

The Manual for Sexual Health Advisers

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

The Department of Health has provided funding to the Society for Sexual Health Advisers (SSHA) to assist them in the production of this manual.

Copyright Society of Sexual Health Advisers 2004.

This publication is copyright but may be freely reproduced for the purpose of providing sexual health promotion and care

Section E

Community settings

Community health advising

Outreach work

Ethical issues in outreach work

Working in prisons

Community health advising

T I N A S H A R P

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.

REFERENCES

- 1 Chlamydia trachomatis. Summary and conclusions of the Chief Medical Officer's Expert Advisory Group. London: Department of Health; 1998.
- 2 Clinical effectiveness group-association for genito-urinary medicine and the medical society for the study of venereal diseases, 2002. Guidelines for the management of genital tract infection. BMJ Publishing Group.
- 3 Central Audit Group in Genitourinary Medicine: Clinical guidelines and standards for genital chlamydia infection, 1997 Health Education Authority.
- 4 Templeton A (Ed) The prevention of pelvic infection. RCOG Press. 1996
- 5 Ibid p.4
- 6 Sharp T, Mitchell H, Carder C. "Improving links" Chlamydia liaison audit 2000-2001. Unpublished. Camden & Islington CHS NHS Trust, London.
- 7 Bailey M, Robinson AJ, Sharp T, Carder C, Ridgway GL. To evaluate the benefit of a chlamydia co-ordinator in facilitating management of Chlamydia screening across contraceptive and genitourinary medicine clinics. Poster presented at: The AGM and Annual Symposium of Faculty of Family Planning and Reproductive Health Care, May 2002, London.
- 8 Ross JDC, McIver A, Blakely A, et al. Why do patients default from follow up at a genitourinary clinic?: a multivariate analysis. Genitourinary Med 1995; 71:393-5.
- 9 James NJ, Hughes S, Ahmed-Jushuf I, Slack RCB. A collaborative approach to management of chlamydial infection among teenagers seeking contraceptive care in a community setting. Sexually Transmitted Infections 1999; 75:156-161
- 10 Harvey J, Webb A, Mallinson H. Chlamydia trachomatis screening in young people in Merseyside. British Journal of Family Planning 2000; 26(4): 199-201.

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} 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

C O N C L U S I O N

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.

R E F E R E N C E S

-
- 1 Morton AN, Wakefield T, Tabrizi SN, Garland SM, Fairley CK. An outreach programme for sexually transmitted infection screening in street sex workers using self-administered samples. *Int J STD AIDS* 1999;10:741-743.
 - 2 Brace NE, Zimmerman HE, Potterat JJ, Muth SQ, Muth MD, Maldonado TS. Community-based HIV prevention in Presumably Underserved Populations- Colorado Springs, July to September 1995. *MMWR* 1997;46(7):152-155.
 - 3 Ibid.
 - 4 Bell G, Ward H, Day S, Ghani AC, Claydon E, Kinghorn GR. Partner notification for gonorrhoea: a comparative study with a provincial and a metropolitan UK clinic. *Sex Transm Inf* 1998;74:409-414
 - 5 Day S, Ward H, Ghani AC, Bell G, Goan U, Parker M et al. Sexual histories, partnerships and networks associated with the transmission of gonorrhoea. *Int J STD AIDS* 1998;9:666-671.
 - 6 Bell et al 1998. *op. cit.*
 - 7 Day et al 1998. *op. cit.*
 - 8 Rogstad KE, Clementson C, Ahmed-Jushuf IH. Contact tracing for gonorrhoea in heterosexual and homosexual men. *Int J STD AIDS* 1999;10:536-538
 - 9 Bell G, Rogstad K. Off street sex workers and their use of genitourinary medicine services. *Int J STD AIDS* 2000;11:592-593.
 - 10 Woodhouse DE, Potterat JJ, Muth JB, Reynolds JU. Street Outreach for STD/HIV Prevention- Colorado Springs, 1987-91. *MMWR* 1992;41:98-101.
 - 11 Morton et al 1989. *op. cit.*
 - 12 Brace et al 1995. *op. cit.*
 - 13 Jaquet C. Help on the streets. *Nurs Times* 1992;88:24-26.
 - 14 McMillan I. Touching base. *Nurs Times* 1993;16:27-8.
 - 15 McDonnell RJ, McDonnell PM, O'Neill M, Mulcahy F. Health risk profile of prostitutes in Dublin. *Int J STD AIDS* 1998;9:485-488.
 - 16 Judson FN, Miller KG, Schaffnit TM. Screening for gonorrhoea and syphilis in gay baths – Denver, Colorado. *Am J Public Health* 1977;67:740-742.
 - 17 van Den Hoek JAR, van Haastrecht HJA, Scheerings-Troost B, Goudsmit J, Coutinho RA. HIV infection and STD in drug addicted prostitutes in Amsterdam: potential for heterosexual transmission. *Genitourin Med* 1989; 65:146-50.
 - 18 Withington Department of Genitourinary medicine. Sauna Outreach: An evaluation of a pilot scheme undertaken to assess the sexual health needs of sauna workers in Manchester January to June 2001. NHS 2002.
 - 19 Bell & Rogstad 2000. *op. cit.*
 - 20 Rhodes T, Holland J, Hartnoll R. Hard to reach or out of reach?: An evaluation of an innovative model of HIV outreach in health education. London: Tufnell Press, 1991;

-
- 21 Bell G Brady V. Monetary incentives for sex workers. Letter to the editor. *Int J STD AIDS* 2000. 11:483-4
 - 22 Potterat JJ, Muth SQ, Bethea RP. Chronicle of a gang STD outbreak foretold. *Free Inquiry In Creative Sociology* 1996;24(1):11-15.
 - 23 Potterat JJ, Meheus A, Galloway J. Partner notification: operational considerations. *Int J STD AIDS* 1991;2:411-415.
 - 24 Mellinger AK, Goldberg M, Wade A, Brown PY, Hughes GA, Lutz JP, Harrington-Lyon W. Alternative case-finding methods in a crack-related syphilis epidemic – Philadelphia. *MMWR* 1991;40(5):77-80.
 - 25 Gerber AR, King LC, Dunleavy GJ, Novik LF. An outbreak of syphilis on an Indian reservation: descriptive epidemiology and disease-control measures. *Am J Public Health* 1989;79:83-85.
 - 26 Rhodes, Holland & Hartnoll 1991. op.cit. p3-8.
 - 27 Rhodes, Holland & Hartnoll 1991. op. cit. p21.
 - 28 Potterat, Meheus & Galloway 1991. op. cit.
 - 29 Potterat, Muth & Bethea 1996. op. cit.
 - 30 Kelly JA, Lawrence JS, Diaz YE, Stevenson LY, Hauth AC, Brasfield TL et al. HIV risk behaviour reduction following intervention with key opinion leaders of population: an experimental analysis. *Am J Public Health* 1991;81:168-171.
 - 31 Potterat, Muth & Bethea 1996. op. cit.
 - 32 Walkowitz J *Prostitution and Victorian Society: Women, class and the state*. Cambridge: Cambridge University Press 1980. Cited by Day S, Ward H. Sex workers and the control of sexually transmitted disease. *Genitourin med* 1997;73:161-168.
 - 33 Withington Department of Genitourinary Medicine 2002. op. cit.
 - 34 Potterat, Muth & Bethea. 1996. op. cit.
 - 35 Bell & Brady 2000. op. cit.
 - 36 Wilson J. Outreach programmes for female commercial sex workers. *Int J STD AIDS* 1999;10:697-698.
 - 37 Morton et al 1999. op. cit.
 - 38 Brace et al 1995. op. cit.
 - 39 Jaquet 1992. op. cit.
 - 40 McMillan 1993. op. cit.
 - 41 McDonnell et al 1998. op. cit.
 - 42 Judson et al 1977. op. cit.
 - 43 van Den Hoek et al 1989. op. cit.
 - 44 Bell & Rogstad 2000. op. cit.
 - 45 Potterat, Muth & Bethea 1996. op. cit.
 - 46 Ghani AC, Ison CA, Ward H, Garnett GP, Bell G, Kinghorn GR, Weber J, Day S. Sexual partner networks in the transmission of sexually transmitted diseases: an analysis of gonorrhoea cases in Sheffield, UK. *Sex Transm. Dis.* 1996; 23(6):498-503.
 - 47 Potterat, Muth & Bethea 1996. op. cit.
 - 48 Ibid. p11.
 - 49 Jaquet 1992. op. cit.
 - 50 Withington Department of Genitourinary medicine 2002. op. cit.
 - 51 Potterat, Muth & Bethea 1996. op. cit.
 - 52 Harwood S. Sheffield Working Women's Opportunities Project (SWWOP) annual report 1999-2000. Sheffield: SWWOP 2000.
 - 53 Potterat, Muth & Bethea 1996. op. cit.
 - 54 Jaquet 1992. op. cit.
 - 55 Withington Department of Genitourinary Medicine 2002. op. cit.
 - 56 Rhodes, Holland & Hartnoll 1991. op. cit. p128.
 - 57 Woodhouse et al 1992. op. cit.
 - 58 Judson, Miller & Schaffnit 1977. op. cit.
 - 59 Potterat, Muth & Bethea 1996. op. cit.
 - 60 Hopkins S, Lyons F, Mulcahy F, Bergin C. The great pretender returns to Dublin, Ireland. *Sex Transm Inf* 2001;77:316-318.
 - 61 Rothenberg R, quoted by Potterat JJ, Muth SQ, Muth JB. Partner notification early in the aids era: misconstruing contact tracers as bedroom police. *Research in Social Policy* 1998;6:1-15. p9.
 - 62 Potterat JJ, Rothenberg RB, Woodhouse DE, Muth JB, pratts CI, Fogle JS. Gonorrhoea as a Social Disease. *Sex Transm Dis* 1985;12(1): 25-32.
 - 63 Morton et al 1999. op. cit.
 - 64 Jaquet 1992. op. cit.
 - 65 Rhodes, Holland & Hartnoll 1991. op. cit. p28.
 - 66 Potterat, Muth & Bethea 1996. op. cit.
 - 67 Withington Department of Genitourinary medicine 2002. op. cit.
 - 68 Rhodes, Holland & Hartnoll 1991. op. cit. p193.
 - 69 The European Network for HIV/STD Prevention in Prostitution (EUROPAP/TAMPEP). *Hustling for Health: Developing services for sex workers in Europe*. 1998. p20.
 - 70 Rhodes, Holland & Hartnoll 1991. p105.
 - 71 EUROPAP/TAMPEP 1998. op. cit. p65.
 - 72 Ibid. p34.
 - 73 Ibid. p9.
 - 74 Ellis S, Barnett-Page E, Morgan A, Taylor L, Walters R, Goodrich J. HIV prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission. The Health Development Agency 2003
 - 75 Potterat, Muth & Bethea 1996. op. cit.
 - 76 Melinger et al 1991. op. cit.
 - 77 EUROPAP/TAMPAP 1998. op. cit. p9
 - 78 Withington Department of Genitourinary Medicine 2002. op. cit.
 - 79 Rhodes, Holland & Hartnoll 1991. op. cit. p28.
 - 80 Potterat, Muth & Bethea 1996. op. cit.
 - 81 EUROPAP/TAMPAP 1998. op. cit. p16-17.
-

-
- 82 Ibid. p15
- 83 Ibid. p33.
- 84 McDonnell et al. 1998. op. cit.
- 85 van Den Hoek et al. 1989. op. cit.
- 86 Judson, Miller & Schaffnit. 1977. op. cit.
- 87 Hopkins et al. 2001. op. cit.
- 88 Gerber et al. 1989. op. cit.
- 89 Brace et al. 1995. op. cit.
- 90 Mellinger et al. 1991. op. cit.
- 91 Potterat, Muth & Bethea. 1996. op. cit.
- 92 Day S, Ward H. Sex workers and the control of sexually transmitted disease. *Genitourin med* 1997;73:161-168.
- 93 Rhodes, Holland & Hartnoll. 1991. op. cit. p12.
- 94 Frankland J, Blakely V, Moore L, Trickey H. Monitoring and evaluating outreach work: An assessment of methods and techniques applied to an HIV prevention project for women prostitutes and their clients. 1997. Health Promotion Wales technical report 22, p10.
- 95 Bell & Rogstad. 2000. op. cit.
- 96 Frankland et al. 1997. op. cit.
- 97 Harwood. 2000. op. cit.
- 98 Jaquet. 1992. op. cit.
- 99 Bell & Rogstad. 2000. op. cit.
- 100 Frankland et al 1997. op. cit.
- 101 Bell & Rogstad. 2000. op. cit.

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

ACKNOWLEDGMENTS

The steering group would like to thank the following for their helpful comments; John Potterat, Jo Adams, Peter Clark, Kathy Jones, Debbie Burnett.

REFERENCES

-
- 1 Department of Health. The national strategy for sexual health and HIV. London: DoH, 2001, www.doh.gov.uk/nshs/strategy.htm accessed 1 May 2002.
 - 2 Potterat, Muth & Bethea. 1996. *op. cit.*
 - 3 *Ibid.*
 - 4 *Ibid.*
 - 5 Potterat JJ, Muth SQ, Rothenberg RB, Zimmerman -Rogers H, Green DL, Taylor JE, Bonney MS, White HA. Sexualnetwork structure as an indicator of epidemic phase. *Sex Transm. Infect* 2002;78(Suppl 1): 1152-1158

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 through 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

Health Group, HM Prison Service HQ, Page St, London, SW1 4LN

ACKNOWLEDGMENTS

The steering group would like to thank the following for their helpful comments;
Dr Mary Piper, Senior Public Health Advisor in Prison Health, Department of Health.

REFERENCES

-
- 1 McKerrow G. Inside story, *Positive Nation*, May 1997 p.23-24
 - 2 Edwards S, Tenant-Flowers M, Buggy J, Horne P, Hulme N, Easterbrook P et al. Issues in the management of prisoners infected with HIV-1 : the Kings College Hospital HIV prison service retrospective cohort study. *BMJ* 2001; 322: 398-399
 - 3 HM Prison Service AIDS Advisory Committee. The review of HIV and AIDS in prison. London: HM Prison Service, 1995.
 - 4 Joint Prison Service and National Health Service Executive (NHSE) Working Group. The future organisation of prison health care. London: Department of Health, 1999.
 - 5 Strang J et al. HIV/AIDS risk behaviour among adult male prisoners. Research findings No. 82. Home Office Research, Development and Statistics Directorate. 1998 p.1
 - 6 Weild AR et al. Prevalence of HIV, hepatitis B and hepatitis C antibodies in prisoners in England and Wales: a national survey. *Commun Dis Public Health* 2000; 3 (2):121-126
 - 7 Strang J et al. op. cit. p.6
 - 8 HM Prison Service AIDS Advisory Committee .op cit. p.13 - 20.
 - 9 Strang et al. op.cit. p.4 -5
 - 10 Weild AR et al. op.cit.
 - 11 HM Prison Service AIDS Advisory Committee op. cit p.39
 - 12 Revolving Doors Agency. Bad girls? Women, mental health and crime. King's Fund 2002 p.1
 - 13 *ibid.* p.2
 - 14 *ibid.* p.39
 - 15 HM Prison Service Medical Directorate. HIV and AIDS: A multidisciplinary approach in the prison environment. 1990.
 - 16 HM Prison Service. Health care standards for prisoners in England and Wales. London 1994
 - 17 Council of Europe. The European prison rules. Recommendation number R (87) 3 of the committee of ministers, 1987
 - 18 HM Prison Service and NHS Executive. op cit. p.5
 - 19 HM Prison Service AIDS Advisory Committee op cit. p.52-53
 - 20 *ibid.* p.32-34
 - 21 *ibid.* appendix 4. p57 - 60.
 - 22 *ibid.* p39-40.
 - 23 National AIDS Manual HIV transmission and education in prisons. NAM. Publications p.380 - 382. Nov 2002
 - 24 Strang J. op. cit p.5