex workshops
- Influencing cultural norms surrounding safe sex
- Challenging policies that encourage risk
- Referring to other agencies for problems may encourage risk-taking, such as addiction, or debt

2. To reduce morbidity from untreated STIs by:

- Providing information about transmission routes, symptoms, possible absence of symptoms, complications of untreated infections and treatments available
- Facilitating access to generic services by building rapport and trust and booking appointments at suitable times. Offering reminders, lifts to clinic and/or a fast-track service may encourage attendance.³⁴ Travel expenses may also be useful ³⁵
- Ensuring services are welcoming and non-judgemental towards targeted individuals, through staff training.³⁶ Reassure clients that GUM services are confidential
- Offering screening and/or treatment during outreach ^{37 38 39 40 41 42 43}
- Recording identifying information for individuals that would allow them to be recognised and notified if named as a contact of infection
- Enquiring about the obstacles to service use, and using the findings to influence local service provision.⁴⁴ It is good practice to inform participants of the outcome

3. To reduce onward transmission of STIs by:

- All of the above
- Noting the connections between people. Prior insight can suggest appropriate prompts during partner notification interviews. (For example: “What about your dealer? Do you ever pay him with sex?”)
- Social connections can also suggest ways of tracing contacts
- Noting which individuals are key players in terms of their ability to influence group norms and values,⁴⁵ and their transmission potential in terms of their network position.⁴⁶ Make sure these individuals are well looked after when attending the service ⁴⁷

CAUTIONARY NOTES

Pointing the finger

At-risk groups are targeted “not to point public health fingers at them, but to shake hands with them”⁴⁸ In practice, most populations are appreciative of the attention.^{49 50 51 52} There is always, however, the danger that some may feel invaded, patronised or blamed. One angry sauna worker made this point clearly: “Just because I work doesn’t mean I am not responsible enough to buy my own condoms!”. Sensitive and respectful negotiation is required to avoid alienating the people you are trying to reach. If the work is exposed to public scrutiny through publications, lectures or media interviews, care must be taken to avoid saying anything that could stigmatise those concerned.

Safety

Health advisers may feel more vulnerable when working out in the community where unpredictable, distressing and occasionally frightening situations can arise.⁵³ These are not common,⁵⁴ but it is important to anticipate and minimise potential risks.

Consideration would be given to:

- **Selecting the appropriate staff.** Important qualities include commitment, good communication skills, confidence, assertiveness and clear professional boundaries. A close match with the target group in terms of age, gender, sexuality (if relevant to risk) and ethnicity may make communication and acceptance easier. However, this is not always essential
- **Being prepared.** Before embarking on outreach work, some understanding of the social, cultural, legal and epidemiological issues affecting the group is needed. If physical vulnerability is anticipated, self-defence training may be useful
- **Working in pairs wherever there is a risk to safety,** particularly on the street, in the dark. Some environments may be safe for a lone health adviser, such as massage parlours,⁵⁵ although co-working can provide useful psychological support
- **Carrying a mobile,** with the keyed in number(s) of those who might be called upon for assistance, such as the police or a colleague
- **Informing colleagues.** Clinic staff would be aware of the estimated times and locations for scheduled community work. It is good practice for health advisers to report back to clinic before going home, particularly if working alone
- **Informing the police,** where appropriate. It is good practice to seek the support of the police and agree the best means of making contact if help is needed
- **Having ground rules** for mobile units or drop-in centres which prohibit drugs, alcohol, verbal or physical aggression
- **Carrying a personal alarm**
- **Checking occupational insurance** to ensure staff are covered to work in the community
- **Working to protocols** agreed with the line-manager

- **Documenting incidents** where safety was at risk. These would be discussed with the line manager and co-workers before further outreach sessions were undertaken
- **Seeking support and guidance from others** doing similar work
- **Seeking supervision.** Working at community level can be emotionally demanding because it brings raw exposure to the harshness of some people's lives. Professional dilemmas around confidentiality and child protection issues can be more challenging because there is a need to think quickly and act appropriately without the luxury of counselling rooms for private discussion and senior colleagues on hand for guidance. The informal style of outreach work can make it more difficult to maintain professional boundaries, particularly if working with your own social peer group in clubs or bars. Supervision is therefore essential to protect the safety of worker and clients

Resources

Outreach projects can require a lot of health adviser time, particularly if working in pairs. It is important to ensure that the devotion of substantial resources to small sections of the population is epidemiologically justified. An initial pilot study, and ongoing evaluation, is therefore essential to make sure the intervention is worthwhile. Projects may take a long time to develop from a cold start,⁵⁶ so it is important to secure managerial support for a lengthy pilot phase of at least six months. Before embarking on a project, be sure that resources are available to support the work as long as necessary: disaffected populations can be alienated further if services appear to lose interest in them when the novelty of an intervention wears off.

SETTING UP AN OUTREACH SERVICE

Embarking on an outreach project requires careful planning and preparation. Good practice would include:

- **Targeting a high-risk population.** The aim is to work with social/sexual networks where substantial rates of infection are (or could be) sustained by a culture of unprotected sex with multiple partners and/or failure to access services before onward transmission has occurred.^{57 58 59 60} Epidemiological data can help to identify who is most at risk in terms of, for example, age, gender, post code, ethnicity, sexual orientation and occupation

This can be supplemented by insights acquired through partner notification because "Contact tracing takes you right where the problem is":⁶¹ in other words, the types of contacts most frequently sought and the places most often mentioned point to where outreach work is most needed

It is also important to check which populations might be at risk if national STI trends were to become local: this would highlight the need for preventative work

- **Having clear objectives** from the start. These would be reviewed regularly in the light of experience, evaluation or epidemiological developments
- **Considering how to evaluate** from the outset to ensure the necessary data are recorded. Evaluation is essential because the work may not be effective, or an efficient use of resources, locally

- **Considering the potential to harm** and/or alienate the target group, and ways of minimising this danger
- **Identifying places where the target group congregate** and can be accessed. Commercial sex venues are usually advertised in the local press. Key bars and clubs can be identified during partner notification interviews by asking patients where contacts were met ⁶²
- **Liaising with existing projects** already doing outreach work with the target group. Joint working is recommended where possible ^{63 64 65}
- **Liaising with relevant statutory or voluntary organisations** in contact with the target group to seek guidance and ensure mutual referral policies are in place
- **Ensuring clinic staff are aware and supportive** of the work, particularly if outreach clients are to be given priority access or fast-tracked.^{66 67} Colleagues need to appreciate the reason for this because offering, for example, a drop-in facility to selected groups potentially puts a strain on the service, and may appear unfair to other clinic users who do not get priority
- **Liaising with the police** if working on the streets and/or with groups involved in criminal activity.^{68 69} An understanding of the law, how it is enforced locally, and what there would be a duty to report is required

Police support is essential to avoid the work being sabotaged by, for example, sex workers being identified and arrested as a result of observed contact with the outreach service;⁷⁰ or the possession of distributed condoms being used as evidence of prostitution in court

The police may provide useful information about the target population and guidance on safety issues. “Ugly mug” schemes, whereby sex workers and the police undertake to inform each other of dangerous punters, can be set up

- A hostile attitude toward the police from outreach workers may exacerbate difficulties for the target group. However, if the relationship between the police and the target population is poor, outreach workers need to avoid appearing too close to the police, or they may not be trusted ⁷¹
- **Being aware of child protection responsibilities** and working to guidelines that have been agreed with the local Area Child Protection Committee
- **Avoiding objections from local residents** if a mobile unit is to be used; the police may advise an acceptable route ⁷²
- **Negotiating access with gatekeepers** such as sauna/bar owners/managers. When visiting private premises the health adviser is essentially a guest who must work in a way that is acceptable to the establishment as well as the target group. Good will can be nurtured by being respectful, discreet, reliable, accessible and flexible

For commercial sex venues it is useful to know: how many women work there, so sufficient supplies of condoms/ lubricant can be taken; shift patterns, so visits can be done when there be more workers present; busy times to avoid

For social venues, it is helpful have access to a quiet area where it may be possible to talk to individuals in confidence

- **Allowing time for the work to become established.** Target groups or venues may be suspicious and resistant initially, but become more amenable if they hear favourable reports from peers
- **Working with cultural mediators, where necessary.** If there are marked cultural or language differences cultural mediators may be needed to gain access to and /or communicate with the target group ⁷³
- **Supporting the development of peer-led interventions.** In a review of HIV prevention initiatives, Ellis et al ⁷⁴ found evidence that peer involvement can be effective in reducing sexual risk in key populations, including commercial sex workers and men who have sex with men.
- **Preparing suitable materials,** including cards or leaflets specifically outlining GUM services for the target group. Leaflets on a range of sexual health issues and referral cards for other agencies are also needed

MAKING CONTACT WITH CLIENTS DURING OUTREACH

Making contact with individuals or groups for the first time is challenging because there is pressure to establish rapport and exchange information quickly, often during very brief interactions, and often with clients who are initially wary.

The following approaches may help:

- **Seeking an introduction** from a group member,⁷⁵ ⁷⁶ a cultural mediator,⁷⁷ a bar or sauna owner,⁷⁸ or an established outreach worker.⁷⁹ Endorsement from a person who is known and trusted helps to break down barriers and begin dialogue. This is particularly important if the target population is likely to be apprehensive or hostile
- **Offering something tangible** that the clients want. This is an effective way of making contact and creating good will. Examples include: free condoms, injecting equipment, personal alarms, shelter from the cold in an outreach bus, drinks and food
- **Using an informal style** that is open, friendly, approachable and non-threatening. Trust can be established more quickly if the health adviser explains the role clearly and is confident that the purpose is legitimate

It is important to avoid being apologetic, because this may arouse suspicion and create barriers. It is also advisable to avoid showing fear: this could be exploited and put safety at risk ⁸⁰

- **Demonstrating sensitivity and respect** by taking cues from the client concerning how long they want to talk, what they wish to discuss and how much they want to disclose
- **Using time effectively;** communications may need to be very concise if the person is busy looking out for punters or friends. Key words used as soundbites (such as

“condoms!”) to grab attention can be useful, because they suggest the meeting can be brief

- **Exchanging first names**, if possible, and paying attention to any demographic or biographic details that may help to identify the person in future, and provide a basis for further interaction. It is advisable to avoid asking too many questions initially in case the person feels interrogated, or is wary of how information will be used. However, general conversation can reveal many factors that may influence risk, including social circumstances; lifestyle; priorities; socio-sexual networks; peer group norms and dynamics; attitudes to safer sex and service use; beliefs
- **Discussing sexual health issues and services**. When sufficient rapport has developed, sexual health concerns may be addressed and condoms distributed to individual clients (although not to sauna or bar managers, who may sell them). GUM services may be outlined and appointments booked. The offer of a telephone reminder, a lift to clinic or travel expenses may encourage attendance
- **Clarifying confidentiality**. Health advisers working jointly with other agencies would make it clear to those workers and to clients that information regarding the sexual health of individuals is confidential to GUM and would not be shared with others in the outreach team
- **Addressing other problems**. It is important to be aware that sexual health might not be a priority for the targeted individuals, and that too much focus on this may inhibit rapport: *“...issues around HIV are not always a priority for a prostitute...other problems are more pressing. Services which focus on HIV prevention alone may have difficulty establishing credibility”*⁸¹

Clients whose sexual risk-taking is related to underlying problems, such as addiction, debt, mental health problems or homelessness may benefit from referral to the appropriate agencies for support⁸²

- **Making notes** discreetly, in between contacts (See Ch. 28: Ethical issues in outreach). The aim is to record any information that could be useful, including contacts made, issues raised and interventions used (See ‘Record keeping’, below)
- **Protecting records**. Every effort would be made to ensure outreach notes remain confidential and are stored in GUM as soon as possible. It is good practice to record data on loose sheets of paper during outreach and transfer to cumulative records back in the office: this is safer than taking a log-book out that could be lost

The same approaches would be used for further outreach sessions. If there is regular contact with a client group, it is important to remember as much as possible about individuals, including names, circumstances and previous conversations. This will help to strengthen rapport and co-operation and will improve the chance of locating the person, if necessary, during provider referral.

OUTREACH SCREENING SERVICES

If outreach links with the target group fail to attract them to existing services, it may be necessary to offer sexual health screening on an outreach basis. Types of screening venues have included:

- Drop-in centres that offer a holistic range of services, including needle-exchange, drug counselling, methadone scripts, housing, benefits, as well as condoms, food, drink, shelter, showers, change of clothes ⁸³
- Satellite GUM sessions occupying nearby premises and open during the evening ⁸⁴
- Mobile screening unit ⁸⁵
- Social venues ^{86 87}
- Community Health Centres ⁸⁸
- Drug venues, such as ‘crack houses’ ^{89 90}

RECORD KEEPING

Methods

It may be necessary to record information covertly, in between contacts, to avoid arousing suspicion,⁹¹ if the relationship with the client group is nascent. Established and trusted outreach services can often be open about the need to record whom they have seen, and the issues raised, without jeopardising goodwill.

Records would be kept for each session, and also for each individual if the client group is of manageable size and repeat contacts are frequent.

Data collected

Data would relate to aims, objectives and evaluation criteria. The following may be included:

- Number of individuals seen, per session
- Details of individuals seen, where possible. These may include full names, first names, nick-names, descriptions, location seen, biographical details, risk-factors (for example type and method of drug use), and relevant social and sexual contacts. If appointments are booked it might be possible to obtain a date of birth, address and telephone number for registration. This information is more difficult to gather if contact is fleeting, or group based
- Issues raised (pregnancy, violence, drug use, housing, forced sex)
- Risks identified (unprotected sex, injecting drug use)
- Factors pre-disposing to risk (coercion, homelessness, debt, addiction, mental health problems)
- Condoms/lubricant/needles given
- Symptoms reported
- Information and advice given
- Referrals to other agencies

- Appointments at GUM offered/accepted/kept/outcome
- Feedback on the outreach service
- Feedback on the GUM service
- Critical incidents where a serious crime was reported or observed, or confrontations took place. A written record of the date, time, observations, dialogue, witnesses present and subsequent actions would be made as soon as possible and signed, if there is a possibility of police involvement
- Any new needs emerging

EVALUATION

The extent to which overall aims, such as the reduction of HIV transmission, have been achieved by outreach intervention are difficult to estimate. The long incubation period for HIV delays insight and the multiplicity of other factors that could also influence risk are not accounted for.⁹² In this situation proxy measures of effectiveness may be used. These could include process indicators, such as the number of individuals seen.^{93 94}

- Number of sessions over time
- Average number of individuals seen per session
- Number of individuals seen over time/ frequency of contact
- Number offered risk-reduction information and/or counselling
- Number offered STI screening and treatment advice/information
- Number offered condoms/ gel/ needle sharing equipment
- Number offered / booked/ kept appointments
- Number and type of STIs diagnosed and treated as a direct result of outreach appointments
- Contacts of STIs traced during outreach, or identified as a result of data gathered during outreach. Infections diagnosed and treated as a result
- Number referred to/ attending other agencies
- Costs per contact made, screens secured, hepatitis B vaccines given, infections diagnosed or treated
- Client feedback

LESSONS LEARNED

Part of the aim is to learn from the client group. Methods may include formal questionnaires,⁹⁵

interviews by an independent practitioner,⁹⁶ or the recording of informal comments.⁹⁷ Research questions may be:

- Does the client group value the outreach service?
- How could the outreach service be improved?⁹⁸
- How could GUM be more accessible?⁹⁹
- What factors encourage risk taking? (Questions related to risk are often avoided because they may be perceived as intrusive and alienate the client group,¹⁰⁰ or they may yield unreliable data because the client may feel under pressure to please the outreach worker by under-reporting risk)

Outcomes can be used to influence change, which would be fed back to the client group if possible.¹⁰¹

CONCLUSION

Outreach work may enable health advisers to gain access to vulnerable populations who have relatively high rates of STI. Working at community level can give better insight into the determinants of poor sexual health that may informed more appropriate interventions. Clinical services may become more accessible if their profile is raised and staff become trusted; direct delivery of services in an outreach setting may also be beneficial. Finally, partner notification may be more feasible on minimal data if the health adviser is well acquainted with group members. Evaluation is essential to ensure that such resource-intensive initiatives are justifiable.

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Ethical issues in outreach work

GILL BELL

Targeting sexual health interventions may benefit the recipient at the expense of others, or it may stigmatise vulnerable populations. This section considers some of the ethical issues in outreach work.

INTRODUCTION

Guidelines for the management of an ethical issue can be found in chapter 23, where ethical concepts such as *autonomy*, *beneficence*, *non-maleficence*, *justice* and *confidentiality* are discussed in detail. This chapter gives some examples of the ethical choices that may have to be made in relation to outreach work.

TARGETING

Targeting resources always raises the issue of justice. Is it fair to donate large amounts of funding to small numbers of individuals? One justification is that it redresses existing sexual health inequalities for marginalized groups who have not traditionally accessed services, in line with The national strategy for sexual health and HIV.¹ The wider community is also protected if STI transmission is reduced among core networks.² A robust defence of targeting requires evidence that the groups selected **are** disadvantaged, and/or in a position to propagate high levels of STI transmission.

PATERNALISM

Taking services out to people may be construed as paternalistic and discourage a sense of personal responsibility for health. This may disempower some individuals, making them less able to protect themselves from risk. Screening and treating infection on an outreach basis may make generic services appear even less accessible to the client group. This could compound the problems that peripatetic services are aiming to address, particularly if outreach funding is withdrawn in future. (See also Ch. 23 - Ethical issues in sexual health advising).

COVERT RECORDING

Concealing the fact that records are being kept on individuals is deceitful. Clients are thereby denied the right to make a fully informed choice about whether they wish to engage with outreach workers, and what they wish to disclose. If the practice were to be discovered, trust could be lost and further barriers created.

These ethical costs must be balanced against the potential benefits, both to outreach clients themselves and to the wider community. Open note-keeping may make it impossible to build initial rapport with disaffected communities suspicious of your purpose.³

Outreach records that identify individuals have several important benefits for the clients. They may, in the future, enable otherwise untraceable contacts to be notified of their exposure to an STI. They can be (and have been) used to support clients in court. They also provide robust evaluation data by making it possible to identify how many outreach contacts subsequently attend the GUM service for screening, STI treatment and/or hepatitis B vaccination. Without good quality evidence of effectiveness, funding for such initiatives may be short-lived.

Finally, outreach data can give important insights into the dynamics and structure of networks associated with STI transmission:⁴ this can inform the design of future interventions⁵ that may reduce risk for the individuals concerned, as well as the wider community. Covert note-keeping may also be defended on the grounds that, although client suspicion is understandable, it is ill-founded because the information would not be used to damage or discredit those involved.

FAST TRACKING

Giving priority access and/or a speedier service to some means that others have to wait longer to have their needs met. To defend fast tracking, it is necessary to argue that the individuals who benefit would otherwise find the service less accessible than those who are expected to wait; or that they pose a more significant threat to the sexual health of the community as a whole and therefore need to be seen urgently for the benefit of others.

The promise of fast-tracking needs to be matched by an ongoing service capacity to deliver: epidemiologically important clients may be alienated further if they find that they, too, end up waiting around longer than they expect on a bad day. Creating expectations of the service that can't be reliably met may confound attempts to improve accessibility.

CONCLUSION

There are complex issues that need to be considered in relation to outreach work. It is good practice to discuss difficult choices with colleagues and document reasons for the decision made

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Working in prisons

SANDRA JARRETT AND CARON DEL RIO

Dealing with HIV and other blood borne viruses, as well as general sexual health issues can present particular problems in prisons and requires a co-ordinated multidisciplinary approach to address the special needs of this population.

This chapter explores some of the particular features of prisons and prisoners and some general guidelines for health advisers in working with this population.

INTRODUCTION

Official figures show that there are between 50 and 100 HIV positive people registered by prison doctors, but the actual figure may be much higher. There is concern over hepatitis levels, mandatory drug testing, and the changing relationship between the NHS and the Prison service. There is also confusion over funding issues, particularly around HIV prevention and antiretroviral medication.¹

Health advisers may be involved in different ways with prisons or prisoners:

- Seeing patients in clinic who are or have been in prison
- Seeing patients whose partners are or have been in prison
- Involvement with patients in legal procedures, for example: going to court; the legal process for rape and sexual assault; providing advocacy; referral for asylum or immigration
- Providing a specialist genitourinary medicine (GUM) service within local prisons, for example the service provided by Kings College NHS Trust²
- Providing a dedicated health adviser service within prisons, for example HMP Holloway

SPECIAL FEATURES OF PRISONS AND PRISONERS ³

The vast majority of prisoners are males under 35 years of age and therefore likely to be from the most sexually active groups.

There are concentrations of injecting drug users and commercial sex workers, a proportion of whom will already have HIV or hepatitis B and/or C on entering prison.

Prisoners could be considered to be rule breakers, and therefore may find maintaining safer sex or drug using practices more difficult.

There is a disproportionately higher incidence of mental health problems, ⁴ low self-esteem and a history of self-harm or harm towards others. Behaviour may be unpredictable, violent, or suicidal which may involve blood spillage or the throwing of faeces and urine.

A proportion will be homeless or of no fixed abode, or may be foreign nationals who will be deported at the end of their sentence.

HIV AND STI TRANSMISSION RISKS IN PRISONS

1. Drug use and needle sharing

The prison population has experience of higher levels of drug use and injecting than the general population. ⁵ A Public Health Laboratory Service (PHLS) survey in 1997/8 showed 24% of prisoners have ever injected. 30% of those reported injecting in prison, and of those, 75% shared needles. ⁶ Therefore, although there is significant reduction in the number of injectors, those who continue to inject are more likely to share needles and increase their risk of blood-borne infections.

2. Tattooing

Home Office research in 1998 amongst adult males in 13 prisons in England and Wales showed that 21% of those with tattoos reported being tattooed in a prison. ⁷ A variety of implements can be used for this purpose, but problems may arise though inadequate sterilisation of equipment.

3. Sexual behaviour

According to the Review of HIV and AIDS in Prison,⁸ there are few studies which document the sexual behaviour of prisoners so it is difficult to know the extent of risk behaviour and impact of this behaviour on the rates of HIV or STIs within prisons. However, the survey amongst adult males by the Home Office in 1998 ⁹ confirmed that prisoners were more sexually active and experimental, more likely to use prostitutes, more likely to have sex with women who were at risk from HIV and hepatitis, and less likely to use condoms, than in the general population.

In the PHLS survey 2000, 5.4% of men had had sex with a man prior to coming into custody. The number of men having sex with men during their current sentence has been estimated between 1.6 - 3.4%. At current levels of imprisonment, this translates into 900 - 1,900 men. ¹⁰

There was no evidence that custody led to increased same-sex activity. It is not known how much coercive sex takes place in prison, but it is known that this occurs.

4. Young offenders

There is some evidence in the research literature that young people who end up in prison have engaged in more sexual and drug using behaviour than their counterparts. ¹¹

There is a particular duty of care in relation to young people that needs to be addressed in prisons.

5. Women

There are particular issues for women in prison that are important to address, and the needs of these women may be more complex.

In a report by the Revolving Doors Agency, 1,400 women were surveyed in HMP Holloway serving a first sentence between October 2000 and March 2001, as well as 870 women arrested between October 1997 and March 2002. 55% of women in prison for the first time displayed symptoms of a mental health problem.¹²

Other issues affecting women in prison include:

- Rape and sexual assault, and childhood sexual abuse
- Violent or abusive relationships
- Drug use
- Prostitution
- Hepatitis C infection
- Self harm and low self esteem
- Pregnancy and children
- Separation from children whilst inside prison. The above report¹³ showed that 42 women in Holloway did not know who was looking after their children, and 19 children under 16 were looking after themselves
- Distance from home and family
- Skills and opportunities on the outside may be limited
- Access to health care, both physical and psychological may be more difficult
- Women being used as drug 'mules'. In the Holloway report,¹⁴ 8.3% of the survey were Jamaican women, all of whom were arrested for bringing drugs into the UK. 77% of these women had children, and their safety was the paramount concern. Combined with a long prison sentence, these issues can adversely affect mental health

ONGOING CARE AND SUPPORT

1. Confidentiality

Current Prison Service policy is committed to adherence of medical confidentiality.¹⁵ Information is restricted on a 'need to know' basis. It may be more difficult to achieve confidentiality because of the multiple sources of information on a prisoner from courts, probation, police and the prisoners themselves. The closed environment of an institution makes it harder to maintain confidentiality if prisoners are attending a clinic, have outside visits from support agencies, or are taking antiretroviral medication.

If confidentiality is not maintained, it can cause mistrust, anxiety or discrimination. Therefore, information and communication need to be handled carefully and appropriately.

2. Health care and medical treatment

Prison Service Health Care Standards have the stated aim " to give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service".¹⁶

The European Prison Rules state " the prison medical services should be organised in close relation with the health administration of the community or nation".¹⁷

This implies that the provision of health care in prisons needs to be closely aligned to the NHS and that the principle of equivalence be applied to health care policy, standards and delivery.¹⁸

It is recommended prisoners with HIV remain on normal location if they are well. If they become unwell they would be cared for in the prison hospital and if they are in need of more specialised treatment and care they would be seen in an NHS hospital, and have access to respite and palliative care.

There has recently been a shift in the responsibility of financing the prison health services, and by 2006, all Primary Care Trusts (PCTs) with a prison in their patch will be responsible for commissioning health services.

3. Harm reduction and prevention

Drug use

Those with drug problems will often be placed on a detoxification wing, and weaned off. However, if a prisoner is HIV positive the recommendation is to be maintained, or a slower withdrawal. This presents an ideal opportunity to address information on harm reduction, safer injecting practices and maintenance of behaviour outside prison.

It is not current prison service policy to provide needles and injecting equipment, but this is kept under regular review. Disinfectant tablets for sterilisation of equipment are to be implemented throughout the prison service in 2004, as recommended by the Aids Advisory Committee.¹⁹

Condom use

There has been significant debate about the issuing of condoms in prisons, as the present law prohibits sex between men except that which occurs in a private place between 2 consenting men aged 18 or over. However, prison policy confirms that the cell is a private place, and an illegal act would not be taking place. In 1996, doctors were given authority to distribute condoms to those at risk of infection and prison policy encourages all governors to introduce schemes where condoms are available upon release. It is also recommended that dental dams be made available in women's prisons, but again there is little information on the extent or nature of sex between women in prisons.²⁰

However, it must be noted that although prison policy is clear on many of these points,²¹ the actual practice of care and support for those at risk, or those who do have HIV, can vary widely between establishments. There is need for more research into the needs of prisoners and systematic collection of information on risk practices.

Education

Prison often represents a unique opportunity to provide HIV and hepatitis preventative education and counselling to some difficult to reach groups, for example those in prison for rape or paedophilia, sex workers, those with mental health problems and drug users.

It may be the most stable time for a prisoner, where some support is available and the prisoner has time to reflect on their behaviour.

It is also essential for prison staff to receive regular and adequate training on sexual health and HIV issues.

4. Counselling

The model of pre and post-test HIV or hepatitis C counselling which is practised outside is the one adopted by the Prison Service. (See chapter 14) However, there are some particular problems that may take on a more acute form in prisons.

It is best practice that HIV and hepatitis C testing is only carried out with the informed consent of the prisoner. However, prisoners may not wish to come forward for testing or may feel coerced into testing as well as fears about being identified as HIV positive.

There may be difficulties in maintaining confidentiality.

Prisoners will be restricted in time or place as to when and where they can be seen.

There may be considerations about the appropriateness of testing and how results are accessed for a prisoner, especially if they are on remand or transferred at short notice. Many prisoners will not be registered with a GP, or will have more chaotic or difficult relationships with a variety of statutory agencies including social services and housing.

There may be a mismatch between prisoner and counsellor expectations regarding taking an HIV test.

There may be other social or psychological issues that prevent a prisoner making decisions about their health, and sexual health may not be a priority.

Opportunities for support may be more limited, both formal and informal, and prisoners may be isolated or separated from usual forms of support from friends or family.

The length of sentence may influence prisoners' choices.

There may be fear and hostility from other prisoners or staff.

There may be cultural and language difficulties.

There may be particular problems for achieving and maintaining sexual and drug-using behaviour change both in prison and on release. Precarious coping mechanisms of some prisoners may lead to more impulsive or risky behaviour.

There may be higher levels of depression and anxiety.

Prisoners with HIV, their families and partners may require different types of psychological and social care at different times during the course of infection and at different stages of their sentence. Critical points may include: reception; allocation/transfer (although some prisoners

can be put on 'hold' within a particular establishment if they are HIV positive); mid-sentence crisis; release. Other concerns will be similar to those listed above.

5. Throughcare²²

Throughcare is the process by which the medical, psychological and social needs of the individual prisoner are assessed and organised prior to release, and will involve liaison with agencies such as probation, housing, social services, voluntary support groups, drugs teams and hospitals.

The Criminal Justice Act 1991 puts the throughcare of prisoners on a statutory footing. All adult prisoners sentenced to 12 months or longer, and all young offenders will be released on licence and subject to supervision by the probation service.

For those with HIV or hepatitis, pre-release planning is essential:

- To facilitate adjustment to life outside prison
- To ensure continuity of medical treatment
- To ensure access to further counselling around care and prevention
- To ensure practical support and assistance, for example with housing and benefits
- To access specialist HIV care, for example respite and home care

A coordinated approach to the care of individuals with HIV is crucial because of the multiplicity of problems presented. Therefore, establishing a multidisciplinary policy approach will help prevent management problems and ensure consistency and appropriate interventions. The aim is to provide a throughcare system offering an outcome at least as good as that available outside prison.

GENERAL ADVICE FOR WORKING WITH PRISONS AND PRISONERS

Health advisers are often ideally placed to offer their services within prisons, or to set up links to provide advice, training, and education to their local prisons. Good examples include Kings Healthcare, which has a contract with HMPs Brixton and Wandsworth, providing regular sessions within the prisons, and in HMP Holloway, there is a full-time health adviser within the Women's Health Clinic.

There is often a lack of understanding about how prisons work, there may be conflicts of interest, and there may be misconceptions on both sides between healthcare and prison staff, a 'them and us' mentality.

Therefore it is helpful to have some general guidance and advice. The National Aids Manual also has general advice and information on prisons and prisoners, as well as advice for partners and families of prisoners.²³

Getting information

It is useful to have some knowledge about how a particular prison operates and its structure and purpose, for example remand, long term or young offender institutions (YOIs).

It is important to know who the key people are who work in the prison, for example the governor, the Medical Officer, probation, drugs workers or psychologist. It is helpful to learn from other outside agencies going into prisons.

Security issues

If a health adviser is working regularly in prisons they may need a security check and it may be worth accessing a 'key talk' on security issues within prisons.

It is important to respect prison rules and avoid the following:

- Use of mobile phones
- The supply of unauthorised items or gifts to prisoners
- Allowing prisoners to use phones or be alone in offices

Any breach of security may have serious consequences for the prisoner and may cause difficulties for other agencies coming into the prison.

Be aware of prison culture and that some rules and regulations may be covert

Make sure that ID is always carried and visits will usually need to be prearranged.

Working with staff

It is important to work with the prison staff to break down any misconceptions on either side. The work will be much easier with the respect and cooperation of the officers, some of whom are doing excellent work around HIV and sexual health in very difficult conditions.

Good networking is essential in the care of the inmate - it is important to know when they may be going to court, if they are going to be transferred or released.

Be aware of confidentiality.

Working with prisoners

If a prisoner has an appointment outside, two officers, usually, will accompany them. The understanding is that unless the prisoner is a significant risk, the confidentiality of any medical consultation will be respected, and the prisoner allowed to be uncuffed.

It is important to be aware that appointments may be cancelled at very short notice often due to shortage of officers to transport the prisoner.

The counselling environment is very different - there may be restrictions on time and place, and the inmate will not necessarily be advised of their next appointment especially if it is outside the prison.

It is important to encourage prisoners to use other services and try to identify sources of support, for example a particular wing officer, other prisoners, probation officer or psychologist.

If seeing a prisoner without a chaperone, general health and safety rules apply such as location of emergency buzzer and seating arrangements in the room.

Partner notification

The Home Office study found the rate of STIs higher than in the general population. 22% of the sample reported having had an STI. In the national survey of sexual attitudes and lifestyles in 1994, it was found that 8.3% of men had attended a sexual health clinic and nearly 12% in men aged 25 – 34. The prison sample reports much higher rates than this but direct comparisons with national data are difficult.²⁴

Each prison will have its own individual system for the management of sexual health issues, and the following steps will be useful for partner notification purposes, both patient and provider referral:

- Establish which prison the individual is in. If this is unknown, the court that the individual attended can be contacted to find out which prison they have been allocated to
- Establish the date of birth
- Get a prison number if possible
- Telephone the prison and speak to the healthcare team
- Establish who is responsible for GUM, and the type of service provided
- Liaise with the medical/nursing staff whether in the prison or in the local GU service
- The diagnosis of the index patient may need to be disclosed to clarify any urgency in the testing or treatment of the contact
- The prison will inform the health adviser if the individual has been transferred or released
- Arrange to verify that the prisoner has been screened and treated

If undertaking partner notification, whether verifying a patient referral, or carrying out provider referral, the individual circumstances of the patient and their relationship with the prisoner need to be considered. The risks to contacts or the inmate may override any duty to inform contacts. It may be more difficult to resolve partner notification, but there is usually a medical officer to whom information can be passed on and they can call the prisoner down for a check-up without compromising confidentiality.

USEFUL RESOURCES AND ORGANISATIONS

Resource Guide to HIV Health Promotion in Prisons published by The National HIV Prevention Information service, Health Development Agency, Trevelyan House, 30 Great Peter St, London, SW1P 2HW

National Aids and Prisons Forum

NACRO, 169 Clapham Park Rd, London, SW9 0PU

HM Prison Service Directorate of HealthCare

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Section F

Sexual health promotion

Theories and principles

Standards and guidelines

Theories and principles

HEATHER WILSON

Health promotion is a developing field. An understanding of the theories and definitions of health and health promotion are essential to good practice.

The Ottawa charter is presented as a framework for health promotion within the health adviser role.

The ethical considerations of health promotion practice are reflected upon.

DEFINING HEALTH

The official World Health Organisation definition of health was agreed in 1946 as: “a state of complete physical, mental and social well being and not merely the absence of disease.”¹ Health, therefore, is multi faceted and encompasses the whole person, not just their physical body.

The WHO definition above could realistically allow us to intervene in any aspect of a person’s life and justify it as health promotion. Their 1985 discussion paper of the principles health promotion contains the following useful definition:

“Health is, therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities.”²

The debate about how to define health was very helpfully summarised by Seedhouse.³ He identifies four groups of theories:

- Health is an ideal state
- Health is the physical and mental ability to do socialised daily tasks
- Health is a commodity, which can be bought or given
- Health is a personal strength or ability, physical, metaphysical or intellectual

After discussing the problems with each approach he provides a useful model, whereby there is a limit within which there is a full sense of health, but the boundaries of this limit are necessarily fuzzy. The central core provides the 'Foundations of Achievement' for the individual. This he argues work for health must be enabling, allowing individuals to build on their foundations.

Seedhouse believes that health workers are "under the spell of medicine" and remain bound to the medical model. He argues that the problem is the popular view of health as beginning with disease and not as a quality in its own right.⁴

Other writers have argued that the problem is that health workers are often accountable to clinicians. If medical personnel set priorities, then the health promoter is often required to concentrate on the medical flavour of the month.⁵ Tannahill describes an experience of teaching medical students; when he asked them to define health they suggested "the absence of clinical signs". However, when they were asked to define their own personal health they were concerned with self esteem, physical fitness and mental and social well being. They did not mention illness or disease. When asked to consider the dilemma of 'straight jacketing' patients within a medical definition, yet defining their own health in positive terms, they could offer no defence.⁶

With such flexible and broad definitions of health, the problem for health promoters can be in essence deciding what to promote. If health encompasses a broad spectrum of well being, including psychological and social, confusion and conflict of interest can arise. Health professionals of all disciplines, and even those working in other agencies such as welfare, could make the case that they do health promotion, particularly if they believe that resources will be allocated as a result. An example is given by Yeo,⁷ whereby a Canadian health department guidelines document places transplant programmes under the heading of health promotion.

DEFINING HEALTH PROMOTION

Health promotion theory has a multi disciplinary background. There has been much debate about what makes it a unique activity whereby some tasks will fall within the criteria laid out in accepted theory. There has been a paradigm shift in recent years from health education to health promotion. Some models view health education as one of the activities of health promotion. Health education became tainted with the criticism that it was tantamount to victim blaming.

Tannahill describes health promotion as three spheres of activity, health education, health protection and prevention.⁸ Other theorists, such as Seedhouse⁹, Tones¹⁰ and French also subscribe to the idea of health education being the teaching arm of health promotion. French contends:

*"Health Education is a practical endeavour focused on improving understanding about the determinants of health and illness and helping people to develop the skills they need to bring about change. Health Promotion is a convenient conceptual tool which enables us to order our understanding of those often diverse elements within society that have the potential to promote health."*¹¹

DEPRIVATION AND HEALTH

The Black Report,¹² published in 1982, firmly established the link between poverty and ill health. For health educators it became untenable to continue to simply promote lifestyle change, particularly as the Report demonstrated a link between poverty and heart disease. This added to the growing discomfort about health education programmes that merely stressed behaviour change. With the clear link between deprivation and poor health established, it becomes salient to ask why certain causal factors are selected for intervention and not others, for example putting resources into a stop smoking campaign instead of improving the quality of public housing.

“Words like “lifestyle” and “behaviour change” are now on the lips of every ambitious health professional, and there is a growing research industry busily investigating why human beings (especially the ubiquitous social classes four and five) persist in the perverse pursuit of bad health”.¹³

Health advisers need to be mindful of the complex social and psychological factors that may be contributing to the ‘persistent perverse pursuit of bad health.’ This is especially important in our one to one work with the patients who present regularly with reinfection or multiple infections, or young people who continue to risk pregnancy. Sir Donald Acheson’s Inquiry into Inequalities in Health in 1998 discusses the higher risk of teenage pregnancies in young people from deprived areas. The report points to an overemphasis on the individual factors associated with teenage pregnancy rather than programmes that aim to reduce inequity.¹⁴

This concern that ‘lifestyle’ based health promotion can be tantamount to victim blaming was shared by health professionals globally. The first International Conference on Health Promotion in 1986 addressed this concern and the result was a new framework for health promotion, which would become the international guideline for good practice.

THE OTTAWA CHARTER

In 1986 Jake Epp, the Canadian Minister for National Health and Welfare released a framework for health promotion which addressed the fact that people have unequal opportunities and achieving health is often due to factors beyond the individual’s control. His framework defined health promotion as a multi faceted activity that sought to reduce inequities and increase prevention. It was presented at the International Conference of health promotion in Ottawa and later became known as the Ottawa Charter.¹⁵

The WHO has since regarded the Ottawa Charter as a working document. It is a consensus opinion about health promotion and the framework that it proposes is considered to be good practice for health promotion strategy. It sets out five key areas for practice:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Re orientating services¹⁶

As Yeo argues, the Charter transcends the individual versus the public health debate and overcomes the problem of victim blaming. It does this by bridging the individual and the community and providing what he describes as “an ethic of empowerment or enabling.”¹⁷

APPLYING THE PRINCIPLES OF THE OTTAWA CHARTER TO HEALTH ADVISING

Building healthy public policy

The Teenage Pregnancy Strategy and the Sexual Health Strategy are examples of healthy public policy, as is the Healthy Schools Scheme. Health advisers should be involved with the implementation of these on a local level. In those areas that have a Teenage Pregnancy Co-ordinator, the health adviser should meet with them and be involved in any appropriate initiatives, or work with other agencies and colleagues to develop initiatives.

Health advisers can be involved in the development of and ongoing support for sexual health promotion or condom distribution schemes in relevant services or support groups, such as those for young people, gay men or African communities.

It is good practise for health advisers to liaise with their local public health colleagues wherever possible. This is important if there is a local outbreak of an STI but it can also provide an opportunity to contribute to local public health policy, such as the Health Improvement Plan. (HIMP)

Creating supportive environments

Health adviser's work in the community can help to create environments conducive to the promotion of sexual health. This begins with the clinic environment. Clinic services need to be developed according to local needs. For example, young people's clinics have been established after very large surveys in local schools identified how the young people wanted the clinic to be set up.¹⁸ It is important to identify gaps in provision. If a clinic is attracting significantly more of a particular client group, and this doesn't reflect the local population, then the groups who aren't attending need to be asked how the environment can be changed to suit them. For example, mixed waiting rooms may be difficult for some cultures, and intimidating for some young people.

Health advisers can be involved in other settings, such as youth clubs, drop in centres or outreach projects, which aim to create a supportive environment to their client group. An example of good practise is the provision of a youth work or social work session within a young people's clinic.

Strengthening community action

Community health advisers and health advisers who work in outreach projects, such as those for commercial sex workers, need to consider their role and the style of community work they are practising.

For example, a community development approach usually means involvement with a community group for a certain length of time, with the aim of enabling and, eventually, empowering them to support themselves. Peer education is an example of this, but it can also work in outreach projects, such as with commercial sex workers in stable environments such as sauna's or flats. Some projects have helped sex workers organise their own condom distribution scheme and enabled some sex workers to educate their peers about sexual health and encourage their use of services. This approach requires intensive work initially, but

contact can be reduced once the client group are supporting themselves, thus allowing the outreach workers to move onto intensive work with other clients.

The community action approach, as developed by such workers as Alinsky, requires the worker to become part of the community. Alinsky and his colleagues used to live in the communities they worked in, which were deprived neighbourhoods in the USA. The locals would regard them as “one of them” and work with them to effect change, such as improving housing.¹⁹ These ideas can be usefully adapted to community health advising or outreach work. While working as a sexual health professional requires very strict boundaries, many health advisers are in post for a number of years, and very effective outreach work can be done by building up trusting relationships with and being regarded as an advocate for the groups you are working with. Health advisers have successfully used this approach in community settings, such as support groups, drop in centres or youth clubs.

Developing personal skills

Health advisers have a unique opportunity to do this. The skills we are most likely to be promoting are condom use and negotiating safer sex. Handing out condoms isn't good enough. We are frequently reminded in our work of the internal and external factors that make condom use complicated for the individual. Demonstrating and teaching correct technique is an empowering tool but it must be accompanied by consideration of the situation for that individual and their relationships. “It is important for the counsellor to show that they understand the reservations that the client may have, while still projecting a positive image of condoms”.²⁰ Interventions which aim to enhance self esteem, build skills and develop the community have proved to increase condom use significantly compared control groups who are just provided with condoms.²¹ The Center for Disease Control (CDC) community condom demonstration project intervention in the USA, which had a study population of 15,205 people, found a significantly greater use of condoms in their intervention community than their control community.²²

Health advisers work with a large number of individuals and are skilled at making quick assessments. This volume of experience means that we are realists and able to work from where the patient is at. It is usually not good practise to “tell people what to do.” Often patients are able to disclose to the health adviser behaviours or partners that they have felt unable to discuss with other health professionals. We accept and acknowledge their personal strategies for their own sexual health. Health advisers are aware that there is nothing to be gained by making blanket statements or demands, which place unrealistic expectations on our patients.

Our own values about sexuality and sexual behaviour need to be reflected on and not allowed to impede our work. Dealing with our own experiences is also important. “If workers have unresolved anxieties, distress or anger around some of their own issues and experiences, this may prevent them from being able to offer support to young people in these areas.”²³

Re-orientating services

Health advisers can play a vital role in encouraging services to become sexual health promoting. Training workers is often the best use of oneself as a resource. For example training youth workers or school nurses in sexual health promotion and being available to them to support their ongoing work. Community health advisers work with primary care and are in a position to support sexual health promotion at GP's surgeries. Again running training programmes for GP's, practice nurses, and reception staff may be the best way to achieve this.

Health advisers usually take the lead in their own clinic for sexual health promotion. This includes leaflets and other resources, which need to be kept up to date, and reflect the demographics of the clinic attenders. This is an expensive and time consuming task if not undertaken with the support of health promotion and it is helpful to work in partnership with them.

The clinic service needs to be orientated to suit the needs of the local community, and to facilitate access for disenfranchised groups. This requires effective networking with local services and fast track services where appropriate. For example, fostering links with residential units for looked after children and providing a fast track service for the residents.

Working within educational settings.

Health educators who wish to overcome the problem of “victim blaming” while working within the framework of education have used the methods developed by Paolo Friere. During the 1950’s, while implementing a successful literacy programme for those living in shantytowns in Brazil, Friere developed a process of critical consciousness raising that he named “conscientization”. The community educator would be the facilitator for a community to identify their own problems and priorities. The facilitator would encourage critical thinking, requiring the community to explore the causes of their problems. They would then consider solutions, although the focus was on the learning process and long term goals were encouraged. The final stage would be an action stage, followed by reflection. Friere based his process on his belief that education can never be neutral, it occurs within the context of people’s lives:

“Conscientization occurs simultaneously with the literacy or post literacy process. It must be so. In our educational method, the word is not something static or disconnected from men’s existential experience, but a dimension of their thought language about the world”²⁴

These methods have been applied to health education programmes, and are particularly applicable in peer education. They have been used in the USA to work with school students on substance misuse prevention.²⁵

It is good practise to be involved with local peer education initiatives. These can be much more empowering than “giving a talk” to an assembly. Health advisers have limited time for schools work. The most effective use of that time is to work with those who spend the most time with the students. That is, the teachers, school nurses, parents, and, most effectively, their peers. As the facilitator for a student group the health adviser is a resource that the group can utilise to develop their own programmes and health promotion resources. The teacher working with the group can assist them in distributing the resources to the other students, and to other schools in the area.

The ‘Healthy Schools Scheme’ is a WHO project which encompasses schools all over Europe. Most local boroughs will have a scheme whereby schools work toward awards, which grant them the title of a “Health Promoting School” in a particular area, such as psychological health, drug misuse, or sexual health. It is a very appropriate use of health adviser resources to be involved with the sexual health module of the local scheme. The health adviser can contribute to the preparation of the material for the module and support schools who are working toward the award. Some schools may ask the health adviser to run workshops for pupils in the area of sexual health or contraception. If you have the resources to do so, this should be undertaken with the collaboration of health promotion, who often have the most useful training materials, and the school nurse. It is important not to duplicate or undermine the work already being done by the scheme in your area.

How people learn

Anyone who has stood in front of a class or assembly and attempted to talk about sexual health or contraception will be aware of how ineffective the “talk and chalk” method of teaching is. Learning theory has shown that students need to spend as little time as possible on the passive tasks of listening and reading, and as much as possible on activities and participatory exercises. Because there is so much information in the world, which is easily retrievable, learning has become focused on processes, such as problem solving and logical thinking, rather than memorising facts.²⁶

It is good practise to keep up to date with health promotion resources and training materials. The expertise of local health promotion colleagues is very useful when planning a workshop or lesson.

Health advisers are sometimes asked to show slides of different infections, such as warts and herpes to students. This is not good practise. It has been shown that negative images just lead to denial in those seeing them and a sense of “it won’t happen to me.” They can also be very distressing. There is no advantage to this approach, as we aren’t promoting self diagnosis, and symptoms are often much less extreme than those shown in medical pictures. A recent meta analysis of sex education in schools concluded:

“Adolescents have suggested that sex education should be more positive with less emphasis on anatomy and scare tactics; it should focus on negotiation skills in sexual relationships and communication.”²⁷

A study of an intervention where a person with HIV gave talks to students about their diagnosis found that this just caused the students to feel distressed. Although they may find it “interesting” to meet someone with HIV, this may be of limited educational value. Asking any person to talk about their own experience must be considered very carefully, as it can be voyeuristic and upsetting for those listening.²⁸

ETHICAL AND PHILOSOPHICAL CONSIDERATIONS IN HEALTH PROMOTION

What are we promoting?

Reflecting on how we define health and how this affects our practise raises an ethical dilemma for health advisers.

Health advisers often work with the ‘worried well’ These people will present with an anxiety about illness that is overwhelming. Their quality of life has become impaired by this anxiety, yet they usually have an absence of disease, which, in itself, is not enough reassurance. In contrast, there are the individuals who have multiple medical problems, yet describe themselves as ‘well’ and enjoy a quality of life which may surpass the worried well. This situation can be paradoxical and frustrating if health is viewed as an absence of disease. “There is, in a word, “care” as well as health to consider. Even just listening to, and attending to, the worried well is part of healthcare.”²⁹

The person who feels that condom use causes psychological or psychosexual problems for them can highlight the ethical problems of the individual vs. the public health that is inherent in the health adviser role. However, while a demonstration of correct condom technique may be of some benefit, a holistic view of the individual and their health needs fosters consideration of the power and self esteem questions that are linked to their psychological

health. It can then be more helpful to explore these questions and consider that the patient may have chosen to place their psychological needs above potential physical harm. Health advisers will often choose to discuss harm minimisation or risk reduction techniques in this situation.

Truth is relative

Although scientific method is design to reveal “facts” in an empirical way by objective observation, this doesn’t mean that research, even if it meets stringent scientific standards, has uncovered the “truth”. Popper argued that at best we can only hypothesise and we are only ever left with our own truths about our own version of the world. His theory of Falsification posits that a scientific “fact” is only true until it is disproved or “falsified”. He maintained that the greater the empirical claims of any theory, the more falsifiable it is.³⁰

The production of knowledge is fraught with difficulty and conflicting ideas. For example the social sciences may believe that qualitative research produces useful information, but for some scientists only quantitative objective methods, such as randomised controlled trials, are considered worthwhile. Talbot³¹ has helpfully summarised this debate and he points out that most scientists will reluctantly admit that there is no such thing as “objective scientific knowledge”.

Health advisers need to keep up to date with the latest research and guidelines about sexual health. Sometimes patients will be confused by changes in protocols or regimes; cervical screening guidelines over the past few years are a good example of this. This also happens in community messages, such as advice about thicker condoms, which has failed to be endorsed by clinical research. An appreciation of the fluid and occasionally subjective nature of scientific knowledge, allows for a helpful presentation of the current “facts”. The latest thinking and guidelines on a subject can be summarised in an accessible way, with the aim of enabling the patient to understand the reasoning behind the advice they have been given.

Medical Ethics

“Experts have no special prerogatives entitling them to make judgements for the rest of humankind.”³²

Do we regard good health as a goal in itself? It is reasonable to assume that for most of us, death is a negative state and we value the states of being alive and of being healthy. With this as a value base, health advisers will promote behaviours and treatments that we believe are in the best interests of our patients. “It is common to feel that one’s own preferences reflect values that reasonable people adopt; one can hardly regard oneself as unreasonable”³³

However our patients may not share our regard for their own health, or indeed our definition of what it is for them to be healthy. While we may be motivated by beneficence, the desire to do good, our actual practice is vulnerable to paternalism. Is it paternalistic to give selective information to patients? It would be impractical to belabour all the possible negative side effects of an antibiotic when discussing treatment, but is the decision not to do so pragmatic or paternalistic? We have probably all heard the argument from colleagues that they don’t wish to give upsetting information to patients. For example, they may brush over asymptomatic transmission of the herpes virus, or health promotion leaflets and materials will often simply promote condoms to prevent infections such as herpes or warts, without explaining that they can only partially protect against these infections.³⁴ Is this motivation non-maleficence, (not doing harm) or is it again paternalistic?

The problem of victim blaming in health promotion is intensified in the field of sexual health. Not only are we attempting to educate and empower our patients to protect themselves from contracting STIs, we are also at the forefront of trying to prevent the spread of infection and are involved in surveillance and monitoring with our public health colleagues. Thus we can be in the invidious position of the individual feeling that they are being blamed for their own misfortune, but also for the spread of infection to others. As health professionals we need to resist the idea of the 'innocent party'. Whilst supporting people to protect themselves from infection or unwanted pregnancy, it is important to focus on their personal strategies rather than 'risky' or 'dodgy' sexual partners. I have discussed earlier how the principles of the Ottawa Charter help to overcome the problem of victim blaming, yet it is our dual role, working for the individual and the public health, and the ethical dilemma's within, that provides a further challenge when planning or undertaking sexual health promotion.

CONCLUSION

Health Promotion is a growing field of theory and practice. This chapter has aimed to explore how health advisers can apply health promotion theory to their work as well as reflecting on the ethical dilemma's inherent in health promotion practise. The following chapter provides detailed protocols and guidelines for developing and implementing sexual health promotion in both clinic and community settings.

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Standards and guidelines

DEBBIE KLEIN, FIONA SAWNEY AND DORINDA THIRLBY

Based on a document written for the SW London HIV/GUM Network Sexual Health Promotion Subgroup.

The aim of this chapter is to:

Set out good practice guidelines and recommendations for developing sexual health promotion within genitourinary medicine (GUM) services

Maximise the opportunities for, and the effectiveness of, interventions that promote the sexual health of clinic attendees

Outline best practice standards based on evidence of good practice and national and local recommendations for service developments.

They are in line with national strategies for HIV prevention and sexual health promotion

STRATEGIC FRAMEWORK

Sexual health promotion work in the GUM setting needs to be developed in line with national and local strategies. Each clinic will be working towards meeting several key targets outlined in the following different strategies:

National strategy for sexual health and HIV¹

There are 5 main aims of this strategy:

- Reducing the transmission of HIV and sexually transmitted infections (STIs)
- Reducing the prevalence of undiagnosed HIV and STIs
- Reducing unintended pregnancy rates
- Improving health and social care for people living with HIV

- Reducing the stigma associated with HIV and STIs

This includes the following key actions for GUM clinics to work towards:

- Developing the health adviser's role
- All homosexual and bisexual men to be offered hepatitis B vaccine on first attendance at GUM clinics
- Increasing the offer and uptake of HIV and STI testing through a range of measures
- Each PCT will be leading on local implementation, with the strategic health authority overseeing and performance monitoring the process.

African HIV Prevention Strategy (National AIDS Trust/African Policy Network) ²

This strategy may be used to inform HIV prevention programmes and GUM clinic services as they are developed. It is important to ensure that information and HIV prevention activities are accessible to this patient base and that they are culturally and linguistically appropriate.

The strategy identifies the following needs:

- The need for knowledge (basic HIV and STI information)
- The need for skills
- Building a safer sex culture (gender and age specific issues)
- The need for accessible and appropriate services (including condoms)

Making It Count – Gay Men's HIV Prevention Strategy ³

This is a theory, ethics and evidence based health promotion framework for HIV prevention with gay and bisexual men that has been adopted as the best model for prevention work, and includes the following key aims:

- Men are able to choose who they have sex with and what kind of sex they have
- Men are equipped and competent to negotiate sex
- Men are knowledgeable about HIV, its exposure, transmission and prevention
- Men are aware of the possible HIV related consequences of their sexual actions for themselves and their sexual partners
- Men are free to choose whether or not to test for HIV
- Men are knowledgeable about HIV testing and the meaning of HIV test results
- Men have access to quality HIV testing services
- Clear and unambiguous naming and labelling of condoms and lubricants
- Men are knowledgeable about STIs, their transmission and prevention

- Men are knowledgeable about clinical sexual health services
- Men have access to quality clinical sexual health services

There is a range of methodologies outlined in the framework and key settings are identified, including sexual health services. Factors that influence the reduction of unprotected anal intercourse include:

- Reducing the barriers to sexual choices and increasing the control men have over the sex they have
- Increasing men's sexual negotiation skills and their access to condoms
- Educating men about HIV, its exposure, transmission and prevention, for example, reducing condom failure
- Raising men's awareness of when their engagement in unprotected anal intercourse might be sero-discordant

Teenage Pregnancy Strategy

Each local authority area has developed a teenage pregnancy strategy with the dual aims of:

- Reducing the number of under 18 conceptions by 50% by 2010, by improving sex education for young people, improving services, and targeting prevention work to young people most at risk
- Increasing the support available to teenage parents, and increase the number of teenage parents in education, training or employment
- Each area has a local teenage pregnancy co-ordinator who can liaise with clinics and help to ensure that any outreach work with young people, schools or community groups is co-ordinated

WHAT IS SEXUAL HEALTH PROMOTION?

There are a number of definitions about what constitutes sexual health. The following from the World Health Organisation is probably the most useful in considering health promotion in the GUM service.

"Sexual health comprises:

- *Capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic*
- *Freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships*
- *Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions"* ⁴

In it's widest context sexual health promotion can include "...any intervention that improves a person's physical or psychological sexual well-being." ⁵

QUALITY STANDARDS FOR GOOD PRACTICE

It is recommended that the following standards be endorsed by each clinic to underpin the further development of sexual health promotion. The standards are taken from Effective Sexual Health Promotion ⁶ and provide a useful framework to underpin future work. In order to be effective, sensitive and appropriate in meeting the multiplicity of needs within communities, all sexual health promotion work, including that in GUM clinics:

Have an ideal values base which:

- **Ensures sexual health promotion is accessible to all and takes account of particular needs:** for example in terms of people whose first language is not English and people with a visual or other sensory impairment
- **Affirms diversity:** for example in terms of sexuality, ethnicity, age or ability and reflects this in all practice
- **Ensures that individuals and groups are able to resist coercion,** pressure, exploitation, abuse, harassment and bullying
- **Supports the development of self-esteem.** Self esteem plays a vital role in enabling individuals, groups and communities to negotiate equally and to make choices and decisions that will enhance rather than detract from their sexual health and well-being
- **Builds a clear sense of rights** of individuals, groups and communities to positive sexual health and to services which support this
- **Enables people to develop practical skills**
- **Is grounded in a positive and holistic model of sexuality and sexual health**

Supportive methods of working:

- **Promote collaborative and multi-agency work** including partnerships with the voluntary and community sector
- **Actively counter and challenge discrimination, stigma and prejudice.**
- **Acknowledge and support the rights and responsibilities** of individuals, groups and communities in relation to their sexual health and well-being
- **Create opportunities for discussion,** reflection and exploration of issues, attitudes, values and beliefs in relation to sexual health
- **Are informed by a research and evidence base** which ensures maximum effectiveness and best use of resources
- **Engage people's intellect, experience, thoughts, and feelings** to create a positive culture, which is more tolerant, affirming and celebratory about sexual health and sexuality as a vital element of human experience

Quality services and support would:

- **Be offered in non-judgemental, respectful and sensitive ways**

- **Provide clear, accurate, up to date information** in attractive and accessible forms and languages
- **Offer support** and information which will enable people to make healthy sexual choices and relationships
- **Are provided by staff who are aware of the values base described here** and who are trained, skilled and confident to work in ways which exemplify this

EFFECTIVENESS OF HIV PREVENTION HEALTH PROMOTION INTERVENTIONS

HIV prevention initiatives have been reviewed for evidence of effectiveness for the Health Development Agency.⁷ The authors found that the review-level-evidence was heavily skewed to non-UK research about a narrow range of individual/ group-level interventions, which were relatively easy to control and so lend themselves to experimental evaluation. The report states that it is important to emphasise that no evidence does not equal evidence of ineffectiveness, and has produced research recommendations to supplement the existing evidence base. The review focused on the priority populations for the sexual transmission of HIV in the UK, namely men who have sex with men, African communities, commercial sex workers and people with HIV. The following policy and practice recommendations are made:

1. Men who have sex with men. There is some evidence that community level interventions involving peers and popular opinion leaders can be effective in influencing the sexual risk behaviours for men who have sex with men. There is also some evidence that cognitive behavioural group work focused on risk reduction, sexual negotiation and communication skills training (and rehearsal, for instance through role play) can be effective. However, it is questionable how generalisable these interventions may be to the UK and/ or non-white, non-educated men who have sex with men. Interventions with men who have sex with men are more likely to be effective if they are:

- placed within the broader context of men's lives, addressing the range of factors which influences at both the personal level (for example- knowledge, skills) and the structural level (for example discrimination towards gay men, gay community norm towards condoms)
- tailored and targeted to specific sub-populations of men who have sex with men, for example black gay men and working class gay men
- multi-component (using small group work), focusing on risk reduction, sexual negotiation and communication skills training and rehearsal (for example through role play or identifying 'triggers')

2. Commercial sex workers. Interventions delivered at a community level, particularly peer-led can be effective in influencing the sexual risk behaviours for commercial sex workers.

3. African communities in the UK. Small group interventions delivered at community level can be effective in influencing the sexual behaviours of black and ethnic minority women, however it was not possible to transfer the findings to the UK's African population.

4. HIV counselling and testing. There is some evidence that suggests that counselling and testing can influence sexual risk behaviours particularly amongst serodiscordant couples,

where one partner learns that they have HIV. However the effect of an HIV negative diagnosis may be detrimental where people may have a false sense of security, perhaps leading to increased risky behaviour. The review concludes that current evidence suggests that voluntary counselling and testing should be targeted only at high risk individuals who are likely to be positive.

The evidence suggests that the main features of effective health promotion and education interventions:

- Incorporates theoretical models of behaviour change, or components of these models, as a basis for intervention development and implementation
- Provides basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse
- Use a multi-faceted approach, including a number of components- such as skills development, motivation building and attitude change in addition to factual information. Information provision alone is insufficient to influence behaviour change. Personal and structural factors such as attitudes towards safer sex and condoms, motivation, the influence of significant others, wider social influences, as well as practical skills all play an important part in the ability to change behaviour
- Incorporate specific behavioural skills training, for example, how to use condoms
- Are based on detailed understanding of background behaviours, beliefs and risk perceptions of the target population. Formative research can be useful in developing programmes which are appropriate to the target population in terms of age, gender, sexual experience and culture
- Make use of peer educators
- Place emphasis on promoting condom use, rather than abstinence. Telling people not to have sex is unlikely to be an effective intervention
- Are of appropriate duration. It requires considerable time and multiple activities to change long established sexual risk-taking behaviour

SEXUAL HEALTH PROMOTION IN THE GUM SETTING

It is important to acknowledge that patients are not generally attending the clinic for advice about behaviour change. In order for opportunities for sexual health promotion to be maximised the following issues need to be considered:

- The raising of sexual health promotion issues is generally opportunistic, recognising the need to first address the concerns for which the patient has attended
- Ideally there are regular opportunities for skill sharing, training and the dissemination of good practice in health promotion and the needs of different patient groups
- There is a need to acknowledge that the pressures of time and the need to perform other tasks during the consultation will limit interventions

- The approach to health promotion is best patient led and acknowledges the need to prioritise the patient's presenting problem

IDENTIFYING SEXUAL HEALTH PROMOTION NEEDS

Sexual History Taking

A full sexual history is usually taken for all GUM patients at their first visit and with re-attenders as appropriate. If undertaken in a planned way sexual history taking is an essential tool for risk assessment for targeted sexual health promotion work and for partner notification when indicated.

While sexual health promotion activity is usually recorded in clinic notes, there is a need to develop a standard format for recording sexual histories, including sections on discussing prevention for both nurses and health advisers.⁸

By collecting detailed information, the most appropriate sexual health promotion work can be undertaken dependent on a patient's risk, for example, for pregnancy or for STIs. A full sexual history needs to include the following to enable an accurate assessment of risk:

- Partners in the past three months (and how long ago was their previous sexual relationship if only one partner in the last three months)
- Gender and sexual orientation and enquiry about previous 'same sex' relationships
- Type of sex, for example vaginal, anal and/or oral (different information asked dependant on patient's sexual orientation)
- Nature and context of their sexual relationships, for example duration of the relationship and whether partners are 'regular', 'known', 'casual', 'wife' etcetera
- Contraception/ barrier protection/ safer sex/ risk reduction information. It is important to raise the use of contraception with all sexually active heterosexuals
- Specific risk factors for HIV/ blood borne infections for example whether the patient is, or has had a sexual partner who is a man who has sex with men (MSM), an injecting drug user (IDU) or has had sexual contact with a person from an area of high prevalence, blood transfusion recipient prior to screening or a has had sexual contact with a partner known to be HIV positive)
- Previous STIs and relevant contact information, for example contact slips/ information gained from cross referencing of notes
- Previous vaccination or known natural immunity, for example gay men for hepatitis A or B
- For people under the age of 16 it is also essential to undertake an assessment of competence using the Fraser guidelines and for patients under 18 it is important to be aware of the requirements of the Children Act, and to be aware of the local child protection and referral procedures (see chapter on young people)

Risk Assessment

Demographic details collected at registration may highlight the need for a discussion on increased risk of STIs, for example:

- Young age, especially under 16s ⁹
- Country of origin, for example, people from countries with a higher prevalence of HIV such as South Africa, Sub Saharan Africa
- Ethnicity, for example, identifies as 'Black' ^{10 11}

It is recommended that clear protocols and referral processes are identified in each clinic to ensure that targeted health promotion be offered to all patients who are perceived to be at increased risk of an STI or unwanted pregnancy. This is a clear requirement of the national Sexual Health Strategy, which aims to reduce the number of undiagnosed people with STIs, including HIV, in the population.

TEAM ROLES IN SEXUAL HEALTH PROMOTION

The following is based on work done by the Society for the Advancement of Sexual Health (SASH). ¹² In order to promote sexual health effectively a multi disciplinary team needs to:

- Recognise the importance of sexual health promotion
- Develop a shared philosophy
- Seek to develop trusting, non judgmental and respectful relationships with service users
- Be pro-active when appropriate
- Aim to develop consistency in messages and information regarding sexual health
- Have a clear understanding of the different roles within the team and refer appropriately
- Respect and value each others skills and experience
- Be keen to develop knowledge, skills and attitudes
- Recognise diversity amongst individuals and communities and aim to make the service accessible to all service users

The key to developing health promotion within the clinic is the ability to work effectively as a multidisciplinary team. In order to achieve this, it is important that team roles in health promotion are clearly defined and co-ordinated and the different skills within the team are valued and maximised.

The recommendations on staff roles in sexual health promotion in this paper have been adapted from "Developing a sexual health promotion strategy in the GUM Service" Camden and Islington Community Health Services Trust January 1994. ¹³ While these are still useful guidelines, successful implementation will depend on the issues particular to each clinic, such

as clinic size, structure, current staffing levels, and perceived needs of attendees and availability of resources.

As stated in The Camden and Islington document:

*"Attendance at a GUM clinic involves the patient having one to one contact with a health professional which allows for detailed discussion about the sexual behaviour of that individual. GUM clinics are therefore ideal settings for sexual health promotion to take place, complementing other existing strategies to deal with STIs in the community."*¹⁴

Doctors, nurses, health advisers and receptionists all have a role in health promotion. These roles need to be clearly defined and co-ordinated. If roles are not clearly defined there is a danger of either overloading the patient with advice or missing out health promotion altogether.

Clear documentation of health promotion related discussion means that duplication can be avoided and team members can build on previous interventions. If members of the team are giving different messages about sexual health, for example risks of transmission attached to sexual activities patients will be confused and less likely to follow any advice given. Where good practice is not shared, methods of promoting sexual health which have been shown to have little impact may be used, for example, giving out 'standard' information rather than relating it to the individual. While all clinic attendees are ideally given the opportunity to discuss prevention and related issues, it is important that team members use their skills and experience to assess the appropriateness, relevance and timing of any intervention.

Doctors

Sexual health promotion is an integral part of the GU doctor's role. The routine GUM consultation presents numerous opportunities for HIV/STI prevention. It is considered good practice that doctors discuss HIV/STI prevention with all new patients and with re-attendees as appropriate.

To fulfil this role doctors:

- Identify how they will fit explicit sexual health promotion routinely into their role
- Recognise that patients presenting with an infection or potential infection may be particularly receptive to sexual health promotion advice and harm reduction messages.
- Evaluate current sexual behaviour, using a standard and recommended approach to sexual history taking
- Advise about risks attached to different sexual activities
- Discuss condom use, identifying potential problems and refer for condom demonstration/ discussion where appropriate
- Help the patient reflect on personal situation and encourage them to make changes which will minimise risk
- Identify whether there is a need for referral or further discussion with another team member as per clinic protocol, for example health adviser, psychologist, outside agency

- Discuss prevention and HIV testing regardless of whether the patient raises HIV testing or health promotion themselves. The national Sexual Health Strategy includes a target to increase the uptake of HIV and STI testing, and states that all GUM attendees are to be offered an HIV test on their first screening for STIs, and subsequently according to risk
- Undertake follow up prevention work as appropriate with re-attendees

Nurses

It is considered good practice that all nurses are able to perform a health promotion role when the opportunities for discussion arise. The level of health promotion activity undertaken by the nurses will partly depend on acceptance within the clinic that this is part of their role. Issues of the amount of time the nurses spend with the patient and the lack of privacy for discussion also need to be taken into account.

In order to fulfil their role in sexual health promotion nurses need to be able to:

- Take the lead in giving advice and information on hepatitis B vaccination and human papilloma virus (HPV) and cytology/colposcopy
- Evaluate current sexual behaviour, using a standard and recommended approach to sexual history taking
- Give basic, clear safer sex advice, with reference to risks attached to different sexual practices
- Help patient reflect on personal situation and encourage them to make changes which will minimise risk
- Talk about and demonstrate condom use and routinely offer condoms to patients where appropriate
- Identify patients who need referral onto a health adviser
- Act as a 'safety net' by checking out the patient's understanding and satisfaction with the information/advice given
- Be able to raise and answer questions about HIV testing and identify patients for referral to the health adviser in line with clinic protocols

The family planning trained nurse will also perform a health promotion role in line with the above. In addition the role of the contraceptive nurse will include:

- Advice/information on all forms of contraception, including information on efficacy, advantages and disadvantages and side effects
- Ensure the patient has the relevant information to enable them to make an informed choice
- Check out that the patient is fully aware of how to use their chosen method
- Identify patients requiring emergency contraception

- Identify patients who need referral to a doctor or health adviser

Health Advisers

Health promotion is an integral part of the health adviser's role. The health adviser will discuss safer sex with all patients and offer more in depth prevention work, where this is appropriate. It is therefore important that referral to health advisers be consistent and includes referral for in-depth prevention work based on a clear and consistent assessment process by other team members.

Guidelines and protocols on which patients are referred to the health adviser need to be in place in all clinics with the aim of ensuring that those with particular issues around prevention receive the opportunity for in depth discussion, counselling and support.

Particular consideration needs to be given to including referrals to health adviser that are specifically for prevention counselling, for example, exploring harm minimisation strategies.

Prevention work is also an integral part of the following key health adviser functions:

- Counselling patients with STIs
- Partner notification
- Herpes simplex virus (HSV) counselling and support
- Safer sex support and counselling for patients with, or affected by, HIV
- Pre HIV test discussion and post-test counselling
- Counselling around unplanned pregnancy
- Referral to other services for example psychology, drugs/alcohol services, lesbian, gay and bisexual specific support services

Health advisers also have a key role in disseminating information on prevention and good practice in health promotion across the clinic team.

One of the actions of the national Sexual Health Strategy is to 'develop health advisers' roles and responsibilities within GUM services'. This will have an impact on the ability of health advisers to develop innovative and effective ways of working with different patient groups, including community outreach and support, but this also has clear resource implications.

Receptionists

While the reception team does not have a direct role in sexual health promotion, their importance as the first point of contact with the service ought not be underestimated. The following aspects of the receptionist's role will impact on the effectiveness of health promotion across the service:

- A friendly, non-judgmental approach to patients, in person and on the telephone
- Reassuring patients (where appropriate) about the confidentiality of the service
- Explaining the appointment procedure

- Dealing with difficult and/or anxious patients
- Giving out clinic leaflets or verbal information as to the range of services on offer
- Accessing appropriate members of the team to give information/advice over the telephone
- Being able to give patients a brief explanation of the different roles within the team
- Skills to triage patients presenting with urgent needs in a busy clinic to ensure they are appropriately referred or given appointments

SERVICE STANDARDS FOR WORKING WITH GAY MEN IN GUM

Health advisers may consider developing recommended service standards for GUM clinics to work towards in order to meet the needs of gay men using a framework. These may include the need for each clinic to:

- Have a clear protocol for clinic staff working with gay/bisexual men. This will ideally highlight key areas to discuss in the assessment process and the screening service to be offered, along with information about other relevant lesbian, gay and bisexual agencies
- Have a protocol for hepatitis A and B screening and vaccination
- Agree a process for recording information about sexual orientation of attendees that can be easily audited
- Identify methods for retrospective audit of HIV prevention with gay men. These may include assessment of sexual history taking, as per clinic protocol; identification of which tests have been offered to and taken up by gay/bisexual men; how hepatitis A and B screening vaccination and recall systems have worked; HIV risk discussion and testing; number and type of health adviser referrals, as per clinic protocol; level and amount of risk reduction discussion, support or counselling
- Develop a framework for a health adviser risk reduction interview, based on the 'Making It Count' framework¹⁵ and the skills needed for current sexual relationships. This could include the provision of information about relevant external initiatives, for example the THT/ Healthy Gay Living Centre's (a London gay mens outreach HIV prevention organisation) planned workshop programme
- Ensure that information and/or campaigns provided by gay men's health promotion organisations are also accessible in clinic settings to complement outreach work with gay men and strengthen the impact and opportunity for follow up discussions

FACE TO FACE HEALTH PROMOTION METHODOLOGIES

The "Doing It" Toolkit (Sheffield Centre for HIV and Sexual Health)¹⁶ identifies that in order to be 'effective, sensitive and appropriate', sexual health promotion needs to:

- Be person centred

- Be grounded in a positive, holistic model of sexuality and sexual health
- Create opportunities for discussion, reflections and exploration of issues, attitudes, values and beliefs in relation to sexual health

Implicit in this is that there is no ‘one way fits all’ method of discussing sexual health with patients. Effective health promotion is not simply about information giving. Practitioners will benefit from having a good range of communication skills and techniques they can employ to work effectively with a variety of patients.

Frameworks around the use of counselling skills

The term ‘counselling skills’ does not have a single definition, which is universally accepted. The British Association of Counselling (BAC) Code of Ethics and Practice for Counselling Skills states “ ‘counselling skills are distinguished from ‘listening skills’ and ‘counselling’. Although the distinction is not a clear one, because the term ‘counselling skills’ contains elements of these other two activities, it has its own place in the continuum between them. What distinguishes the use of counselling skills from these other two activities is the intentions of the user, which is to enhance the performance of their functional role (as doctor, nurse, health adviser etcetera), the recipient will, in turn, perceive them in that role.”¹⁷

The BAC goes on to state, “ counselling is an activity with clear boundaries and the client will identify the helper as their counsellor.”

In a clinic setting all professionals who have a health promotion role would be in a position to use counselling skills to enhance that role. In addition, members of the team (generally health advisers) with specific training and expertise would be able to offer (generally short-term) counselling sessions, where appropriate.

One does not need a particular theoretical perspective in order to use counselling skills effectively, however what underpins the practice of both counselling and the use of counselling skills is:

- Confidentiality
- Respect for the patient’s own perception of their experience
- Support for the person in finding their own solution to their difficulties

In a health promotion context counselling skills can be used alongside other forms of interaction such as information and advice giving. A person centred approach to counselling skills would generally be informed by Rogers three conditions for successful counselling.¹⁸ Egan’s three stage skills model of helping¹⁹ is another useful tool in a health promotion context. Both of these approaches are outlined in a number of books focusing on counselling/counselling skills, including ‘Counselling: The Trainer’s Handbook’ Francesca Inskipp (1986)²⁰

Heron’s Six-Category Intervention Analysis (Heron 1986)²¹ is a framework for identifying a range of possible interventions, and has often been used to explore the use of counselling skills within a health setting. As well as outlining the key points of this framework, ‘Counselling Skills For Health Professionals’ by Philip Burnard (2nd edition 1994)²² offers a general overview of the use of counselling skills in a health setting including information about a range of theoretical stances.

While the following is neither an exhaustive list nor detailed explanation of different methodologies, it is meant as an overview of some useful frameworks or models for interacting with patients.

Personal strategy for sexual health

This is a model that was adopted by the Camden and Islington Sexual Health Promotion Group (SHPG). This model may be useful for doctors and nurses who are working within severe time constraints. This model offers the possibility of a routine structure in a consultation, even when taking a more patient centred approach. The SHPG recommends that, in order to help patients develop their personal strategy for HIV/STI prevention, doctors or other health professionals need to be able to carry out the following steps:

- Evaluate current sexual behaviour
- Advise about risks attached to different sexual activities
- Help patients reflect on their own personal situation
- Encourage them to make changes which will minimise risk
- Identify whether there is a need for referral or further discussion with another member of staff (French and George 1994) ²³

In *The Communication Skills of Medical Staff in HIV Prevention* (1998) Jo Mussen writes:

'This model requires a shift away from the traditional focus on the doctor (or other professional) giving expert information on, for example, the comparative levels of risk of different sexual activities and also possibly advising patients to use condoms. While expert information still has an important role to play it cannot stand-alone. The context of a person's life and relationships needs to be investigated and acknowledged if they are to be helped to develop their own personal strategy for sexual health. This model of sexual health promotion therefore takes less of a 'top-down' approach than the medical model. The patient is brought clearly into focus and involved in an interaction with the doctor. The model could be represented as an equation: information on safer sex + the context of the client's life and relationships = a personal strategy for sexual health'.''²⁴

Motivational Interviewing

(Based on Miller and Rollnick "Motivational Interviewing", Guildford Press) ²⁵

This is a framework that enables the practitioner to support patients through the stages of lifestyle change. It identifies a 'change cycle', that each person will go through when considering behaviour change. The main elements of this cycle are:

- Not interested in changing
- Thinking about changing/deciding to try
- Trying to change/changing
- Relapse

Miller and Rollnick suggest it is useful to identify where in the change cycle the patient is, and offer a range of approaches that are appropriate to each stage. This approach also recognises

the importance of ambivalence and resistance within the change process and encourages the practitioner to work with these issues without imposing their own agenda on the client.

Harm Reduction

(Adapted from Evolution: Can Harm Reduction Help in HIV Prevention Work with Gay and Bisexual men)²⁶

The harm reduction model, in common with Motivational Interviewing, is based on a theoretical model of behaviour change. The Stages of Changing Behaviour (researched by Prochaska and DiClemente 1994)²⁷ identifies five stages individuals go through when they seek to change valued behaviour. These stages are:

- Pre-contemplation - not yet considering the possibility of change
- Contemplation - considers change and rejects it. Reasons for concern versus justifications for unconcern
- Planning and preparation - “I’ve got to do something about this problem”
- Action
- Maintenance - identify strategies and support to prevent relapse

This model would see relapse as a possibility within each stage of the cycle. Patients may step in and out of the cycle at any point like a revolving door, dependent on internal and external influences and their strategies for dealing with them.

The process of harm reduction involves considering ‘external guidelines and personal issues relating to the quality of life’.²⁸ The value of behaviours in this context includes their significance in relationships, their potential for physical pleasure and fulfilment and their emotional, social and cultural value. The key stages of the harm reduction process are:

- Clarify the value attached to an activity
- Consider the risk attached to an activity
- Clarify how the value attached to the activity can be maintained while reducing the risk of the activity
- Consider what change is necessary to reduce the risk

Harm Reduction is a model of behaviour change that can be useful in reflecting on change in highly valued behaviour. In a sexual health context this is a way of exploring the value and meaning that unprotected sex or ‘risky’ behaviour might hold for the individual patient. The implications of this model for health promotion thinking are as follows:

- Behaviour change has five distinct identifiable stages of change
- Individuals do not go through the stages in a linear fashion
- At different points, an intervention must focus on different issues with different intensity

- Helping individuals reflect on their ambivalence is a key strategy for helping change

CONDOM DISTRIBUTION AND TEACHING

The aims of condom distribution within the GU clinic setting are:

- To reduce the spread of sexually transmitted infections
- To promote safer sexual practises
- To lower the risk of unplanned pregnancy

It is good practice to have a condom protocol. An example of a condom distribution protocol for GUM is one from Merton Sutton and Wandsworth GUM clinic written in 2001 and included as appendix. This protocol lists the aims and principles that help develop best practice.

Evidence has clearly shown that demonstrating condoms is effective and helps to minimise breakages, especially for younger and less experienced clinic attendees.

DOCUMENTATION OF SEXUAL HEALTH PROMOTION WORK

It is important that good practice is developed through written guidelines/protocols where appropriate, and patients' notes include documentation of health promotion related discussions. Documentation ought to give the next practitioner an indication of the work / discussion that has taken place to avoid duplication of the same messages, and enable them to build on work previously undertaken. Mechanisms need to be identified and agreed for audit of sexual history taking, but this will only be able to be undertaken if sexual health promotion work has been clearly recorded in patient notes.

The following gives ideas for suggested documentation of specific information:

- 'Safer sex discussion' may be measured by time, for example 'brief discussion re safer sex' or 'safer sex discussion 20 min'
- 'Condoms, lubricant given and demonstrated x3 ribbed, x3 extra safe x3 select'
- 'Declines condoms- aware of risk, risk reduction discussed'
- 'Offered (or suggested) referral to psychologist re risk reduction – declines at present'
- 'Concerns with condom breakages - technique discussed'
- 'Difficulty losing erection with condoms- explored when this occurs and will try'
- 'Safer sex negotiation discussion re how to use condoms when out 'drinking''

LEAFLETS

A variety of leaflets are used within the GUM setting, largely provided from public health departments, typically from Health Promotion England, the Family Planning Association (FPA), the Association of Genitourinary Medicine (AGUM), and in-house clinic leaflets.

Leaflets provide a useful tool to stimulate interest and discussions, and to emphasise information given, but need to be used in a planned and appropriate way. They need to be accessible to and appropriate for patients. Simply providing information is not enough to facilitate behaviour change for most people, but may provide a trigger for further work.

Ideally each clinic has a 'leaflet group', for example a health adviser, nurse and doctor. This group may then review the leaflets in the clinic to:

- Make the relevant leaflets available for patients attending GUM
- Standardise the leaflets being given out
- Standardise the leaflets available in waiting rooms
- Ensure they are appropriate to the clinical area they are displayed in
- Promote what leaflets are available and where more specialised leaflets can be found
- Ensure that the leaflets contain the correct and appropriate information and are up to date
- New leaflets are vetted by this group for their suitability, and to ensure they adhere to local guidelines about promotional literature and sponsorship
- Changes to the clinic's own written leaflets may be managed in the leaflets group and then sanctioned by the relevant heads of department meeting
- Clinic written leaflets will need to be checked by the Trust's patient information / liaison departments
- Ensure that leaflets are accessible to all in terms of language, culture, and that they display diverse images to reflect all members of the community

T A R G E T E D D I S P L A Y S

A variety of posters/ leaflets/ display materials are available for use within the GUM setting. These materials are largely provided from public health departments, and some targeted campaigns are sent directly to the clinic, either from the sponsors or direct from Health Promotion England.

- Ideally each clinic has a person or team whom co-ordinates the clinic displays
- It is important that there are permanent notice boards for health promotion materials in waiting areas
- Notice boards for health promotion materials will need to be changed at least bi-monthly
- Clinic displays include the national campaign materials at the relevant time, for example for World AIDS Day or National Condom Week
- Each clinic needs to be aware of other national and local campaigns targeting specific patients, and display posters to complement these at appropriate times, for example

Community HIV/AIDS Prevention Strategy (CHAPS) campaigns which target gay men in community settings

RANGE OF REFERRAL ROUTES

For some patients accessing GUM services this will be an important first step in a process, which may involve other organisations to address their ongoing sexual and mental health needs. Referrals need to be patient centred, and take account of the fact that many people will feel ambivalent about referral to another agency. This ambivalence itself is an issue, which it may be appropriate to explore as part of the sexual health promotion process. The following are suggested as essential core components of sexual health promotion in GUM settings, in order to enable effective and appropriate referral for patients.

All staff needs to be aware of the range of specialist support services for sexual health promotion with different patient groups, for example:

- Gay men: for example lesbian, gay and bisexual health promotion, community and youth groups
- Sex workers: specific outreach and community projects
- Young people: specialist services for young people, other accessible places where free condoms are available
- Refugees/asylum seekers: appropriate community groups
- Injecting drug users (IDU): local drug services and needle exchange schemes

It is important to have information available on all these support services, and accessible to patients and staff.

Effective and appropriately timed referral will be facilitated if staff can give clear information about what the other service offers, explore and agree with the patient why they are making a referral, and how to access the service. Wherever possible arranging an appointment while the patient is still at the GUM clinic will also be useful, and is likely to increase uptake, especially by young people

ACCESS ISSUES

In order for effective sexual health promotion to take place with target groups and individuals in the GUM clinic, the service must obviously be accessible to all.

It is important that clinics provide information about their services and hours of opening in a clear and accessible format. This information needs to be widely distributed to community settings, via appropriate local networks and mailings. A method must be clearly identified in each clinic for reviewing, updating and informing other services of any changes in the clinic provision for example updating database information held by NHS Direct.

Several clinics could consider shared approaches to production of service information such as leaflet and internet information, for example, across primary care trusts (PCI) or the GUM/HIV Network in South West London.

As a minimum, all services ought to have a leaflet/ flyer outlining what they provide and how to access the clinic, and need to consider how to advertise their services, for example in the Yellow Pages/ local phone directories/Thompson Local directories.

It is important to have a named member of staff who may be identified to facilitate outreach information sessions within community settings to promote and explain the clinic service. Under represented audiences in clinics are ideally targeted, for example sex workers. This will help to minimise unnecessary outreach and duplication of community sexual health promotion initiatives

Ideally each GUM clinic has an out of hours recorded telephone message, which includes the opening hours and how to access out of hours specialist advice.

A common approach to the use of interpretation and advocacy services for sexual health promotion work needs to be adopted.

In order to increase access for people who are at work, school or college and cannot take time off during the day all clinics will need to work towards having at least one evening session available (open until 7.30 pm).

MONITORING , EVALUATION AND AUDIT

The effectiveness and appropriateness of sexual health promotion in clinic settings is not easy to monitor and evaluate, but it is essential to inform service developments, to help to identify needs, and improve liaison with community sexual health promotion strategies. In order to compare data and different approaches across GUM services, it is recommended that the following minimum standards be worked towards by all clinics, using common approaches:

- Patient demographic data needs to include age, sexual orientation and ethnicity as a minimum, and this data is ideally collected in a way that enables it to be easily accessed and reported upon, and compared with other clinics
- Mechanisms need to be in place to enable clinics to report on numbers and types of STI by demographic data, for example age and ethnicity, to inform community sexual health promotion strategies
- Information must be recorded clearly in notes about sexual health promotion interventions to enable quality standards to be monitored and audited
- Referrals made out of the GUM service, and referrals received inwards will help to monitor and compare the amount of joint working
- A common list of sources by which patients have heard about the clinic may be developed and recorded. This may then be analysed by demographic data, for example for young heterosexual men. This will help to inform promotion and outreach strategies
- It is important that patient feedback mechanisms and complaints procedures are in place in all clinics, and clearly available to all patients
- Clinical audit is the systematic critical analysis of the quality of health care, including the procedures used for diagnosis and treatment, the use of resources and the

outcome for the patient, which is an essential component of medical practice. Audit provides education for all those involved and by questioning all aspects of practice enhances efficiency

APPENDIX

Sample condom distribution protocol

Merton Sutton and Wandsworth Condom Protocol for GUM written by David Shaw, Wendy Majewska, Dorinda Thirlby, Caron Bowen, 2001.

Nurses, doctors and health advisers should all be able to educate about condom use, and prompts/situations in which condom demonstration should always be provided should be clarified for all staff. Also needs to include information about where they are available in clinic, e.g. HAs only, or HAs/ nurse treatment rooms/ Dr consulting rooms.

AIM OF CONDOM DISTRIBUTION

The aims of condom distribution within the GU clinic setting are:

- To reduce the spread of sexually transmitted infections
- To promote safer sexual practises
- To lower the risk of unplanned pregnancy

Regular use of a good quality, kitemarked (or CE) condoms can help to reduce the chances of acquiring or passing on sexually transmissible infections. Therefore safer sex practise should be promoted with all clinic attendees. In appropriate circumstances, the benefits of condom use should be discussed and condoms offered. To that end the clinic will offer and supply condoms to all clinic attendees. Condom use will be particularly promoted in the following situations:

- In treatment of acute infection, clinic attendees are advised not to have sex, however they often will still have sex. In that case condom use is preferable to unprotected sex in terms of prevention of re-infection, therefore all clinic attendees being given treatment for an infection should be offered condoms
- Safer sex and condom use should be particularly emphasised when dealing with clinic attendees who are, or have a partner who is HIV, Hepatitis B or Hepatitis C positive
- Safer sex and condom use should be particularly emphasised if clinic attendees are in a high risk group and describe high risk sexual activity, or have a partner who is in these group and therefore are vulnerable to infection
- To reduce transmission of/exposure to chronic sexual infections, e.g. wart virus and herpes infection
- Condom use should be discussed and condoms offered to clinic attendees who are taking the contraceptive pill and have been prescribed antibiotics that may affect the efficacy of contraception

Safer sex is more than just condom use. The regular practice of safer sex requires knowledge, motivation and assertiveness. In addition practical skills and access to condom supplies is essential. Ideally therefore, condom distribution should be set within the context of:

- Giving information, ensuring the person has the facts about infections, conception/pregnancy, condoms, lubricants etc
- Encouraging conscious and constructive thought about sexual health options without prejudice or stigma
- Encouraging individuals to take personal responsibility for their sexual health and that of partners,

- Ensuring people have the skills by demonstrating when necessary proper condom/femidom technique, or addressing any difficulties they describe
- Raising awareness of the range of condoms available and encouraging a selective choice of the most appropriate condom for the situation/activity

Condom distribution therefore needs to be part of a dialogue with the individual. The health professional may need to:

- Initiate the interaction, in an open, facilitative way, demonstrating a non-judgemental approach to encouraging dialogue
- Establish the individual's experience of and attitude to condom use and safer sex. Where clinic attendees are condom naïve there will need to be extensive discussion and they should be offered a range of condoms to encourage personal preference
- Enquire about the requirements/preferences of the person/couple e.g. shape/size – standard, larger, smaller, thickness/thinness, spermicide required or not, oral/vaginal/anal use intended, history of allergy/sensitivity e.g persistent 'thrush'
- Give information about the range of condoms, different uses, lubricant use etc
- Establish if the person has the practical skills of condom use, demonstrate if necessary
- Dispense appropriate supplies and document in notes
- Give advice about how to get obtain further supplies

CONDOM DISTRIBUTION

- As a guide, 12 condoms per client per visit (but room for local interpretation). Supplies should be documented in the notes
- Condom naïve clinic attendees should be given a appropriate range of condoms
- Those clients perceived to be at increased risk make be given larger supplies
- Persons in high risk categories may be given larger supplies
- If a particular type is requested, these may be given, but the client should also be informed of others that are suitable
- Discuss the use of lubricant and give as appropriate
- Oil-based lubricants such as Vaseline, baby lotion/oil, massage oil etc. will weaken the condom and may cause it to break, as will certain pessaries and creams
- Nonoxynol-9 has now been shown not to inactivate HIV and other STI organisms and may cause mucosal irritation in some clinic attendees
- Advise re ongoing supplies from retail outlets, family planning clinics and mail order companies. If a female patient receives the oral contraceptive pill from a family planning clinic, she may also request condoms
- Give appropriate back-up leaflets

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Section G

Working with specific groups

Working with African people

Working with young people

Working with gay men

Working with lesbians

Working with interpreters

Working with African people

DORINDA THIRLBY AND KATHRYN LEE

The high incidence of HIV in African communities in the UK require that policies need to be in place to specifically respond to this group of people with the aim of facilitating access to GUM services

A health adviser needs to be sensitive to the stigma of HIV and be aware of relevant cultural issues when African people seek HIV medical care/ testing

An example of a specific outreach/ health adviser post

INTRODUCTION *

Current statistics from the Public Health Laboratory Service (PHLS) show that African communities in the UK are the second largest group affected by and living with HIV. Those groups most seriously affected are from the Democratic Republic of Congo, Malawi, Kenya, Uganda, Tanzania and Zimbabwe.

The term African is used to describe a diverse group of people. People who are established in the UK, who are refugees, asylum seekers, students and others who may have migrated for employment or to be reunited with family. Other factors to consider are the many diverse educational, personal and religious beliefs within this group.

The majority of transmission is documented as occurring via heterosexual sex or transmission from mothers to babies.¹ There are evolving challenges facing the providers of HIV services as increasing numbers of people are being diagnosed with HIV within African communities in Britain. The Immigration and Asylum Act (2002)² and, in particular, the dispersal programme has led to African asylum seekers being redistributed to parts of the country with previously limited experience in providing services for this group. It is therefore important that health advisers are able to consider the specific needs of people from African communities. It is good practice that health advisers have an awareness of both local and national services so they can give relevant information to patients requiring specific services or support.

* In the absence of having an African healthcare worker involved in writing this chapter, it has been based on the relevant research undertaken to date and it is hoped when the manual is revised that this can be rewritten by someone from an African community.

SUPPORTING PATIENTS WITH INFORMATION

Health advisers can support patients by counteracting the stigma, myths and stereotypes experienced within African communities regarding sexual health and HIV. Studies suggest that on migration to the UK, many people may be at risk of contracting HIV because of social and community networks and low levels of perceived risk. There is also clear evidence showing that people within this group have a greater need for sexual health services, although they are less inclined to access them.³

Research undertaken by the Terrence Higgins Trust has found discussion of sex and sexual health matters is difficult, sometimes taboo for many African women. Especially where sex is associated with procreation and fertility it may be difficult for women to initiate condom use.⁴

Access to condoms and femidoms is vital in making the means of safer sex available without embarrassment. It is extremely important that health care providers do not reinforce the stigmatisation of any ethnic group. To do so may isolate that community further making health promotion more difficult. It is useful to consult with local African groups about where and how to target sexual health promotion.⁵ It is also important to prioritise sexual health promotion to Africans in an accessible format. Although there are regional variations within languages, there may be a standardised dialect within the same language. Community groups may be able to provide information on common dialects that are spoken locally.⁶ Making sexual health services accessible is essential, as early identification of STIs among African communities is necessary to improve sexual health and to help to reduce the transmission of HIV.⁷ (See Ch.36 -Working with interpreters)

FEAR OF DISCRIMINATION

Many people with HIV already experience problems such as isolation or rejection from family, friends and sometimes their own communities. Sigma research undertaken in 2001 suggested that up to 20% of people living with HIV had experienced some form of discrimination in the last 12 months.⁸ It is therefore worthwhile for the health adviser to discuss with African patients any experiences of discrimination and offer appropriate support and referral. Motivation to access services may be low and African refugees and asylum seekers will need clear information about the legal right to free and high quality medical and social services and encouraged to make use of these.⁹ 'Folk beliefs' held about HIV can make it more difficult for some people to make the most of available services and sometimes open discussion about HIV can be difficult. For some it may be more productive to talk about being sick as opposed to having HIV.

Peer education is considered to be an important aspect of sexual health promotion. This may provide a valuable opportunity to address any misconceptions held about safer sex and HIV. Single sex workshops are particularly useful.¹⁰ For example, in situations where one spouse lives in Africa and the other is in this country, then the management of long distance HIV prevention is particularly important when the spouses meet up. The most relevant intervention for those already aware of their HIV status is secondary prevention work. Acquiring the skills to negotiate safer sex is a priority in this situation as circumstances can change following a new diagnosis. This is good practice in all HIV care.

PERCEIVED RISK/ ACCESS TO SERVICES

Perceived risk of HIV is low, as is the motivation to access services for testing.¹¹ Research has shown that this group may be reluctant to use HIV testing services, and as a result, more work

needs to be done to dispel the stigma associated with HIV and testing. The advent of HAART seems to have had little impact on prognosis and AIDS diagnosis among this community. Again, this appears to be due to the poor uptake of testing services owing to social stigma. Consequently testing needs to be positively encouraged to reduce the proportion of undiagnosed infection and minimise the risk of onward or vertical transmission.¹² It is therefore important that clinics are promoted in the community as being free, confidential and open to all.¹³

However, information alone may not change an individual's perception of risk reduction. Negotiating safer sex challenges deeply rooted ideas about identity, gender, sexuality and power. Cultural beliefs may have a strong influence on this.¹⁴ Religion can also play an important role in shaping peoples understanding and in the information they receive about sexual health and HIV. There is concern that HIV positive individuals may make exclusive use of faith healing at the expense of orthodox anti-retroviral medication. Although the church is considered an important site of intervention and may constructively be used for prevention work with congregations, a supportive relationship needs to be cultivated between the churches and people living with HIV.¹⁵ By encouraging collaboration with outside agencies the health adviser can work on interventions aimed at prevention within target groups such as young people.

SEXUALITY

Evidence has shown that African men who have sex with men often face a double prejudice; homophobia from their communities and racism from the predominantly white gay community.¹⁶ This patient group needs to be managed supportively by the health adviser and referrals to other agencies are made appropriately. Accessing information relating to safer sex and risk reduction may have previously been difficult and fear of discrimination against homosexuality may have prevented any open discussion about sexuality. This fear of discrimination could have a negative impact on the health and well being of this group.

SPECIALIST HEALTH ADVISER POST

There are many different ways that the health advisers can foster good relationships with their local African communities. One such initiative is Acomo Oloya's post based at St George's hospital and in Merton Sutton and Wandsworth health promotion. Acomo works as a health adviser with a role as Outreach Co-ordinator (African Communities) in HIV and sexual health. The aims of her post are:

- To strengthen the links between statutory and voluntary agencies and to develop culturally appropriate HIV and sexual health services for black African communities
- To have an outreach remit that involves working with the black African communities to identify needs of services users and potential services users, explaining different ways of disseminating information, and promote greater understanding of UK medical culture and services to enable African people to access services confidently
- To work closely with African community organisations and groups to promote collaboration between sexual health services and community and to develop HIV prevention and sexual health promotion strategies
- To have health adviser drop-in sessions specifically for African people

- To provide training in the African communities to promote better understanding of STIs, their complications, and testing issues
- To provide training for healthcare professionals to enable them to work appropriately with African patients, and act as a point of consultation with these issues
- To look at the need for change in services to facilitate access¹⁷

CONCLUSION

There are important points to consider when working with people from African communities needing HIV or sexual health care. African people come from diverse communities and it is important that the health adviser is aware of this when discussing prevention, treatment and care. The high incidence of HIV in this group means that increasingly health advisers may be involved in supporting individuals through pre and post test care. Being aware of specific needs, current issues and policy and the services available for referral will equip the health adviser to meet these new challenges.

INTERNET RESOURCES

| | |
|--|---|
| www.blink.org.uk | Black information link. |
| www.blackhealthagency.org.uk | Information and helpline telephone numbers. |
| www.loveafrica.org | Sexual health information |

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Working with young people

DORINDA THIRLBY AND SANDRA JARRETT

The high incidence of sexually transmitted infections (STIs) in young people requires that policies be in place to specifically respond to this group of people with the aim of facilitating access to STI prevention, treatment and care.

The health adviser needs to be aware of the legal framework surrounding sex and young people and be alert for signs of sexual abuse and exploitation.

INTRODUCTION

The definition of a young person can range from those aged under 25, to under 16 years.¹ In English law a young person is a minor until they reach the age of 18 years. A young person can legally consent or refuse medical treatment once they are 16. However it is good practice to encourage parental involvement until they are 18 for serious or life threatening conditions. Within this guidance the focus is on the legal implications for young people under 16 in line with regional/ national guidance. However these principles can be applied to all young people accessing services.

Young people under 16 years are likely to access sexual health services for a variety of reasons. The principles to which health care personnel adhere to when providing services to this group are laid down in the Children Act 1989² (which applies to all under 18's) and the Fraser Ruling following the Gillick case in 1985.³ The ethos of the Children's Act is to listen to the child's wishes and feelings and to treat children with respect as individuals. The child's welfare is always the paramount consideration.

CONFIDENTIALITY AND CHILD PROTECTION ISSUES^{4 5}

The care of the young person must be guided by the standards laid down in statute for sexually transmitted disease (STD) services⁶, the Children Act 1989,⁷ the European Convention on Human Rights⁸ and the Human Rights Act.⁹ In the future consideration will have to be given to the recommendations of the Sex Offences Review "Setting The Boundaries"¹⁰ if this becomes law.

(See also Ch. 22: Law and the sexual health adviser)

The Sexual Offences Act 1956 ¹¹ states that it is an offence to have sexual intercourse with a girl aged under 16 years. However, a man has a defence in law if:

- He is under 24 years old and
- He has not previously been charged with a life offence, and
- He believed the girl was aged over 16 years

In practice, the police rarely take action in cases where the girl is 13 or over and has consented to sex. However, a girl of 12 years or under cannot give consent to sex in law, and sexual intercourse in this situation is automatically defined as rape. This is no legal defence and conviction results in a statutory life sentence. The legal age of consent to anal sex for gay men is 16 years.

FRASER RULING (FORMERLY - GILLICK COMPETENCE) ¹²

In 1985 a legal case was brought by Victoria Gillick who felt it should be illegal for doctors to prescribe contraception to girls under 16 years of age without parental consent. The Law Lords ruled that a girl under 16 could give valid consent for contraception if she were able to understand the proposed treatment and its implications. This principle has come to be known as Fraser Ruling, and this principle of competence has now been extended into most areas of clinical practice. The Fraser Ruling provides guidance for healthcare workers working with young people under the age of 16 in that they can give valid consent for medical examination and treatment – depending upon the nature and seriousness of the decision to be made, in conjunction with the child's mental and emotional maturity, intelligence and comprehension of the information they have been given. This requires a healthcare worker to make a judgement in each individual situation/ case.

Operational aspects of Fraser ruling

It is important that the healthcare worker makes a clinical judgement of the child's competence in each case. Certain criteria need to be met in order for a child to be deemed competent:

- The young person understands the potential risks and benefits of the treatment and the advice given
- The value of parental support is discussed. All healthcare workers are obliged to encourage the young person to inform their parents of the consultation. If s/he will not inform a parent, the healthcare worker must explore the reasons why. It is important that the young person seeking contraceptive advice is aware that although the healthcare worker is legally obliged to discuss the value of parental support, the healthcare worker will respect their confidentiality
- The young person's physical or mental health may suffer if s/he is not prescribed treatment / contraception

- The young person's best interests require the provision of medication / contraception without parental consent

It is good practice for the healthcare worker to record the factors taken into account in making the assessment of the young person's capacity to give valid consent. It is strongly recommended that s/he records what information has been given to the young person, including questions asked and the responses given. This is invaluable if the young person's ability to make decisions were to be questioned or where parents disagree with the decisions made. Any patient aged under 13 requires discussion with the consultant. Any patient under 16 who does not meet the Fraser guidance also needs to be discussed with the consultant.

GUIDELINES FOR WORKING WITH YOUNG PEOPLE UNDER 16

- It is recommended that health advisers, with other members of the multidisciplinary team have a written protocol on the management of young people in the clinic
- It is advisable to train reception staff in working with young people as they play a crucial role as the first contact in the clinic. It is important that they are as welcoming and non-threatening as possible
- Ideally, any person under 16 who walks in during advertised clinic hours would be seen even if s/he does not have an appointment
- Where possible it is advisable that the young person is 'fast tracked' through the service
- It is highly recommended that all under 16s see a health adviser. Where possible the health adviser may assist the young person with their registration, triage and make an assessment of their sexual health needs
- It is essential that recall/ follow up contact arrangements are discussed, and a 'safe' contact address and/or telephone number recorded, for example a mobile telephone number which will not compromise their confidentiality
- It is important that the young person is reassured at every opportunity that the service is confidential, as concern about confidentiality is the main reason for not accessing services. It is advisable to explain that their confidentiality will be respected, and information would not normally be given to a third party, for example parent, GP or school nurse, without their express permission. However, confidentiality is not absolute. If disclosure is necessary to protect the young person or a third party from significant harm, confidentiality may be broken. It is important absolute confidentiality of information is not stated
- All young people may be seen with a friend if they wish, at any point throughout the consultation and/or examination. Groups of young people may be seen together where this facilitates access to information on services and health promotion advice
- It is important the health adviser ensures that the young person understands the possible consequences of sexual activity and is aware of the law relating to underage

sex. Safer sex is discussed and condom use demonstrated to all under 16s who are sexually active or potentially sexually active

- It is advisable the health adviser document which school the young person attends, particularly if they are under 16. This also provides useful data for targeting health promotion
- It is important the healthcare worker is satisfied that the patient has sufficient understanding of what is involved in any investigations and treatment proposed to give valid consent. This is ideally a multi-disciplinary decision although as the prescriber, the doctor is legally responsible
- It is important the age of the young person's partner is documented in the notes
- It is good practice to offer a screen for sexually transmitted infections to all sexually active young people. Many will initially decline, but may agree to a screen at a later date when they have developed greater confidence in the clinic staff. Where urine tests or self-taken swabs are available, they can be offered to young people who decline a genital examination
- It is advisable the healthcare worker discuss and document follow-up arrangements
- It is important that any concerns about a young person are discussed with other staff involved in their care and further concerns discussed with the senior doctor or consultant. Any patient aged under 13 requires discussion with the consultant. Any patient under 16 who does not meet the Fraser guidance also needs to be discussed with the consultant.
- It is recommended health advisers work in their referral area with the relevant school nurses, practice nurses, young peoples services; and contraceptive services to facilitate access. Specific flyers for the service can therefore be used and suitable health promotion leaflets/ materials made available
- Consider developing a designated young person's service, where young people need not see other adult attenders. There can be appropriate music/ videos, leaflets and posters for younger patients to make a more welcoming environment. Sex and relationship education can be promoted from the start of the visit ¹³

CONTRACEPTION AND UNDER 16'S

- Any patient aged under 13 requires discussion with the consultant. Any patient under 16 who does not meet the Fraser guidance also needs to be discussed with the consultant.
- If the young person is 13 or over, make an assessment as to whether sexual intercourse was consensual or not. Discuss cases of possible abuse with a consultant
- Assess whether the young person is Fraser competent. If they are and there is no suggestion of abuse, contraception can be provided without involving a consultant
- Record discussion of the different methods of contraception have been discussed, including their relevant benefits, risks and side effects

- Give written information and record that it has been given
- Record whether the parent(s) are aware of the situation and discuss the value of parental support
- Record that discussion has taken place about notifying the GP and the outcome of this discussion

WORKING WITH YOUNG MEN

Boys tend to get less sex education in the family and from informed services such as health professionals;¹⁴ When young boys attend genitourinary medicine services (GUM) it is important they are targeted by health advisers for sexual health education which focuses on their concerns on sex and relationships in order to enhance their confidence, for example with safer sex and condom use. It is important to recognise boys tend to learn what they know about sex from male friends. Learning from their peer group may be complicated as often it is not acceptable that boys show ignorance and stories with other boys are often through real or imagined 'performance' stories.¹⁵ Boys may experience a lot of peer pressure to lose their virginity at an early age. Sexual intercourse may be seen as a way to become a man.

Boys may mask their vulnerabilities by behaving in a 'macho' way or by 'joking' or 'messing about' in the clinic, but it is important to be aware of this and their likely vulnerability. It is important to provide a safe environment, for example by seeing them with friends. Attendance of younger boys/ men may be encouraged by getting young girls attending the clinic to bring their boyfriends and male peers to the clinic. When young men attend there needs to be appropriate literature and resources for boys to give the message they are welcome. It is good practice to have male staff present in young person's services.

WORKING WITH YOUNG GAY MEN, LESBIANS AND BISEXUALS

It is important young person's services are able to discuss sexual orientation, behaviour and identity with young people who are gay, lesbian and bisexual. Specific issues on working with young gay men and lesbians are covered in the relevant chapters.

SEXUALLY TRANSMITTED INFECTIONS

Sexually active teenagers have higher rates of STIs¹⁶ The presence of a possible sexually transmitted organism, particularly in a young person, may indicate sexual abuse. Discuss all cases of STIs in a young person aged under 13 with a consultant. (The Royal College of Physicians has addressed the issue of confidentiality in this situation and discussion with a paediatrician does not constitute a breach of confidentiality in relation to VD regulations)

- If the young person is aged 13 or over and there is no suggestion of abuse, the young person can be treated as an adult if s/he is Fraser competent
- Ensure the young person understands the tests being taken and the reasons for the tests

- Ensure the method of contacting the patient with results is explicit and recorded in the notes

TERMINATION OF PREGNANCY (TOP) REFERRALS

- Sexual healthcare workers need to make themselves aware of their local referral procedures for termination of pregnancy in young people as some hospitals have 'fast track' service
- There needs to be discussion with the young person about the need for permission from the parent or person with parental responsibility prior to a TOP. If consent is not given, this needs to be made explicit in the referral letter
- In view of the high prevalence of STIs in this age group it is important to encourage uptake of sexual health screening prior to the TOP
- Future contraception needs to be discussed prior to the termination being carried out, and written details of local family planning services given

CHILD PROTECTION ISSUES

Although sexually active young people are likely to be involved in consensual sexual activity, other child protection issues need to be considered in the overall assessment of the young person including:

- Past and continuing sexual abuse/ assault (See guidelines below on suspected child abuse)
- Undiagnosed mental health problems, including self-harm, eating disorders, alcohol and substance misuse
- Risk or involvement in prostitution/ commercial sex work. Young people involved in prostitution are now considered in law to be victims of sexual abuse, even if they consent. Discuss all cases of suspected child prostitution with a consultant
- Vulnerability of those living away from home/ accommodated by the local authority
- Vulnerability of disabled young people/ or those with learning difficulties, irrespective of age

Suspected child abuse

It is important health advisers are aware of their local child protection policies and procedures and know how to contact the child protection team at any time. Each NHS trust has a named doctor and a named nurse or midwife who take a professional lead for child protection matters within a Trust.¹⁷

All staff working in genitourinary medicine (GUM) should:

- Be alert to the possibility of child abuse and neglect

- Be aware of local Area Child Protection Committee (ACPC) procedures and protocols
- Know the names of the relevant named and designated professionals
- Be familiar with local procedures for checking the child protection register
- Receive training and supervision needed to recognise and act upon child welfare concerns and to respond to the needs of the young person
- Be aware of the guidelines for the management of young people under 16 years attending GUM clinics
- Know the 'Chain of Evidence' procedure"¹⁸

The first responsibility of health care workers is to the young person when abuse or potential abuse is suspected. The effective management of child abuse demands a multidisciplinary and inter-agency approach. If an under 16 year old discloses abuse, or a health care professional suspects that abuse may be occurring, it needs to be made clear to the young person that this information may need to be discussed with other colleagues in the interest of their health and well being. In this first instance discuss the case with senior health adviser/ professional and consultant/ senior doctor in the department.

The following are associated with an increased risk of abuse:

- History of physical or sexual abuse
- Partner more than 3 years older than patient
- Low self esteem
- Learning difficulties
- History of social services care
- Communication difficulties
- Early age of first intercourse

If a child discloses information about abuse, it is best practice to involve a community paediatrician, preferably with the consent of the young person. If consent is given, an examination should **only** be carried out by a forensic medical examiner or evidence may not be admissible in court. A forensic medical examination will only be needed urgently if:

- There has been a recent sexual act and there may be evidence such as semen
- The child sustained physical injuries necessitating urgent medical assistance
- The perpetrator is likely to abscond and evidence secures arrest and detention
- The child requests immediate treatment

In any situation where there are concerns, staff members involved in the care of the young person need to discuss their concerns with each other and their senior team member as appropriate. Confidentiality may need to be breached if consent is not given, but this is only after careful consideration and discussion with a consultant. If further advice may be sought from the local designated doctor for child abuse. Advice can also be sought from the child protection team without disclosing the young person's identity.

In practice it is an extremely rare occurrence that confidentiality needs to be breached, but if it is necessary then it is important the young person is informed of the decision. Other issues to consider prior to breaching confidentiality is if the young person is not willing to co-operate they may deny the disclosure to the outside agency. They may have also given a false name and address to the clinic. A breach of confidentiality might result in other young people not accessing the service in future.

Before contacting a paediatrician or child protection team, collect the following details:

- Name
- Date of birth
- Address including postcode
- Who they live with, and relationship to them
- School
- Nominated social worker, if the patient has one

B I B L I O G R A P H Y

The Marlborough Clinic protocol written by Sarah Bell & Dawn Whittaker

The Roehampton Clinic protocol written by Dr Emma Fox.

Physical signs of sexual abuse in children - Royal College of Physicians, 2nd edition. The Royal College of Physicians of London, 'Physical Signs of Sexual abuse in children. 2nd edition (1997).

Inter-agency Borough Guidelines on Child Protection – Wandsworth Area Child Protection Committee 1997.

'Someone with a smile would be your best bet': What young people want from sex advice services. Brook Publications.

Promoting sexual health services to young people. Brook Publications.

'You think they won't tell anyone, well you HOPE they won't: Do young people believe sex advice is confidential? Brook Publications.

Teenage Pregnancy. Social Exclusion Unit June 1999.

Confidentiality and people under 16. Guidance issued jointly by the BMA, HEA, Brook Advisory Services, FPA and RCGP.

APPENDIX 1

Example proforma from the Marlborough Clinic

| Date | Seen by |
|------|---------|
|------|---------|

To be completed on initial contact at FIRST VISIT by staff member
All Under 16's must be seen by the Health Adviser

YP welcomed
Confidentiality discussed
Services offered by the clinic discussed

- Sexual Health Advice
- Full screen and HIV Testing
- Contraception
- Emergency contraception
- Pregnancy Testing
- Free Condoms provision

| | | |
|-------------------------------|-----|----|
| Previous internal examination | YES | NO |
|-------------------------------|-----|----|

Correspondence details

| | | |
|---|-----|----|
| May be contacted by clinic | YES | NO |
| If NO YP must understand implications of no contact | | |
| Written contact acceptable | YES | NO |
| Address | | |
| Verbal Contact acceptable | YES | NO |
| Telephone number | | |
| Acceptable to leave message | YES | NO |

How did the YP hear about the service?

| |
|---------------|
| School |
| Youth group |
| Advertisement |
| Friend |
| Parent |
| Other |

Reason for attendance today

| | |
|---------------------------|----------------|
| Sexual health advice only | |
| STI screen | Pregnancy test |
| HIV test | Contraception |

Fraser Guidelines

To be completed if under 16 years old

| Sexuality | Homo | Hetero | Bi | Unsure |
|-----------|------|--------|----|--------|
|-----------|------|--------|----|--------|

| | |
|-----------------------------|-----|
| Age of first intercourse | |
| Number of lifetime partners | |
| Age of current partner | |
| Length of relationship | |
| Continuing intercourse | |
| Consensual intercourse | Y N |

| | | |
|----------------------------|---------------------|------------------|
| Parent / guardian aware of | Sexual activity Y N | Clinic visit Y N |
| Responsible adult aware of | Sexual activity Y N | Clinic visit Y N |

YP understands fully how to use his/her chosen method of contraception and is aware of the risks and benefits of this method?
YES NO

YP able to understand implications of sexual examination and blood tests?
YES NO

Social and Mental health history

| | |
|---------------|--|
| Lives with | |
| School | |
| Social worker | |

| | | | |
|--------------------------------|------|---------|-------|
| Mental health history | | | |
| Drug use | Past | Current | Never |
| If yes, what? | | | |
| Involvement with drug services | Y | N | N/A |
| General information | | | |

In my opinion, this patient is sufficiently mature to give consent to examination and treatment, and understand advice given to them:

| |
|------------|
| Signature |
| Print name |
| Position |
| Date |

APPENDIX 2

Suggested Proforma for Health Advisers

Clinical Effectiveness Group (Association of Genitourinary Medicine and the Medical Society for the Study of Venereal Diseases)
National Guideline on the Management of Suspected Sexually Transmitted Infections in Children and Young People

| | | | | | | |
|--|------|---------|----------------------------|-----------------------------------|-----------------------|--------------|
| Date | | | | | | |
| RISK ASSESSMENT FORM FOR PATIENT UNDER 16 YEARS | | | | | | |
| Reports | Past | Ongoing | Other young people at risk | Parent/ Guardian/ Care unit aware | Social Services aware | Police aware |
| Sexual Contact | | | | | | |
| Involuntary | | | | | | |
| Voluntary partner age<23 | | | | | | |
| Voluntary partner age>24 | | | | | | |
| Family member | | | | | | |
| Substance Abuse | | | | | | |
| Alcohol | | | | | | |
| Heroin | | | | | | |
| Crack | | | | | | |
| Speed | | | | | | |
| Ecstasy | | | | | | |
| Cannabis | | | | | | |
| Temazepam | | | | | | |
| Other | | | | | | |
| Solvents | | | | | | |
| IV route | | | | | | |
| Prostitution | | | | | | |
| Street | | | | | | |
| Sauna | | | | | | |
| Escort | | | | | | |
| Abuse | | | | | | |
| Physical | | | | | | |
| Emotional | | | | | | |
| Neglect | | | | | | |

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Working with gay men

MIKE JONES

Gay and bisexual men and men who have sex with men (MSM) are a diverse population of individuals who reflect every social and ethnic group in the UK. The sheer size and diversity of this population makes any attempt to cover all of the relevant issues in depth somewhat problematic.

This section therefore aims to cover core issues relevant for sexual health advisers working with this client group. For a more detailed analysis of some of the subjects covered a reading list is provided at the end of the chapter.

INTRODUCTION

The sexual health needs of gay men are of course both similar to and different from those of their heterosexual counterparts. Much of the advice and information provided in the general sections of this handbook will also apply to gay men. There are however two unique factors which continue to mark out gay men as different from their heterosexual peers and which affect the work we do with gay men/MSM.

Firstly, in the UK and elsewhere there is a historical background of social and institutional disapproval of male to male sexual contact and relationships.

Most gay men grow up in an environment where there continues to be both overt and covert hostility towards men who are sexually attracted to other men.

These negative messages not only affect and influence gay men but also those working with them on sexual health issues.

Secondly, the advent of HIV in the last 20 years and its disproportionate impact upon gay men in the UK has profoundly influenced contemporary gay male sexuality and culture. From the mid 1980s to the mid 1990s sexual health education aimed at gay men/MSM tended to be defined by HIV prevention messages. This might be viewed as sometimes being to the exclusion of other sexual health concerns for both HIV negative and positive men. More recently, sexual health educators have responded by placing HIV within the broader context

of gay men's sexual, physical and emotional wellbeing. A reflection of the growing realisation that for safer sex and risk reduction messages to be effective other factors like self esteem, mood, general sexual health, alcohol and drug use have to be taken into account.

WHO ARE GAY MEN / WHOSE DEFINITION?

In working with gay/bisexual and MSM it is important to respect and understand an individual's identification of his sexuality.

Though the patient in front of you might be behaviourally homosexual, bisexual or heterosexual it is the patient's perception of his sexuality which should guide you in the work you do with him and the language you use.

Gay men are men who have sex with men..... but not all men who have sex with men identify as gay .

In these guidelines the term **gay man/MSM** will be used to describe all men who have or who have had male sexual partners. Generally the term 'gay' means more than 'a man who has male sexual partners'. To self identify as gay in our society suggests (to varying degrees) an acceptance and awareness of shared experience and identification with other homosexual men. It also suggests a perception of difference from the experience of heterosexual males.

The use of the word gay might therefore be seen as partly descriptive of a cultural and community identity as well as of sexual identity.

A bisexual man is usually defined as a man who is sexually attracted to both women and men. Though a bisexual man is someone who behaviourally might have sex with both men and women his choice might be to identify his sexuality as either bisexual or gay.

A man who has sex with men (MSM) is a term that has come into more recent usage to describe the broad spectrum of men who do not identify as gay or bisexual but who nevertheless have sex with men. Sexual behaviours in this group can range from men who usually have sex with women but who occasionally have sex with men, to men who are almost exclusively behaviourally homosexual.

The reasons why MSM do not identify as bisexual or gay are as diverse as the individuals involved. Some MSM from ethnic minority and other socio/cultural groups do not identify with the mainstream gay scene and 'out' gay men

This might be because of issues around race and exclusion^{1 2} or because they come from cultures where identities like gay or lesbian do not have equivalent words or concepts.^{3 4 5} For some men sexual identity is more fluid than 'straight, gay or bi'. Sometimes sex between men or certain types of sexual activity like mutual masturbation are defined as 'playing' or not perceived to be 'real' sex.

In some cultures or in some male only environments sexual identity might be defined by role during penetrative sex mirroring attitudes around heterosexual sex .The 'penetrator' retains a heterosexual identity but the 'penetrated' is perceived as homosexual.⁶

Other reasons for not identifying as gay or bisexual include internalised homophobia. Some MSM have internalised society's negativity about homosexuality to the degree where they reject any communality with openly gay identified men. There are also men who are

‘situationally homosexual’ in male only environments or institutions where female partners are unavailable, in prisons for example.

Another important group in the MSM category are some male sex workers.

Not all male escorts or ‘rent boys’ (that is, men who sell sex to men) identify as gay or bisexual. Some identify as heterosexual and may have female sexual partners.

The examples above present situations where the health adviser needs to be extremely sensitive to the personal circumstances of the patient.

Men who have sex with men but who do not identify as gay or bisexual are frequently wary of disclosing their sexual activity with men to medical staff.

This can also be true of gay or bisexual men who are just starting to explore their sexuality and men who are new attenders at your clinic. They might be anxious about how they will be treated by medical staff if they disclose their true sexuality. Some men might describe male partners as female or not mention male partners in a consultation. This is more likely to happen if the doctor, health adviser or nurse does not specifically ask a patient if he ‘has or has ever had male partners’? It is advisable to ask this question as a routine part of sexual history taking.

Images, posters and leaflets, which portray same sex couples and information about sexually transmitted infections (STIs) written for gay men/MSM can be displayed in all sexual health clinics. These convey the message to patients that the clinic is a safe environment for gay men/MSM to discuss sexual health concerns and that staff are aware of health issues specific to these patients.

THE LAW AND GAY MEN

Prior to the late 19th century sex between men might or might not be prosecuted under a variety of laws depending on the zeal or whim of the authorities of the time ⁷ *

The offence of gross indecency (any consensual sex between men other than anal sex) came onto the statute books in 1885 and this was used with the offence of buggery (anal sex) to criminalise all sexual activity between men.

Following the Wolfenden report gay sex was only partially decriminalised under the sexual offences act of 1967. The age of consent was set at 21, the law stating that no more than two men were to be involved and the sex had to take place in a ‘private’ not ‘public’ area. Definitions of what constitutes private or public space continue to be open to interpretation and legal debate.

In 1994 the age of consent for sex between men was lowered to 18.

In November 2000 the government invoked the Parliament Act to force through legislation to make the age of consent 16 in England, Scotland and Wales and 17 in Northern Ireland. This means that the age of consent is now the same for heterosexuals and homosexuals across the UK.

* The Stonewall website at www.stonewall.org.uk provides useful information on the history behind legislation affecting gay men.

The legal concepts of buggery and gross indecency (male to male sexual contact in a 'non private' space) remain in place. Gay men can still be prosecuted for having consensual sex. There has been recent discussion at government level on changing the law on gross indecency to a new offence of public indecency. This would apply equally to both homosexual and heterosexual sex. If this happens it will effectively end the legal discrimination against gay men inherent under the existing law.

THE HEALTH ADVISER INTERVIEW

Sexual health, HIV, risk reduction and gay men

20 years into the HIV /AIDS epidemic and with the advent of anti-retroviral drugs sexually experienced gay men are making increasingly complex choices around sexual health and risk taking.

Some writers ⁸ refer to a 'post AIDS ' generation of gay men in Europe, the U.S.A and elsewhere for whom the HIV/AIDS epidemic is no longer viewed as a crisis but as a fact of life, to be lived with and managed like many other risks.

The content of your interview with your patient/client will of course depend upon his knowledge base and needs. Working with someone just beginning to explore his sexuality can be very different to working with someone who is sexually experienced.

There are several key areas that it is important to discuss with any gay man/MSM attending a GUM service, particularly a new attender.

The following areas for discussion will depend upon why he has been referred to the health adviser or has requested to see the health adviser and should be tailored to the needs of the patient.

The interview

As with any patient, in order to establish trust and confidence it is first important to find out what he may already know, what he perceives his needs to be and to build on these.

In the interview, especially with young or sexually inexperienced patients, any or all of the following topics are relevant:

- General sexually transmitted infections (STIs) information
- Risk reduction/safer sex and condom use
- HIV transmission
- Knowledge of HIV status and that of partners
- Hepatitis A and B status and vaccination
- Hepatitis C status and knowledge of transmission and health risks, particularly if patient is HIV positive

- If the patient is HIV positive it is important to address any concerns he might have around risk reduction with partners of either positive or negative/unknown HIV status

Awareness of STIs, transmission and symptoms

If the patient has been referred with a diagnosis of an STI firstly ascertain his knowledge and understanding of the infection and of how it has been transmitted

It may be important to clarify whether the patient is aware of which STIs have a higher incidence amongst gay men/MSM and why this is.

If there is a local or national increase in the incidence of an STI amongst gay men (for example, syphilis) then it is important the health adviser check that the patient is aware of this.

If the patient is HIV positive he may have some different concerns around STIs. Frequently asked questions include whether or not STIs are more serious for positive men and are they harder to treat or likely to increase viral load?

HIV transmission and risk reduction.

The first step in any HIV risk reduction discussion is to understand the patient's knowledge base, his awareness of and assumptions about sexual risk taking.

A key part of the health adviser role is to provide the patient with the information necessary for him to make informed choices about his sexual wellbeing. This means addressing gaps in the patient's knowledge and challenging any assumptions not based on fact or evidence. This will guide the patient towards developing a personal sexual risk reduction strategy that makes sense and is workable for him.

Questions for your patient

- Does he understand how HIV is transmitted?
- Does he have concerns about being infected or of infecting others with HIV?
- Does he already have a personal risk reduction strategy?
- Does he ever have sex, which is less safe than he would like it to be?

Most gay men/MSM in the UK are aware of primary routes of transmission of HIV even if relatively sexually inexperienced. However, perceptions of risk of HIV transmission vary considerably from person to person.

When discussing sexual activity it is important to ascertain whether the patient 'ever has sex which is more risky than he would like it to be'?

This can be a more helpful question for opening a discussion about risk reduction with a patient than 'do you ever have unsafe sex'. If he voices concern about his risks then it is probable he will be open to further discussion.

HIV health promotion and risk reduction messages for gay men/MSM have evolved from the early 1980s to the present in response to the realities of sexual choices and risk taking. The original 'safe' sex message of "never have unprotected anal intercourse (UAI)" has evolved

into the 'safer' sex message of "never have UAI with someone of unknown or different HIV status".

This is in response to the fact that many gay men have incorporated HIV testing and HIV status into their personal risk reduction strategy.^{9 †}

Gay men often prefer not to use condoms with a regular partner of the same HIV status for reasons of love, trust and intimacy. Therefore being absolutely certain of a partner's HIV status via testing is recommended to any couple not using or considering not using a condom. They can also be advised to set some ground rules about safer sex with other sexual partners and to be open with each other if unsafe sex has occurred outside of the relationship.¹⁰

A more controversial issue is whether an HIV positive man having unprotected anal intercourse with another positive man can be infected with another strain of HIV. This could mean being (re) infected with a strain of HIV, which is more aggressive or drug resistant than his current strain of virus. There is evidence to support the view that superinfection can occur.^{11 ‡}

Some HIV positive men argue that the evidence for superinfection is somewhat limited and that low viral load reduces this risk considerably. They might choose to have UAI with other positive men for both personal and political reasons.

Therefore they feel they are making an informed choice about risk taking in order to enjoy genuine intimacy with other positive men, particularly regular partners.

It is vital that we as Health Advisers are aware of current debates within the gay community about sexual risk taking and have access to accurate information about STIs and health risks for HIV positive gay men. We are then in a position to have a useful dialogue with our patients and to ensure that their sexual choices and strategies are informed by the best available evidence.

HIV negative and positive gay men have been making increasingly complex decisions around sexual risk taking as the nature of HIV transmission became clearer. Sexual health surveys show that at any one time around 30% to 40% of gay men are not using condoms for anal intercourse.¹² This does not necessarily mean that 30% to 40% of gay men are always having high risk sex. This figure includes HIV negative men who are only having UAI with a regular partner who is also known to be negative (low risk UAI) through to men who are unsure of their status who are having UAI with other men of unknown status (high risk UAI).

Men who are most at risk of contracting or transmitting HIV are those who have UAI with partners of different HIV status. Anonymous testing of blood taken at GU clinics reveals that up a third of HIV positive gay men/MSM may be unaware of their HIV status. Evidence suggests that these are not men who have never tested for HIV. They are often men who do not perceive themselves to have been at risk since their last test or who were not offered a test at their last sexual health screen.¹³

Therefore in working with gay men/MSM who are having UAI who do not perceive themselves to be at risk it is important to ascertain if they are certain of their HIV status. If

† Project Sigma (Tel: 020 7737 6223) have surveyed Gay Men's sexual behaviour since 1993. From 1997 these surveys have taken place nationally and yearly. For survey reports and other publications on gay men's sexual behaviour and attitudes contact

‡ A very readable précis of this report can be found on AIDSMAP www.aidsmap.com Under Fieldhouse R. First unequivocal case of HIV superinfection.

not it is appropriate to raise the issue of HIV testing as part of their personal risk reduction strategy.

R I S K R E D U C T I O N

If the patient wants to reduce the level of risk he is taking it is worth exploring patterns in mood, behaviour, environment or choice of partner when risky sex happens.

- Does risky sex happen with regular or casual partners? Does he have risky sex when depressed, anxious or stressed?
- Does it happen when he is drunk or taking recreational drugs? Or at a particular venue?
- Is he having risky sex because he feels unable to discuss HIV status or testing with a new or regular partner?

It might be possible to help him reduce risk by exploring ways of changing factors in his life which impact on his sexual choices. This might involve several counselling sessions to identify potential changes that can be made.

Any changes should be realistic rather than idealistic. Some men feel they have failed if they cannot maintain safer sex with every partner. It is therefore important to emphasise that **any** reduction in higher risk sex will reduce his statistical chances of being infected with or transmitting HIV.

The health adviser should be wary of being viewed as punishing or policing around safer sex. By using positive and affirming language about the patients desire to reduce risk and by identifying factors likely to increase risky behaviour he can be encouraged to return for further discussion after risky sex occurs.

Other options for men who want to reduce risk but are finding change difficult can include referral for ongoing counselling or psychology support if available.

Some cities in the UK have counselling organisations specifically for gay men and MSM, which are a valuable resource and can link people into their communities. Several gay men's and HIV organisations run groups and courses for gay men exploring issues like relationships, assertiveness, risk reduction and sexual wellbeing. Many men have found sharing their experiences with other gay men in a workshop or groupwork setting to be very useful. ¹⁴ § Some agencies providing these services are listed at the end of the reading list.

P U B L I C H E A L T H A N D R I S K R E D U C T I O N V E R S U S P A T I E N T A D V O C A C Y A N D C H O I C E ?

Some gay men have felt or fear pressure to HIV test before ready from clinic staff. Some have felt judged by clinic staff around sexual practices and personal risk reduction strategies. HIV positive men have reported feeling unable to discuss their sexual health needs with clinic staff because of previous negative responses to their sexual activity. ¹⁵ ** It is therefore important to

§ Reports containing research and information on needs of HIV positive people when seeing sexual health care professionals.

** An analysis of research relevant to primary prevention in relation to people with HIV. Contact THT London. Tel 020 7831 0330

ensure that in any discussion with this client group, health advisers are sensitive to and respectful of the individual needs and choices of the patient.

Health advisers are in a difficult position because we have a public health as well as patient advocate role. The laudable aims of improving public health are not always easily applied to the complexities of human sexual behaviour.

Good risk reduction work is not only about providing information. Helping the patient to identify and address factors in his life which affect his ability to reduce risk, is a fundamental part of developing a workable risk reduction strategy appropriate to his needs.

A patient who knows that the health adviser is providing him with clear and unbiased information and is listening to and addressing his needs is probably more likely to feel able to discuss his sexual activity and to return for further advice and counselling. The patient who feels that the health adviser, irrespective of that patient's needs or concerns, is imposing an agenda and who feels judged or patronised may not be open to future discussion. Always ask the patient to clarify any terminology he uses that is new or confusing and always check that the patient understands the information you are giving him.

Covering all of the above in one session may prove difficult given pressure of time. In addition the patient will only retain a percentage of any information given.

Too much in depth description of STI and HIV transmission to the exclusion of more positive messages can prove alarming and off putting. This is particularly true of anyone just starting to explore his sexuality. If a good working relationship has been established between the health adviser and the patient he can be encouraged to return if he feels this would be helpful.

A health adviser can also back up verbal information with leaflets written specifically for gay men. It is important to remember that a patient may be living with others who do not know about his sexuality and where privacy might be a problem.

He may be wary of taking leaflets that could identify him as a gay man/MSM. Sometimes general sexual health leaflets are more acceptable and it is always worth checking this out with the patient first.

PARTNER NOTIFICATION AND GAY MEN

Guidelines given elsewhere in this handbook on partner notification for STIs and HIV are also of course applicable to gay men.

The most significant difference is that gay men/MSM are likely to have more sexual contacts than heterosexual men and women ¹⁶. Furthermore, because of the opportunities for casual sex in clubs, bars, saunas and cruising areas it is likely that a higher proportion of these contacts will be casual or anonymous and therefore untraceable. ¹⁷

Cities like London Manchester and Brighton have large populations of gay men and many venues and places where casual sex is available. Also many men using the scene in these cities are from other parts of the UK or tourists from abroad. ¹⁸

This poses particular problems for partner notification resolution and clinics with a high proportion of gay male attenders in urban areas will find that they have higher numbers of 'untraceable' contacts reported. Different approaches to disease control and public health

have been adopted where effective PN is difficult or impossible in the midst of an STI epidemic. Targeted club and venue based information campaigns about infections can be extremely effective at raising awareness and encouraging men to attend GU services for screening.

Recent examples of these are outreach and venue based campaigns to raise awareness of syphilis amongst gay men in London and Manchester. This has involved collaboration between GU clinics / health advisers, gay men's outreach organisations and the Public Health Services.

Patients with early syphilis have mentioned particular sex venues, Internet chat rooms or cruising grounds as places where they suspect they encountered the partner or partners who infected them. This has been fed back to public health and gay men's outreach organisations who have targeted those sites with advice and information about the infection and how to access screening and treatment.

Through the collation of up to date information about local syphilis epidemics appropriate interventions to reduce incidence have evolved where PN has been difficult.

WORKING WITH YOUNG GAY AND BISEXUAL MEN

Young gay men, particularly those aged 18 and under, form a smaller percentage of clinic attenders than heterosexual men or homosexual men above 18. Many young gay men do not become sexually active until after their teenage years. Those who are sexually active as teens frequently find it hard to disclose their sexuality. As a result those who do attend usually do so with an acute medical problem.¹⁹

Sexual Health clinics are ideally suited to meeting the needs of this group. The confidentiality, anonymity and non-judgmental approach of clinics should make them an ideal venue for young gay men to seek advice and help on issues of sex and sexuality.

To attract this client group clinics have to make determined efforts through appropriate advertising, tailoring services to their needs and focussed staff training.^{20 ††}

PSYCHOSEXUAL AND EMOTIONAL NEEDS OF YOUNG GAY MEN

Young gay men frequently experience major difficulties coming to terms with their sexuality as a result of the stigma that much of society still attaches to homosexuality. Young gay men are at a greater risk of violence than their heterosexual counterparts. A 1994 study by Stonewall found that one in two gay identified under 18 year olds surveyed suffered at least one violent assault and one in four received some form of harassment from members of their own family.

They may find it very difficult to approach any adult or authority figure (for example teachers or GP's) for advice and help, expecting to encounter the homophobia and negativity they experience around them. Younger gay men may view homosexual sex as abnormal having internalised the messages received from family and society. It is therefore important for the

†† Axis is a sexual health clinic specifically for gay and bisexual men aged under 26. The report contains useful information on setting up a gay men's service and on issues specific to young gay men.

health adviser to normalise homosexual sex and to place it in context as part of a range of human relationships.

It is not therefore surprising that young gay men can suffer from low self esteem and may be wary of any interventions that may focus on their sexuality. Many deny both to themselves and others their sexual attraction to other men, preferring to view themselves as heterosexual or bisexual.

In addition many young gay men may be unclear about the age of consent, legal issues around gay sex and the confidentiality of GU services. All of these factors can make it difficult for a worker in a GU clinical setting to establish the trust and confidence of some gay men.

The pressures on young gay men are reflected in suicide rates, which are proportionally higher than in equivalent heterosexual age groups.²¹ Young gay men from ethnic and religious minorities can face particular pressures and problems when familial and religious identity and duty conflicts with sexual identity and desire.^{22 23 24} This is especially true in communities where arranged marriages are the norm and where adult identity and family honour is inextricably bound up with marriage and children.

Referral to counselling and support organisations aware of the specific problems faced by young gay men/MSM in this situation should be offered. [‡] Staffs at sexual health clinics thus need to be aware of the potential vulnerability of young gay men and the anxieties they will have in attending the service. It is important not to use language that could be construed as judgmental when working with any patient. This is particularly important in the case of young gay men and in any initial consultation it is also important to emphasise the confidential nature of sexual health clinics.

HEALTH EDUCATION NEEDS

For whatever reason young gay men attend the clinic it is an ideal chance for health educational work, as they will all be in the early stages of their sexual lives. Even if they have received some sex education at school it is unlikely that much, if any, will have covered homosexual sex. Like most young people many young gay men learn about sex from peers or sexual partners and the information they have may be incomplete or inaccurate.

Like any young person a young gay man may find it embarrassing and difficult to discuss sex, particularly homosexual sex, with an older person so it might be advisable to keep language as neutral or clinical as possible. Always ask the patient to clarify any terminology he uses that is new or confusing to you and always check that the patient understands the information that you are giving him.

LEGAL ISSUES WHEN WORKING WITH YOUNG GAY MEN

For information on this subject on men aged 16 and over please read the previous section on the Law and Gay Men. Much of the law relating to consent, treatment, under 16's, sexual

^{‡‡} Naz Project London. Works with men from South Asian, Turkish, Iranian and Arab backgrounds. 020 8741 1879. PACE. Lesbian and Gay counselling service which can advise on local services. 020 7837 6768

abuse and rape applies irrespective of the sexuality or gender of the young person involved. The most relevant law here is that relating to the offence of 'buggery'.

In theory even if a 15 year old is having consensual anal sex with a partner of the same age both could be prosecuted for buggery. In practice sex between consenting males of the same or similar ages if under 16 is unlikely to be followed up by the police. This is similar to police practice around consensual under age heterosexual sex. There is a common law presumption that a boy under the age of 14 cannot commit the offence of buggery.

The sections in this handbook on working with young people, under 16's and child protection provide further information on legal issues which are also relevant for young gay men.

GAY MEN/MSM AND ACCESS TO GU SERVICES

All clinics can ensure that gay men are able and willing to access their services. If gay men are not using their local GU service and are travelling elsewhere for treatment then questions need to be asked about why that might be.

There are several ways to monitor whether or not gay men are making use of a GU service and to improve access:

- Are data on clinic attendances by gay men captured? For example by 'diagnosis acquisition'
- Are data on gay male attendance analysed or audited?
- Does the clinic have any links with local health promotion services working with gay men? Or with voluntary sector organisations working with gay men or people with HIV?
- Is the clinic advertised in places where gay men meet or socialise, for example posters or leaflets in bars, clubs, and saunas? Is the clinic advertised in any gay media covering your area?
- Does your clinic have guidelines/protocols for doctors working with gay men so that a standardised service is offered?
- Does your clinic have clear policies on Hepatitis B (and Hep A) vaccination for gay men?
- Does your clinic screen all HIV positive gay men for Hepatitis C?
- Are there training needs for health advisers, doctors or nurses?

USEFUL LITERATURE AND RELEVANT ORGANISATIONS

NB This list is far from comprehensive but most of the literature listed here contains advice on further reading and sources of help and information. Organisations listed here are those that have a national or high profile role in gay men's sexual health, support or counselling. They can usually advise on services in your area:

Making it count: A collaborative planning framework to reduce the incidence of HIV infection during sex between men. Second edition. Sigma Research 2000.

For information on organisations providing advice, counselling support and group work for gay men/msm contact;

- Terrence Higgins Trust (THT) - National organisation. Central Helpline THT Direct tel 0845 12 21 200
- London Lesbian and Gay Switchboard - Can provide info on local lesbian and gay services across UK including local lesbian and gay helplines. Tel 020 7837 7324
- National AIDS Helpline Free 24 hour advice and help on HIV related issues. Tel 0800 567 124

USEFUL WEBSITES

www.tht.org.uk THT provides information on national services for gay men as well as other groups.

www.mesmac.co.uk Provides information on services across the UK offering support and advice for men who have sex with men. There are also regional mesmac websites.

www.metromate.org.uk Provides information on the wide range of groups for gay men provided by

Gay Men Fighting AIDS (GMFA) and BIG UP at GMFA. Some groups specifically for men from Caribbean and African backgrounds. London based.

www.freedoms.org.uk Provides information on condoms, safer sex and links to national services for gay men. London based.

www.naz.org.uk Provides information for gay men/msm of South Asian, Turkish, Iranian and Arab backgrounds.

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Working with lesbians

KATHRYN LEE

This chapter aims to examine common barriers that some lesbians may face when attending a sexual health service. Making the service more accessible may help to reduce misconceptions held by both service provider and service user.

INTRODUCTION

There is no standard definition of what constitutes a 'lesbian'. Sexual orientation is most often described through behaviour and identity. It is important to note that views of sexual behaviour and sexual identity may vary significantly across differing cultures and ethnic groups.¹ Lesbians and women who have sex with women (WSW) are found among all sub-populations of women and are represented in all ethnic and racial groups, all ages and all socio-economic strata.

Lesbians and WSW have some specific sexual health needs. A number of surveys have highlighted that misconceptions about the health risks of lesbians need to be addressed. Lesbians and health care providers often hold these misconceptions alike. In a survey conducted in Manchester, lesbians did not consider themselves at risk of STI and HIV. There were a large number of women who felt reluctant to disclose their sexuality to health care professionals due to fears of discrimination and a perceived lack of confidentiality within health care settings.²

SEXUAL RISK

As with all patients it is important to remember that the care given by the health adviser should be individualised and based on patient need. A number of factors influence the sexual health of WSW. Namely the nature of sexual activities, the number of partners, a history of having sex with men and previous exposure to STI. Traditionally WSW have been perceived as a low risk group and have been largely over-looked in terms of sexually transmitted infections and cervical cytology screening initiatives. This is clearly demonstrated by the lack of acknowledgement of WSW in the National strategy for sexual health and HIV.³ However, studies of prevalence of STI in WSW have shown significant numbers of WSW diagnosed with genital herpes, bacterial vaginosis, hepatitis A, B and C and genital warts⁴

High percentages of women in all studies gave a history of having previous or current sexual contact with men. Research highlights the risk behaviour profile of WSW as significantly more likely to have sex with men who identify as gay or bisexual. This demonstrates that a woman's sexual identity is not always an accurate predictor of her sexual behaviour, with women who define themselves as lesbian sometimes engaging in high-risk sexual contact with men. For a case of 'heterosexual' transmission to occur, neither person need be heterosexual.⁵ Research shows that WSW who believe themselves to be in a low risk group for STI and HIV are less likely to practise safer sex than heterosexual women with partners from high prevalence groups, such as gay men.⁶

An accurate sexual history is paramount when assessing risks and intervention. Sensitive sexual history taking is now judged to be an element of good practice in any sexual health service.⁷ There is relatively little data regarding the risk of female to female transmission of HIV, although available research suggests the risk to be very low. Other factors must be taken into account, such as the use of intravenous drugs or sexual contact with men. Viral STI (such as herpes and genital warts) are diagnosed in women who have had exclusively lesbian sexual experiences. Woman to woman transmission of trichomonas is also well documented. However the reason for the high rates of bacterial vaginosis amongst lesbians is unclear.⁸

Studies have demonstrated the prevalence of STI but evidence of transmission between women is lacking, all studies cited highlighted a need for further research in this area. Evidence suggests that risk behaviour is high amongst WSW but these risks are related to factors outside their experiences of sex with women.⁹

SAFER SEX

Advice about safer sex is common to all sexual orientations, but clear advice should be given to WSW regarding the use of sex toys and condoms; risks from oral sex; and the transmission risks of digital penetration. Studies reinforce that the promotion of dental dams is unwarranted and unacceptable.¹⁰ As with all patients, the health advice given needs to be clear, current and non-judgmental. It is essential that the health adviser is familiar with common sexual practices among WSW, and is able to openly discuss with patients any sexual health risks which may be relevant to them.

CYTOTOLOGY

Studies show abnormal cervical cytology to be as prevalent in WSW as their heterosexual counterparts. Historically, WSW have been discouraged from attending for cervical cytology screening as the risk of abnormality was perceived to be low. Research has clearly demonstrated cervical cytological abnormalities in WSW, including those who report never having had male sexual partners.¹¹ Lesbians should therefore be encouraged to attend for cervical cytology.

PARENTING AND CONCEPTION

A survey showed that almost one quarter of WSW attending sexual health services wanted more information about parenting and conception.¹² For WSW the issue of conception raises dilemmas in relation to the potential exposure to STI/HIV. Lesbian women may attend sexual health services to seek advice on donor insemination, HIV /STI testing, pre-conceptual care or adoption. The health adviser should have the resources available to make relevant

referrals to local and national services and be equipped to discuss the options available to them, especially with regard to STI and HIV.

IMPROVING ACCESSIBILITY TO SERVICES

Access to health care services may be adversely affected because of assumed discrimination or stigmatisation. WSW may have already encountered negativity in a health care setting associated with their sexual orientation, and been affected by prejudice and homophobia. Studies have shown that many women identifying as lesbian felt they had endured bad experiences in sexual health services because of their sexuality.¹³

Revealing ones lesbian identity for some is an understandably difficult task. Many WSW do not feel safe disclosing their sexuality in healthcare settings, and often neither they nor the health care worker initiate any discussion regarding sexual practice.¹⁴ Assumptions of heterosexuality can lead to a lack of disclosure and this invisibility of lesbian service-users may contribute to exclusion and poor utilisation of services by WSW. By failing to disclose or discuss sexuality, appropriate health interventions may be overlooked.¹⁵

It is important to remember that there are real concerns for lesbians about confidentiality. Disclosing sexual orientation may leave some patients feeling vulnerable so it is vital to be clear about how the information will be used, where it will be documented and who will have access to it.¹⁶ The health adviser should have a comprehensive awareness of local and national resources and support networks available to WSW.

Young lesbians particularly may need support and reassurance when confronting issues about coming out to family or peers and self-esteem issues around acceptance of their own sexuality.

CLINIC ENVIRONMENT

The clinic should be a positive environment, displaying inclusive material in the waiting areas and reception. Patients should be asked gender-neutral questions about partners or personal circumstances when booking in at reception. The waiting room should display a mission statement outlining the services position on equality and this should specifically identify lesbians as being part of that commitment. Finding relevant information about sexual health may be difficult for some WSW.¹⁷ There is a need for current, understandable and appropriate written information for WSW, with clear guidance about sexual risks and the need for cervical screening. The clinic could be profiled in the local or national lesbian press to promote an inclusive service and raise awareness about sexual health matters affecting WSW.

The health adviser has some responsibility for ensuring that members of the multidisciplinary team are adequately trained and aware of the specific needs of WSW clients. Sexual history taking and the language used should make the consultation conducive to disclosure.

Evaluating the views of lesbian service-users is an important factor in establishing if clinic services are lesbian-friendly. The feedback given by clients can be used to adopt inclusive strategies and raise the expectations of WSW using the service by dispelling fears associated with disclosure, visibility and vulnerability. By developing an understanding of the barriers lesbians face when using sexual health services, access can be improved and a more relevant, sensitive and successful service can be provided.

RECOMMENDED RESOURCES

- Saffron L. Lesbian parenting from all angles. Pinkparents (UK) Ltd.
- www.pinkparents.co.uk (Information and advice about parenting.)
- Feeling Good, Feeling Sexy. Manchester Health Promotion Specialist Service. Tel: 0161 291 3642 (Lesbian Sexual Health information for clients.)
- www.fflag.org.uk (Support for families and friends of lesbians and gays.)
- www.lesbianstd.com (information about sti)
- www.dcnetwork.co.uk (Parenting/pregnancy.)
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Working with interpreters

CHRIS FALDON

Sexual health advisers will need to work effectively with interpreters to break down communication barriers. This is not always an easy task and requires careful planning.

INTRODUCTION

Many people in the UK use a first language that is not English, or a dialect not readily understood by others. Others may be deaf and English is a second language. This may mean that their understanding of abstract concepts, grammar and complex words may be limited.¹ This can create barriers to accessing health services. In GUM settings even when English is the first language of service users there are many potential barriers to good communication such as fear, shame, anger and embarrassment. A genuine attempt is needed to overcome these when conducting a sexual health interview. When an interpreter is required, it is to be acknowledged that this is often a socially, culturally and politically complex and skilful activity.² It requires careful planning at both an interpersonal and institutional level. Health advisers may often be the key professionals involved in facilitating the interpreting service for a client. This chapter sets out to provide some basic advice on how to work productively with an interpreter.

The function of interpreting in health care settings has evolved greatly over recent years as the inadequacies of using family members (including children), non-medical staff and sometimes other patients have come to light. Such practices ran the high risk of patient misdiagnosis and incorrect treatment with potentially catastrophic consequences. Untrained interpreters are likely to have little or no understanding of medical concepts or terminology and the primacy of ensuring that any messages conveyed are complete and accurate.

Many public sector services including the National Health Service have relied on a service provision model that supplements established approaches to communication with specialist provision. The use of interpreters in interviews, leaflet translation, special telephone and computer technologies are problematic in these services and are regarded as expensive and difficult to obtain. It is argued that a social inclusion model starts from the perspective that everyone has a right to the information and support that will enable participation in the social and cultural life of their community. Alternative approaches to communication in public life need to be built in to provision at the outset.³ Clients are therefore entitled to a professional interpreting service. This is enshrined in legislation for deaf people under the Disability

Discrimination Act with businesses and organisations being legally obliged to look at how they provide access.⁴

GUM clinics as part of a much larger public service may well struggle to shift the emphasis from language to communication but it is in the best interests of everyone to ensure that communication is enhanced through using an interpreter when required.

Services will vary considerably across the country but the following principles are to be noted:

- Professionally trained interpreters working to a code of ethics⁵ are capable of maintaining a neutral and independent position. Their use is to be encouraged where at all possible
- Using a friend or family member to interpret is fraught with difficulties and is to be discouraged unless the client insists

ASSESSMENT OF NEED

It may not be obvious that someone requires an interpreter due to them having grasped sufficient English to communicate basic information. Often they will present to reception and the health adviser may be requested to assist with registration. To elicit their comprehension of English it may be helpful to ask the following:

- Questions that demands more than a Yes/No response
- To repeat a message you have given in their own words

There can be a temptation to struggle through a consultation if the person has made an effort to attend and has got so far through the system. However it is to be noted that the health adviser has a professional obligation to ensure that any tests and procedures performed require fully informed consent. This may not be possible if there is a communication barrier and therefore the input of an interpreter is just as much for the benefit of the professional as well as the client.

Identify which language the person speaks before requesting an interpreter. This may be conveyed in advance or the patient/client brings a card naming the language required. If this however is to be established it may be helpful to request that an interpreter service provides a printed list of languages they offer with a translation of the following:

“Please indicate which language you speak and we will try to obtain an interpreter to help us.”

A British Sign Language (BSL) /English interpreter can make it easier for a Deaf sign language user and a hearing person to communicate with each other. An interpreter interprets from one language to the other. In the UK this will usually be from BSL to spoken or written English, or spoken or written English to BSL.⁶ In Ireland this will be Irish Sign Language. As in spoken English there are regional variations. Some however will use Sign Support English or finger spelling. Deafblind people have a combined sight and hearing loss. Although many deafblind people still have a little useful sight and hearing, and can therefore use speech and hearing aids to communicate, some will require manual communication in the form of the deafblind alphabet. If the booking of a communication service is required for someone who is deaf or deafblind, it is vital their communication needs are assessed before making it.⁷

BOOKING AN INTERPRETER

It is important that local policies are adhered to, though the following information will be universally applicable:

- Try to give notice to the interpreting service when booking the appointment e.g. one week, unless there is an urgent need. Some areas may need even longer. This is often true when booking an interpreter for a Deaf patient. If this results in an unacceptable delay then it may be necessary to arrange the use of a telephone interpreting service. The London based service 'Language Line' (0800 169 2879) is expensive but can usually provide an interpreter within minutes to participate in a 3-way conference call. They handle over 120 languages on a regular basis⁸
- Make a provisional appointment time and date with the patient and discuss the easiest way to contact them if there is a need to rebook. Document how to contact them in the notes
- Stipulate the length of time that the interpreter will be required
- Confirm what language(s) they speak and what dialect
- Consider whether you can maximise the use of the interpreter, it may be possible to get the patient's partner in at the same time, or consider if they need other appointments arranged to see another member of staff; for example if the person is coming for an HIV test it may be useful to offer a GU screening appointment at the same time

WORKING WITH THE INTERPRETER

The following guidelines will assist the health adviser in how to work more effectively with an interpreter:

- When the interpreter arrives the member of staff who is seeing the patient may be informed that the interpreter has arrived
- Prior to seeing the patient it is good practice that the member of staff working with the interpreter has a discussion with them about what is required. Give permission for the interpreter to interrupt the interview where necessary. The interpreter is unlikely to be an expert in cultural issues but may provide some guidance on factors that could affect the interview
- Time spent with the interpreter explaining briefly what is known of the case may be valuable. Specific information could be given with regards to the nature of the clinic
- Check with the interpreter how to correctly use and pronounce the clients name
- Brief them about the type of questions they need to translate. Some common terms and vocabulary may need to be explained

- Information could be made available about clinic confidentiality. For example if there is a known recent casual contact that this should not be made known to the other partner
- Does any of the above cause any concern for the interpreter?

Time invested in such a discussion will ensure that the interpreter is suitable. If there seems to be a conflict of interests then this is to be made explicit and the health adviser may consider cancelling the appointment and write a complaint or provide feedback to the interpreting service. Such circumstances should be rare if the interpreting service offers training to its staff. There may be opportunity for the health adviser to provide input into this training programme.

THE INTERVIEW

The following guidelines will help the health adviser, patient and interpreter to get the most out of the interview:

- Arrange a place where the interview can be conducted in private
- Arrange the seating to allow for easy communication. It is important for the interpreter to be placed between the two parties since this is a more neutral position.⁹ However in the case of working with a Deaf client position the interpreter close to the main speaker if possible, and clearly visible to the Deaf person. The interpreter is to be well lit, but not from behind - not in front of a bright window¹⁰
- Provide a glass of water to the interpreter – they will be speaking twice as much as anyone else
- Establish that the interpreter and client speak the same language or dialect
- Allow extra time for the interpreter to introduce himself or herself to the client and explain their role
- Stress the confidential nature of the interview
- Check if they are acceptable to the client
- Introduce the health adviser and roles
- Look at the client and not the interpreter. Maintaining good eye contact will reinforce the feeling of direct communication
- Use simple language as free from jargon as possible
- Speak clearly at a normal pace. Interpretation is almost simultaneous, but there will be a slight delay as the interpreter picks up the meaning of a phrase. Break up speech into short sections. A message may be lost if more than four or five sentences are delivered at one time
- Listen actively to the interpreter and the client. Allow time for the client to respond or ask questions

- Check if the client has understood everything at the end of the interview

COMMONLY ENCOUNTERED DIFFICULTIES

Using an interpreter is not without its problems and they may fall into the category of:

- The interpreter does not speak the clients language and English fluently
- The client feeling uncomfortable with the interpreter which may hinder open communication
- The interpreter not translating exactly what is being said
- The interpreter losing their neutral stance and acting as an advocate for the client
- Not allowing sufficient time for the interview
- Overuse of complex vocabulary
- Discomfort of the interpreter with the sexually explicit nature of the interview

If these are identified and cannot be easily rectified then the interview may be terminated and rescheduled.

POST INTERVIEW

Following a consultation the interpreter could be offered advice/ feedback about the session. It is necessary to document the interpreters name and agency in the patient's notes.

Arrange a suitable appointment with the patient if follow up is required. Check if the interpreter is available. Should the interpreter not be available then rearrange the follow up appointment directly with the interpreting service. Any difficulties encountered during the whole process are to be reported directly to the interpreting agency.

CONCLUSION

Health advisers are well placed to facilitate high quality communication between the client and clinic professionals through the use of an interpreter. There are many obstacles to achieving this but if overcome through paying attention to detail, then the sexual health of the client can be significantly enhanced.

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