

# Newcastle SHASTD Conference 2002

## Health Promotion Focus Group

**Facilitator: Heather Wilson**

### *Do Health Advisers value the health promotion part of their role?*

Everyone agreed that they value health promotion and see it as an integral part of their role. However health promotion practice varied enormously.

### *Community health promotion*

Some HA's were running regular programmes in schools and colleges. Some were doing outreach work, such as in drug and alcohol agencies and with commercial sex workers.

Examples of good practice included:

Camden and Islington, where health advisers are part of the schools team, run by health promotion to deliver consistent programmes in local schools.

Most HA's would like to undertake more community health promotion, but the biggest constraint was time. Two options to overcome this were discussed:

1. Increasing the numbers of health advisers in sexual health clinics to allow for more community work.
2. Developing the role of community health advisers. Those community HA's that people were aware of were focusing on infection management and partner notification. A broader remit for community HA's would make the job more holistic and also maximise on the networks that community HA's are ideally placed to develop.

It was agreed that all health promotion initiatives should be undertaken in partnership with local health promotion departments. This is not only good practice but avoids duplication and maximises resources.

### *Individual health promotion*

All HA's were undertaking health promotion in their one to one interviews with clinic attenders. Although we were all keen to use the latest resources, the cost of leaflets and posters was a barrier and most HA's were using leaflets which weren't necessarily the most comprehensive or best quality, but were provided free from their local health promotion department. We only had very limited supplies of the leaflets produced by agencies such as the Terrence Higgins Trust. There was an overwhelming sense of frustration at the lack of time during clinics to spend on health promotion with patients. This was a particular issue with giving negative results. While everyone thought it was the ideal time to spend discussing avoiding future infections, in

practice there were usually so many patients waiting to be seen that the giving of a negative result is regarded as a “quick” appointment. HA’s feel that they are “drowning” in the sheer numbers of patients, this in turn engendered feelings of guilt and frustration.

### ***To what extent is health promotion “victim blaming”***

The ethics of health promotion were discussed. The way other clinic staff and patients see the HA role is crucial. Often the patient will expect a lecture or “telling off” by the HA. We had experience of patients presenting with comments like “you’re here to tell me I’ve been naughty aren’t you?” Or “you’re going to tell me off aren’t you?” We had also experienced other agencies and professionals perceiving us in this way. It was agreed that none of us told patients what to do or passed judgement on them. To the contrary everyone was very aware of starting where the patient is and tailoring any health promotion to suit the individual and not try to promote blanket solutions.

### ***Recommendations***

1. Increase the numbers of HA’s in clinics to enable time to spend with individuals on health promotion and for more outreach and community health promotion.
2. Increase the numbers and develop the role of community health advisers to include community and outreach work.
3. New, better quality leaflets need to be developed that are free to clinics.
4. The HA role and philosophy of practice needs to be more transparent to patients and other professionals.

## **Ethics Focus Group**

### **Facilitator: Gill Bell**

This workshop considered the following ethical dilemma, at the request of a delegate.

A newly diagnosed HIV positive woman refuses to tell her current partner her diagnosis. She claims not to believe the result, although she has been persuaded to take anti-retrovirals for the sake of her unborn child. The health adviser believes that she is unlikely to change her mind, or attend regularly for further discussion in the future.

Her partner is attending the same clinic for wart treatment. He tests negative for HIV. He reports ongoing unprotected sex with his partner, and is not aware that he is at any potential risk.

Should the clinic warn him, against the index patient’s wishes?

The group considered the relative duties to the woman, her partner and the unborn child, and explored the possible consequences of telling him, and of not telling him.

There were concerns that, if he were told, the woman may be alienated from the service. The child would be at greater risk if she failed to continue with anti-retrovirals as a result. She may be left unsupported at a difficult time if her relationships with her partner and the clinic were jeopardised.

The public health implications of breaching confidentiality were considered: people would be discouraged from testing, and may be more likely to transmit undiagnosed infections.

The duty to protect her partner from avoidable infection was also acknowledged. Every effort should be made to build a relationship with the woman to allow ongoing discussion of the need to notify. If he were to be informed by the clinic, the woman should be made aware of this to give her the options of telling him herself, or leaving the area beforehand.

A vote was taken at the end of the discussion. Two voted in favour of informing him, nine voted against.

## **Recall Focus Group**

**Facilitator: Gill Bell**

Questions considered

1. If a patient has not supplied the clinic with a method of contacting them, whatever the reason for recall the patients' choice should be respected.
2. Home visits are not a cost-effective use of Health Advisers time.

Recommendations from question 1.

1. Best method of contact should be established at registration. If not then the HA should see the patient to clarify why and a full explanation of the consequences of being unable to recall the patient should be given. This should be documented in the casenotes along with the reasons given by the patient for not wanting to be contacted. It is important to value the patient's choice.
2. An explanation should be given that there may be need to override this request for no contact in extreme circumstances and these should be outlined.
3. A consensus to do this must be reached within the team and agreed with the lead consultant.

4. A public health role may override the patient's request for no correspondence but the reasons given by the patient must be taken into account.
5. Different intervention is needed in some circumstances and the HA is relied upon to use their judgement. E.g. Under 16's.
6. It is advisable to wait before taking any action against the patient's wishes in case they subsequently attend, although obviously this needs to be capped.

#### Recommendations from question 2.

1. The HA should always have the right to refuse to do a home visit on the grounds of personal safety.
2. Visits are only justifiable in exceptional circumstances and should be a last resort at the end of the recall process and only in certain situations. E.g A patient with untreated primary Syphilis.
3. The Trust safety policy should be adhered to regarding off site visits and a local protocol should be in place.
4. The reasons for undertaking a home visit and the outcome must be fully documented.
5. The decision to undertake a home visit (if possible) should be agreed with the whole team.

## **Partner Notification Focus Group**

**Facilitator: Lesley Anderson**

11 Participants split into 2 groups.

One group looked at the question; "*Home visits for contacts are an improper use of resources*"

The discussion focussed on the type of infection that health advisers would do home visits for; it would depend on whether it was GC, STS, Chlamydia or HIV and also the urgency to make contact.

It was thought that it depends on clinic location and less effective in bigger cities, as the population tends to move around more. Not everyone gives correct details for contacts, it was therefore important to verify an address.

It was felt that it should be a case-by-case assessment and a last option case. As Health Advisers have a major Public Health role we would need to be satisfied that we had "done everything we can".

Would we need more training in working in the community was a subject that was discussed.

Research was discussed as being required to show “how effective is it”. Have there been any studies to show whether partner notification for contacts has an impact on reducing the infection rate.

The other group looked at “*All patients with Chlamydia without attending partners will be re-interviewed by the Health Adviser*”

The health advisers who took part in this group discussed at length what currently happens in their clinics at the present time. Most appeared to advocate a return visit by the patient to check compliance where further discussion about contacts could take place, or erythromycin given and advised to return in five weeks for further interview, if the patients did not return then a telephone interview would be conducted. The group thought the ideal would be that all positive chlamydia patients had a face-to-face interview with the Health Adviser or a telephone interview the aim was to do one follow up.

This all depended on the clinic resources and the assessment of individual client need as this would influence the level of Health Adviser input in the following up of patients.

# Counselling Focus Group

**Facilitator: Tony Proom**

*Question for debate;*

*All health advisors should hold some formal counselling training.*

*Debate;*

- Will this put people off the job?
- Health advisors practice at differing levels, from using counselling skills as a communication tool to more in depth formal counselling/psychotherapeutic practise.
- There do exist health advisors with excellent communication skills who do not hold a formal counselling qualification.
- For registration purposes the above should be recognised as experiential learning.
- There is no wish to exclude or 'put off' existing health advisors.
- Where are the resources to cover time and financial commitments for counselling practise and training?
- Will there be a role clash with existing counsellors?

*Agreed action points;*

- Counselling certificate recognised by a body such as BHAC or UKCP is essential.
- Possibly the training to be a specific sexual health counselling certificate
- Clinical supervision is essential and a must
- Existing experience must be recognised as valid.
- This is to be a 'core skill' for new entrants in to the job.

*Further Discussion*

- We all as health advisors have various levels of counselling skills.
- We all as health advisors have varying amounts of time in which to practise these skills.
- Much of our work involves assessment prior to referral onto other specialised services, some of which are psychotherapeutic services.
- Counselling skills are seen as the minimum standard for the job.
- Sometimes there may be pressure to 'do counselling'.
- People may/or may not want to further their counselling skills.

*Action points*

- Counselling skills are a minimum standard for the role of health advisor.
- Training in counselling skills and also basic psychotherapeutic assessment of patients would be welcomed.

## Community Outreach Work Focus Group

**Facilitator: Debbie Burnett**

It was suggested to the facilitators that the groups look at three questions in order to focus the discussion and hopefully develop recommendations or action points. The people attending this workshop had a wide-ranging discussion on the topics suggested and agreed some action points.

The following three questions were addressed and points raised are noted.

### ***To what extent should health advisers be responsible for undertaking outreach work?***

Our public health remit was stressed.

Some HAs felt outreach work was within our remit and some felt that we should concentrate on basic GUM work.

It was felt that HAs should be making effective links with local schools, family planning clinics, etc.

“A responsibility but not *the* responsibility’ as one person put it.

An example of the recent syphilis outbreak was discussed with regard to HAs work around outreach given their public health remit.

People wondered who has the power in the community and how much HAs should feed into that structure.

### ***Do health advisers need training in outreach work?***

The HAs present shared lots of examples and experiences around outreach work in their own practice. They felt it *should* be part of the core health adviser training. Examples of work being done in schools, in factories, with gay men and working women and in saunas were mentioned.

Concerns around safety issues were raised. One HA felt her health visitor training had helped.

People generally felt that types of outreach work undertaken depended on an individual’s training and experience.

It was difficult to define exactly what was meant by the term *outreach work*.

The idea of HAs doing clinic exchanges was seen to be potentially useful and led to a broader discussion on *how do you train HAs?* One person felt that school nurses should be given more training.

Increasing the role of local health promotion units was also mentioned.

A couple of participants said they thought HAs should not be primarily responsible for work in schools and that teachers should do more. This led to a discussion as to

whether it would be more appropriate if HAs were more involved in training other professionals.

***Should health advisers be based within or accountable to D.G.U.M.s?***

Participants said that as there are different types of HAs, the role was blurred and not clearly defined in many cases.

Community based PCT HAs are growing in number.

It was felt that the work around registration was valuable in the future definition of the role.

It was agreed that HAs *need to be professionally accountable and aware of their remit.*

People raised the idea that our job title should be changed to *sexual health advisers.*

Also that *all health adviser job descriptions be standardised*

*all health advisers should be following SHASTD guidelines*

*all health advisers should be closely linked if not accountable to GUM services*