SHASTD

ANNUAL CONFERENCE REPORT

MSF
the union
for skilled and
professional
people

Cwmbran, Wales
April 26th to 28th April 2000

SOCIETY OF HEALTH ADVISERS IN SEXUALLY TRANSMITTED DISEASES

Conference Team:
David Cox, Sandra Jarrett, Anita Johansson, Sandra Smith, Jean Beards and Tony Hussein.

44	(v) Young People's Clinic Anita Johansson, Health Adviser, Cardiff
45	Evaluation Summary. Sandra Jarrett, Southern Region Rep. and Conference Co-organiser

INTRODUCTION TO SHASTD 2000 CONFERENCE

Dear Colleagues

At this years conference we have had a stimulating and exciting time with many presentations, workshops and discussions by Health Advisers skilled and recognised in their field of expertise.

Over the years I have been conference organiser, I have seen the flourishing confidence and professionalism of many health advisers who have taken the opportunities to present their work at conference. This in turn has encouraged others to take that risk, within SHASTD and beyond, with great success.

I would like to thank all the people who have presented, ran workshops and gave of their time to make the conference a great success. I would especially like to thank the team from Wales for their hard work and enthusiasm; Sandra Smith, Jean Beard, Anita Johansson and Tony Husein.

During the last 3 years Sandra Jarrett has been working alongside me in organising the conferences. She has been a great support. I would like to thank her and wish her well as she takes over as conference organiser.

David Cox

(2) Oral Presentations

(i) 'SEXUAL HEALTH ON THE WEB - AN IDIOTS GUIDE!'

Chris Faldon, SHASTD Vice President, Newcastle

Introduction

Sexual health educators including Health Advisers have the thrilling opportunity of launching their work into hyperspace! However there are many potential pitfalls when attempting to exploit this relatively new medium of communication. Some will be unforeseen yet with careful planning unintended and undesirable outcomes can be minimised.

This presentation was very visual in portraying images from Internet websites. It did explore some important themes for consideration in the construction of a website with sexual health content. The actual mechanics of website design were not covered but professional, legal and ethical issues were raised.

Chris Faldon was a complete novice to the Internet until 1998. Since then he has embraced the challenge of building the SHASTD site with appeal to both professionals and the general public. Lessons learnt were shared and passed on.

Jargon buster

- 'Internet' – Global collection of networks & computers, all of which share information, or at least e-mail, using agreed-upon Internet protocols
- 'World Wide Web' – Easily accessible fraction of the Internet composed of documents and objects linked together
- 'Browser' – Software allowing the 'surfer' to connect to sites & navigate through the 'Web' with relative ease.
- Modem – The box that connects your computer to a telephone line
- The Internet: A 'living resource'

Health & the Internet

Arguably the Internet is one of the most exciting developments since antibiotics. In the USA in 1997 there were 17.1 million searches for Health & medical information. In 2000 this rose to over 30 million. The NHS Direct Website launched December 1999 contains 14,000 pages. It cost £3.75 million

Sexual Information on the 'Net': Welcome to the house of fun!

- Learn about sexual health to sexual oddities
- Read steamy stories of wild sexual adventures
- View porn pictures and real-time movie clips
- Have sexual conversations with strangers in 'chat rooms'
- Send sexy or romantic e-mail to your lover

Influence of Pornography
- Porn & technology: Old bed-fellows! ie Polaroid instant camera
- Computer sale growth fuelled by porn
- 90-95% males on internet have checked out porn
- 10 –15% would buy a magazine
- ?60-70% of all internet traffic is adult in nature
- I'm innocent your honour!
- $560 million dollars spent 1998 on access to adult web sites
- Morally opposed to porn? Bin the modem!

Net sceptics
- Powerful tool of pornographers, paedophiles & extremists
- Uncontrolled source of exploitation & corruption
- Accessible to vulnerable people in society

Net proponents
- Sexual health information is not pornography
- Positive exploitation – Access & control issues
- Worth the risk
- Professional development is greatly facilitated

The accessibility of the web
This is its greatest strength. More than one billion people will be connected to the Internet by the end of the year 2000. Production and distribution of health education materials is so much easier. They can be attractively presented and updated regularly.

The privacy of the web
This is another great strength. Millions of pages of information are to hand
Its confidential mode of communication helps to overcome traditional and cultural taboos that pose obstacles to exploring deeply personal issues. Here is an example of a posting to the SHASTD Website;

"I have had a problem for quite a while now, on my penis there are some lumps, i am fairly certain that it is not an STD and I do not wish to attend a clinic as i find this very embarissing, would it be possible for me to send you a picture of my problem for you to diagnose it? so the i can go to a clinc knowing what i am facing."

The format of the web
There is the potential to interact with the information. Well designed sites with quality content will attract visitors. The SHASTD site receives approximately 40,000 'hits' per week. Most of these are from the general public.

Serving the professional
NHS Net Intranet
Connects NHS trusts, HA's, GP's and others. It is the gateway to the Internet for many. It is estimated that all 26,000 GP's will be on it by end March 2000. Appointment booking and specialist referral should be possible by March 2002. In Manchester GP's are making ambulance bookings online. In Glasgow GP's are accessing test results. Future? – Patient access for prescriptions, results.

Legal issues
No specific legislation exists to govern Internet. No prosecution of Health Professionals who have a website has yet occurred. If it was a 'pay as you go' site the Obscene Publications Act (1959) may be called in if 'offensive' images were published which could 'deprave and corrupt' a significant proportion of viewers. Standards may be lower than those applied to print and videos. The Protection of Children Act (1978) is concerned with the taking and distributing photographs of children. A site would do well to avoid such images. A site produced for the 'Public good' is a good defence in law.

Policing issues
Criminal Justice & Order Act (1994) was amended to include electronically stored information. The Internet Watch Foundation seeks to monitor and police the Net.

Control Issues
Rating systems exit but are effective only if web authors use them.
Internet Service Providers: move towards making rating a hosting requirement. Home page warnings can help.

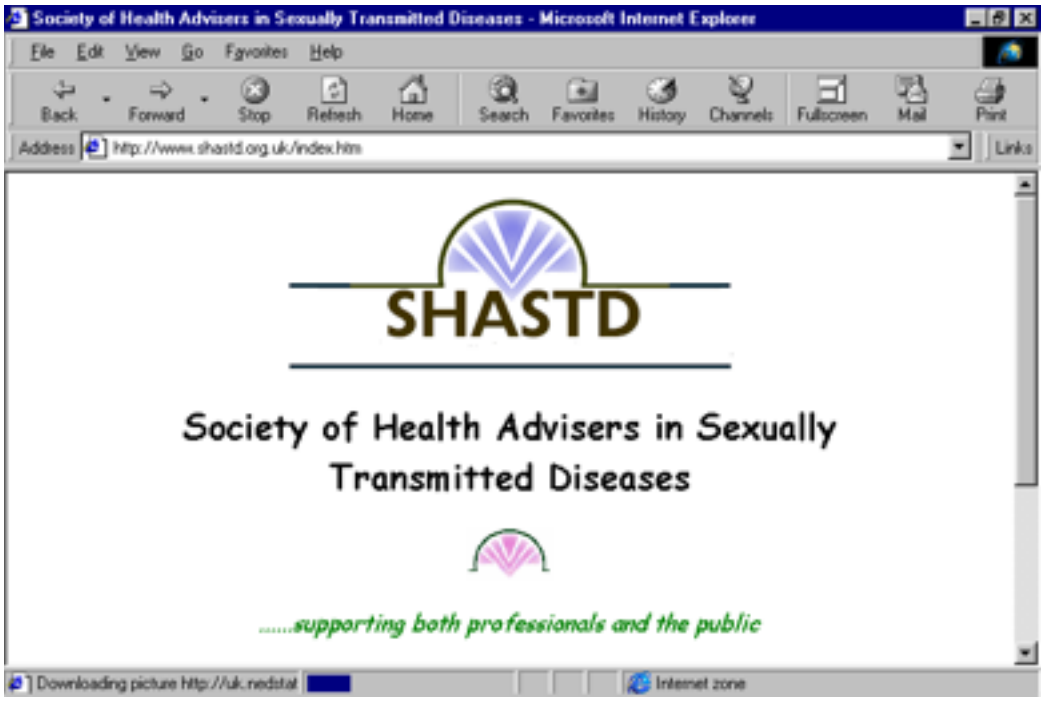
Sexual website development

Should an organisation seek to have a web presence the following should be considered.

- Who is it for?
- Are there clear educational & professional aims?
- Design & content is crucial
- Maintenance issues. A site is easy to build but hard to keep fresh.

Useful resources

Health Education Authority (1998) Sexual health in cyberspace.
Crumlish, C. (1999) The internet for busy people. Osborne.
SHASTD website. www.shastd.org.uk



(ii) TESTING TIMES:THE CHANGING ROLE OF THE HEALTH ADVISER IN HIV CARE.

by Sandra Jarrett

Background context and significant changes.

Epidemiology

There are 33.6 million people living with HIV infection globally. 5.6 million became infected in 1999.
The steepest increase is from the former Soviet Union and mainly through IVDUs, including an increase in syphilis.
India and the Middle East has also seen an increase.
The most affected area is still sub-Saharan Africa which accounts for 69% of prevalent infections, although Western Africa is starting to be more affected e.g. Nigeria and Ghana.
In 1999, there were 2.3 million new infections in women and 570,000 in children under the age of 15.
In the U.K. the numbers of infections have risen 29% between 1995 and 1998.
Sex between men- a rise of 23%
Heterosexual sex- a rise of 72%
IVDU- a rise of 3%

There has been a significant reduction in the numbers of Aids cases and deaths from HIV infection in Western Europe and North America due to new anti-HIV treatments. A combination of longer survival and large numbers of new infections is increasing prevalence.
There is little progress in reducing the number of new infections and the cost of medical care is rising.

Funding and Resources.

There has been an end to ring-fencing, and the prioritisation of services. This has resulted in the reduction or closure of services in both the statutory and voluntary/charitable sectors.
There has also been a move to 'normalise' HIV and incorporate it into existing services.
The cost of anti-HIV treatments has also contributed to the streamlining of services, and a loss of so-called 'soft' services, which has increased the pressure on those who remain.
Those centres which see a high number of patients are increasingly specialising due to the growing complexities of treatment, and the changing epidemiological pattern in that higher numbers of women and children are being infected, many from black and ethnic minorities.
There are now many HIV designated clinics; HIV antenatal and paediatric care; treatment clinics; clinical trials; Clinical Nurse Specialists and Nurse Practitioners;

There have been significant changes to Housing and Benefit legislation; to Immigration laws which impact on the work we do with patients e.g. with asylum seekers.
There have been different government health policies which impact on resources and direction of services e.g. Health of the nation; the National Sexual Health Strategy; Teenage Pregnancies etc.
Future development of primary care groups and community/outreach work will impact on our work in an acute hospital setting.

HIV Testing.

There has been an increase in different testing sites and Same Day Testing services, but probably most health advisers are involved in pre-test discussion with patients. There are already clear guidelines around this subject which most people adhere to.
Suggestions.

- have a clear policy for referral and discussion.
- recognise the opportunities for training and supervision of other staff who may be involved in testing e.g. midwives, nurses, doctors.
- evaluate and audit
- retain visibility

Post-Test Counselling

There is a wide diversity of practice in this area depending on resources, prevalence, location, clinic culture etc.
Giving results
Ensure some involvement in result-giving, as you would any other STI such as gonorrhoea or chlamydia.
Preparation: a good relationship with virology in order to get results beforehand.
liaison with other staff
a written policy is helpful
Interview: if negative, an opportunity for health promotion and future behaviour change; check window period.
if positive, give result immediately
the same person who did pre-test should ideally give the result.
check understanding and give clear information
Assessment: Helps prioritise need and identify current and future concerns
personal details

genogram
housing, financial, legal situation
support networks
medical and sexual history
next of kin/contact in emergency
immediate concerns
future concerns
action plan
follow-up appointment
summary in notes and/or letter to consultant

Conclusions

1. Be clear about what your role is and what you can do. Apply your role in other areas to HIV e.g. advice and information on a new diagnosis; partner notification; primary and secondary prevention; sexual health issues; crisis intervention; assessment and referral; etc.
This helps to prioritise workload and set boundaries e. g. newly diagnosed, pregnant women, children and families.
2. Know the local resources and key people for liaison and referral. Network.
3. Know your local prevalence, in order to target resources appropriately and offer meaningful services.
4. Be involved in training in your area for student nurses, medical students, schools and community groups.
5. Attend training and continue your professional development.
. Use local/national sexual health guidelines and policies to support your involvement in continuing care for people with HIV.
7. Be proactive and publicise your service as much as you can.
8. Document your work. Be transparent.
9. Delegate and share.
10. Don't do everything!

Contact Tracing / Partner Notification'

DEBORAH JANE TIMMS SENIOR HEALTH ADVISER. ROTHERHAM

Contact Tracing and Partner Notification are phrases that as Health Advisers we use and hear all the time but…

The questions I want to ask are:

- Is there any difference?
- Does it make any difference what name we use?

Contact tracing follows the fundamental aim of epidemiology: the source of infection must be traced and treated. In addition secondary contacts must not be neglected.

Contact tracing is not unique to GU Medicine. There are other professionals who also use contact tracing in infection control: Environmental Health Officers dealing with the out break of E Coli in Scotland, Infection Control Nurses in hospital . Health Visitors, in the control of TB (in some areas in the United Kingdom TB Health Visitors are being re-introduced) and in Public Health Departments. The recent outbreaks of Meningitis has highlighted the importance of contact tracing.

In GU Medicine what is so special about dealing with primary and secondary contact?
As we are aware we all work within the VD Regulations, which enshrine the need to give patients maximum confidentiality when dealing with a sexually transmitted infection. Patients are entitled to confidentiality in any area of medicine, but the sensitive nature of sexually transmitted infections demands particular tact and discretion – as in the NHS (VD Regulations) 1974 –"Every Health Authority and Area Health Authority shall take all necessary steps to secure that any information capable of identifying an individual obtained by officers of the Authority with respect to persons examined or treated for any sexually transmitted disease shall not be disclosed. " This is the big difference between contact tracing within the realms of GU and other areas of medicine.

In the early 1940s the "Tyneside Scheme" Tyneside Experimental Scheme in Venereal Disease Control [1944] employed Health Visitors to interview patients in GU Departments. Until then contact slips had been used with a poor response. Patients had great difficulties in persuading their partners to attend clinics. Sixty years ago sex was not discussed and knowledge of infections was limited. However, it was found that Health Visitors were able to assist in this task. In the early days in the Newcastle Region and in the West Riding of Yorkshire Health Visitors visited named contacts when index cases failed to persuade contacts to attend. The main barriers to attendance were social, financial and domestic. Contacts were unable to take time off work or didn't have the money to travel to the clinic for investigation. One of the outcomes was that GU Departments obtained travel funds so that patients could claim fares and keep their anonyminity.

The role of the Contact Tracer was developed in response to these problems. During the '40s and '50s more clinics acquired contact tracers. In 1962 the Chief Medical Officer, for England and Wales in his Annual Report stated that every clinic should have one.

Contact Tracing, in addition to seeking early diagnosis and treatment was aimed at health education for the patient and the partner. It was recognised as a part of a strategy for the control of Sexually Transmitted Infections (STI). It enables treatment of individuals who may be unaware of their infections. It also prevents reinfection of the source patient and the transmission of the disease to other people.

According to Dr R S Morton (Honorary Lecturer in History of Medicine, University of Sheffield), in 1968 a committee of Consultants made it clear that provided Contact Tracers did not disclosed their sources to contacts,similarly ,contacts would be sure that if they were found to be infected they too could be assured of the same strict confidentiality. This same committee initiated the idea that all clinics report their contact tracing results quarterly in the cases of Gonorrhoea and Syphilis.

In 1968 the Society of Social Workers for the Studies of Venereal Diseases was formed. Ten years later the Society adopted a formal constitution and became known as the Society of Health Workers in Venerology and Genito Urinary Medicine. To avoid confusion with Social Workers and Health Visitors, it became necessary in 1981 to change the title once again to the present one of the Society of Health Advisers in Sexually Transmitted Diseases.

WHY USE THE NAME 'CONTACT TRACER'? WHAT DOES IT MEAN?

"There is a complexity and profusion of terminology and naming alternatives which causes difficulties in writing about STDS and Contact Tracing."
I have taken this from the orange handbook (our bible) "A Handbook on Contact Tracing in Sexually Transmitted Diseases" published twenty years ago.

It was noted staff undertaking contact tracing had widely varying backgrounds, training, qualifications and status. The options were to describe them as social health workers, health workers or contact tracers. Social health workers were ruled out because at that time (the 1960s) anything that had social worker in its title was politically contentious. Health Workers was preferred, but the Department of Health and Social Security drew attention to representation they had received that this term was already used, in a generic sense, to describe anyone working in the NHS. It could, if used in a specialised context, cause confusion with Health Visitors. In the end 'Contact Tracer' was adopted by default.

It is important to look at the word 'Contact'. The word contact presents difficulties because in the jargon of contact tracing it has been used as a synonym for the sexual partner of a patient. 'Contact' is also commonly used descriptively, as in contact tracer (a tracer of

contacts) and contact investigation (investigation for contacts), and as a verb meaning to establish contact with, or get in touch with a person.

In Collins Thesaurus it is put as "approach, call, communicate with, get or be in touch with, get hold of, reach, ring, speak to, write to".

Of note in the Control of Venereal Disease Regulations November 1968 "those employed as Contact Tracers…the task calls for tact, patience and, on occasions, courage and resource." It was also noted that the work was exacting, time consuming and a great deal of skill was needed!

SO WHEN DID HEALTH ADVISERS AND THE TERM 'PARTNER NOTIFICATION' COME INTO USE?

The term Health Advisers came in to common use in the mid 80's my original contract of employment in 1981 is Contact Tracer (Health Visitor) Special Clinic.

In a consensus statement from " Consultation on Partner Notification for Preventing HIV Transmission" from the World Health Organisation 's Global Programme on AIDS and Sexually Transmitted's Diseases January 19889 in Geneva, it was stated that Partner Notification is similar to "contact tracing ", The practice of identifying, counselling and treating sexual partners of persons with STI was an important component of STI control programmes.. However HIV infection differs in important ways from many other STI.

During the 1980s HIV infection appeared raising legal, social and cultural, political and ethical issues that were debated long and hard. It particularly raised issues about the rights of the individual verses and the needs of the general community in terms of the public health.

For contact tracing to be ethical the advantages to the patient and/or contacts and community must outweigh the disadvantages. For example,in tracing bacterial conditions, (such as gonorrhoea) the benefits were clear to all parties. The index patient avoided re-infection, contacts avoided long term complications of untreated infection and the community benefited from a reduction in infecting transmission potential.

The benefits for an incurable sexually transmitted infection, such as HIV were not so clear. There was no evidence that a persons knowledge of their infectious status would prevent

onward transmission. The fatal nature of the illness at that time led to fears of reprisals on index patients whose identity might be guessed. Some contacts might assert a right not to know that they had a terminal illness. Energetic public education at this time saved the British public well.

At community level, the high proportion of cases among gay men led to a fear of intensified discrimination. In that context, contact tracing may have been perceived as a threatening and unjustified intrusion. Randy Shilts in his book "And The Band Played On", describes how gay men in San Francisco had conquered discrimination, and had "come out". With the advent of HIV all their anxieties resurfaced , fearing the prejudice they may have to fight once more.

One of the big question asked was " Did contact tracing give advantages or disadvantages to the person traced and if the latter was there any proven or probable advantages to the community outweighing the disadvantages?." Another question at that time was " Did active contact tracing lead to discrimination." [these quotes are from a discussion paper on Ethical Political and Cultural issues in Partner Notification for HIV Infection by JohnGallwey (1989)]

It was also considered that if an individual was identified as being at risk and proved to be infected, clinical, psychological and social support must be available. Very few of these services were available at this time and contact tracing in the absence of such support was seen to be unethical by many in the medical profession. The highest number of HIV cases were among gay men , therefore to target contact tracing at them could be seen as 'selective'.

The legal issues raised at the time were that "The Venereal Diseases Regulations" requires confidentiality to be maintained on information obtained in examination or treatment of a person for any sexually transmitted disease (including HIV) and forbids disclosure of information to any other person, " except for the purpose---- of treatment or prevention of spread (of infection)"

The law as it stood enabled contact tracing to take place. But co-operation was voluntary, HIV was not made into a notifiable infection and therefore no changes were required to the National Health Service [Venereal Diseases] Regulations Act 1974.
So the term Partner Notification came into being, and along side that Patient (Index Person) Referral and Provider Referral.

For the last ten years Contact Tracing and Partner Notification have been used and discussed at length within the SHASTD. Some, Health Advisors use Contact Tracing and others Partner Notification.

When interviewing a patient a Health Advisor should:

- Obtain full sexual health history
- Health Education
- Partner Notification
- Contact Tracing

Obtain full sexual health history . Despite the fact that doctors will have done a full history and examination ,we go through it again , its often amazing what new information comes to light!

Health Education. What the infection is, how they caught it, who they may have given it to, how they can avoid it in the future.

Partner Notification. Who they have had sex with, what is the relationship, do they wish to inform the contact, or do they wish the Health Advisor to do it on their behalf [to maintain confidentiality].

Contact tracing. If the Index patient wishes to inform the partner, then the Health Advisor has to document names, cross reference records etc . If the Index patient has given the information for the Health Adviser to trace , then the Health Adviser's role is to locate the contact and encourage them to attend for screening as soon as possible, so reducing the number of infected persons.

So to address the original question of Contract Tracing or Partner Notification

- Is there any difference?
- Does it make any difference what name we use?

Yes there is a difference and it does matter. Partner Notification is an important method by which we establish and negotiate with the patient and their contacts the importance of attendance to Departments of G.U. Medicine for screening and treatments.

However Contact Tracing, as I mentioned before, is a critical strategy in the control of sexually transmitted infections as it enables treatment of individuals who may be unaware of

their infections. If speedy carried out it also prevents re-infection of the source patient and the transmission of infection to other people.

Before HIV in the early '80s we talked about 'Contact Tracing ', as Health Advisers we knew our role. Then came H.I.V. and those of us in G.U.Medicine did alot of soul searching and the term "Partner Notification " came into use.

However the term "Contact Tracing clearly describes the activities of Health Advisers and strongly shows a pro-active approach to partner notification.

- It has much more clarity and impact than the W.H.O.'s obscure term.
- It clearly states to other professionals our role in public health control.
- It also reminds us that our casework is not completed unless we have offered to find the contact ourselves.

So in the first year of the new millenium we should proclaim our beliefs in 'Contact Tracing' as the fundamental role of Health Advisers.

REFERENCES

- Handbook on Contact Tracing in Sexually Transmitted Diseases. Department of Health 1988
- Tyneside Experimental Scheme in Venereal Diseaes Control [1944] Section 1 in the BMJD 1944
- Consensus Statement from Consultation on Partner Notification for Preventing H.I.V. Transmission. Geneva 11-13 January 1989 W.H.O.
- And The Band Played On. Randy Shilts. Penquin 1987
- Discussion Paper on Ethical, Political, and Cultural Issues in Partner Notification for HIV Infection . John Gallwey Oxford 1989.

Munchhausen's And Rape -The Abuse Trap: A Case Presentation

Dorinda Thirlby
(Senior Health Adviser/Clinic Manager Roehampton GUM clinic)
George Leach (Clinical Supervisor for several Healthcare Trusts)

This was a joint presentation about a woman who came to Dorinda's clinic saying that she had been sexually assaulted. Dorinda discussed her work with this client as the health adviser 'on call' and how she had taken the case to supervision with George - who works in a number of clinics. In supervision it emerged that the woman was a multiple attender of GUM clinics, diagnosed with Munchausen's disorder.

George gave some background theory about Munchhausen's and Personality Disorders, their prevalence, and the effects they have on clinicians. He also discussed the important role of supervision when working with rape/ sexual assault.

Munchhausen's Syndrome

This was first described by Asher in 1951, and named after the unfortunate Baron von Munchhausen who was a pioneering sufferer of the condition. In the fourth edition of the Diagnostic and Statistical Manual an attempt was made to give it a new name (Factitious Disorder), but this is not commonly used.

Common features of Munchhausen's Syndrome

The Syndrome can present with psychological or physical features or both. Typically the client with Munchhausen's will present at A&E simulating an acute illness. Their claims will be supported by a dramatic history, which is plausible and may even be partly based on truth. These clients are often knowledgeable about hospital procedures. Their alleged condition often gets extensively investigated, and sometimes surgery is performed. They have extensive knowledge of hospital procedures and routines.

Although these individuals usually present their stories with a dramatic flair, they become vague and inconsistent when questioned in greater detail. As one symptom is dealt with or found to be without foundation they develop new symptoms.

If they are discovered and confronted, they tend to discharge themselves.....only to present soon afterwards somewhere else. It is also significant that these clients usually have no wish to talk about their underlying psychological difficulties.

This Syndrome is more common among men than women, and is likely to be associated with a severe personality disorder.

According to the Diagnostic and Statistical Manual there are a number of features of Munchhausen's Syndrome:

- Firstly there is the intentional production of symptoms. These may include, the fabrication of subjective complaints (e.g. acute abdominal pain) self inflicted conditions (e.g. injecting saliva under the skin to produce abscesses, or the exaggeration or exacerbation of pre-existing general medical conditions (e.g. a person with epilepsy feigning a seizure) or any combination or variation of the above.
- Secondly the unconscious or partly conscious motivation is to assume the sick role.
- Thirdly: there is an absence of externally apparent incentives for the behaviour. No secondary gain.

George discussed the effects that contact with such clients might have on the clinicians who are hooked into a sincere attempt to help them. Initially the practitioner may be very motivated to rise to this challenge, superficially the case is urgent and helpable . These clients can also make clinicians very anxious and give them the feeling that something MUST be done. It is almost diagnostic that clients with personality disorder get under your skin (not in an empathic way). For example, in supervision George has noticed that the Health Adviser is left with a disturbed, uncomfortable feeling after contact with such clients.

When the truth comes out however, the clinician is likely to feel angry and possibly punitive because the client has been wasting time that could have been devoted to genuine cases. Interestingly, the clinician can also feel foolish for 'being had' and colleagues may unhelpfully pile in to say they thought the client was faking all along. This can leave the clinician with a sense of shame. It is always difficult and usually impossible for the real problem to be dealt with if the client is intent on acting out the disturbance rather than looking at why it happens

George questioned whether there is a common "footprint" that Muchhausen's clients leave behind in the treatment setting. Why might this happen? Might it be connected with the real abuse (sexual or otherwise) originally suffered by the client, usually in childhood?

Supervision

George gave a definition of supervision:

> 'Clinical Supervision' is a term used to describe a series of formal, planned and regular discussions which has the purpose of facilitating reflective practice. This supports the practitioner in their role, encourages the development of practice skills, and maintains professional and ethical standards in the context of on-going professional development.
>
> - Leach French and Miller 1997

Supervision and Health Advising

The support provided by supervision is important in a sexual health setting particularly because of some of the stressful features of Health Advising. Health Advisers are front line workers – they see people who have usually not been filtered through a psychological assessment process. This is inherently stressful. While they are working with a client, the Health Adviser may simultaneously be thinking about avenues of referral, or indeed the absence of such an avenue for that particular client. So the Health Adviser may be on the front line with challenging clients for whom there is little back-up in terms of referral options, or where the immediacy of the problem means that it has to be engaged with there and then.

The client may also be in crisis, which means that they themselves are struggling to cope with some aspect of reality, and that the Health Adviser is being co-opted into that struggle.

People with mental health problems don't always know they have them, and even if they do they may have sexual health needs. Health Advisers have to understand and respond to a bewildering and unpredictable array of psychological problems.

A significant number of clients who come through the doors are people with Personality Disorders. There is a high prevalence of Personality Disorder in the general community. It runs at between 5 and 15 percent, with the higher figure relating to areas of greater social deprivation. There is a shortage of appropriate treatment facilities for people with Personality Disorders and this leads to overuse or abuse of other treatment settings.

All of this of course has to be done against the clock and while the Health Adviser is being exposed to sometimes very distressing material and to situations in which they can feel powerless to help.

In working with people who have been raped, George felt there were particular support issues. Consider how institutions respond to people who have been raped. There are encouraging signs of change and that people who have been raped now receive more sensitive and supportive care. But there is still a long way to go.

The violence of the rape can resonate within the treatment setting, when the client seeks help. Hearing about the client's trauma exposes the practitioner to a kind of secondary trauma. There may be a natural, defensive impulse to turn away.

Empathy can be a painful business because it means understanding someone from their own point of view. Sometimes it can spill over into identification where it is as if the client's experience is one's own. This can be compounded by the fact that the practitioner may have abuse issues of their own.

The client may experience their encounter with the treatment setting as a repetition of the abuse. Sometimes it is the symbolic repetition of the abuse event that triggers an emotional response in someone who had previously seemed quite numb. Vaginal examination for example. The treatment setting may be seen as shaming and guilt inducing, or rescuing and protective. These transferences set up many possible countertransference responses in the practitioner. For example there may be a profound distrust of their own ability to help without hurting, feelings of blame towards the client, or a desire to protect the client from reality.

What might it do to practitioners to do a lot of this work over a long time? Miller's work on burnout would suggest that without adequate support, practitioners could only do this kind of work for so long without suffering the emotional blunting, withdrawal and reduced level of functioning characteristic of burnout.

Munchhausens & Rape

It would be wrong to think that the traumatic nature of the work with such clients is less than with those who have really been raped. This is because there is a three layered trauma going on for the practitioner. Firstly the trauma of hearing the story as if it were real, secondly the trauma of finding out it was not true after all and dealing with the aftermath, attitudes of colleagues etc., and thirdly exposure to the less conscious trauma that underlies the client's need to abuse the practitioner. This was the abuse trap referred to in the title,

and to fail to be aware of it means that the original abuse continues to be perpetrated in some way.

SHASTD/MSF PAY AND CONDITIONS SURVEY 2000

Heather Wilson SHASTD President
Colin Adkins MSF Health Section Research Officer

Introduction

The SHASTD Pay and Conditions Survey follows on from the pioneering survey[1] carried out in 1993/994. This year's survey is particularly timely in view of the fact of the Agenda for Change talks on a new pay system for the NHS which are currently taking place and the associated Job Evaluation (JE) exercise. Briefing materials on Agenda for Change and the JE exercise are available from MSF.

The key objectives for SHASTD/MSF are:

- an appropriate level of reward for the work of health advisers;
- a common grading structure with terms and conditions of employment through a process of harmonisation which does not result in any overall detrimental effect for health advisers;
- a move towards the recognition of the professional status of health advisers and the establishment of the necessary infrastructure which will enable health advisers to become a registered profession in their own right.

The Aims of the Survey

To get a clear idea of the present scales and gradings in order to analyse any changes which have taken place since the last survey and provide the basis for a way forward to meet one of our key objectives of a common grading structure.

To use the information acquired to advise on another key objective of a professional career structure for health advisers.

To inform MSF negotiators participating in Agenda for Change.

[1] **Health Advisers Pay and Conditions Survey 1993/94: Christine Fogg & Viv Westbrook**

The Method

The questionnaire and covering letter, addressed to 'The Health Adviser', was sent to every clinic in the UK during Winter 1999 requesting that the survey was returned by 31st January 2000. Where there was more than one health adviser in post, the letter and survey asked that the necessary photocopies be made. All SHASTD/MSF members were also mailed directly.

The SHASTD web-site was used to extract the details of each clinic.

The project received the full support of the SHASTD Council.

The Response

A total of 253 responses were received out of an estimated potential of 300. This is a response rate of 83%. Presently, SHASTD has 287 health advisers in membership.

This compares with 230 responses to the 1993/94 survey. Where there are comparative figures from this survey, these will be in placed in the rest of the text in square brackets [] in order that you can make any comparison.

Summary of Findings

About Health Advisers

Gender

206 or 81% of the respondents were female and 47 or 19% were male.

Current Title

186 or 74% [74%] had 'health adviser' as their title.
50 or 20% [14%] as 'senior health adviser'.
6 or 2% as 'nurse specialist' or 'charge nurse'.
3 [2] or 1% as 'trainee health adviser.

8 or 3% [11%] did not work under the name health adviser, but were responsible for relevant duties within their clinics.
This effectively standardises the job title as health adviser.

Qualifications

194 or 77% [77%] of respondents were qualified nurses. The majority of respondents had at least one other qualification to their credit. The most frequent was a counselling course (46%) [55%], a degree (40%), CQSW/DipSW (5%). 107 or 42% had a range of other qualifications.

Terms and Conditions

Work Hours

The majority of health advisers (66%) [77%] work on a full-time basis while 31% [23%] work on a part-time or job share basis.

Type of Contract

The majority of health advisers (64%) were on Trust contracts, while 30% were on Whitley contracts.

Grading

The majority of health advisers are on nursing grades (51%) [66%], while 28% [31%] are on Administration and Clerical (A&C) grades, 17% on Trust scale (which may be linked to a nursing or A&C scale) and 3% on senior management scale. The spread across the grades was as follows:

Nursing grades			A&C[2]
E	3%	2	2%
F	7%	3	2%
F (top)	3%	4	1%
G	17%	6	17%
G (top)	9%	7	7%

[2] **We suspect that an error may have taken place in the completion of the surveys in respect of A&C 2-4.**

H 8%
H (top) 5% Other 14% Max/top 4%[3]

Salaries

42% of health advisers earn less than £21k, while 46% earn over £21k. The mean is £20,850. Of concern are the 10% who state they earn less that £15k, although this is part-time earnings. Average full-time earnings are £22,470 and average part-time earnings are £16,532.

Average salary by clinic size is as follows: Urban Small - £21,367; Urban Large - £21,112; Provincial Small - £18,675; Provincial Large - £20,936.

Average salaries for those on Trust contracts are £20,512 and for those on Whitley contracts are £22,161.

Average salaries for those in receipt of London Allowance is £22,161 and for those not in receipt of London Allowance is £20,585.

Annual Leave

28% of health advisers have less than 25 days annual leave, while 25% have 25 days, while 42% have more than 25 days. The mean is 24.97. Of concern is that 9% of health advisers have less than 20 days annual leave which may be in contravention of the Working Time Directive which gives a 4 weeks a year minimum, although this may be partly due to total days entitlement derived from part-time working. The average annual leave for full-time health advisers is 26.53 days for part-time health advisers are 21.38 days.

Allowances

There is an even split between those health advisers who receive a travel allowance (50%) [59%] and those that did not (49%). 9% [17%] had the option of a car lease scheme.

45% [43%] of health advisers receive a STD allowance. 60% of those on Whitley contracts and 40% of those on Trust contracts receive the STD lead.

---

[3] **Assumption made that this refers to nursing grade I.**

17% [10%] are entitled to a clothing allowance.

29% receive London Allowance. Only 4% receive some form of other allowance: telephone allowances (2%), travel allowance (1%) and other not specified (2%).

Health Advisers at Work

Size of Clinic

As defined by the National Gonorrhoea Audit health advisers work in the following size clinics: Urban small – 65 or 26%; Urban large 98 or 38%; Provincial small – 42 or 17%; Provincial large – 31 or 12%.

Number of Health Advisers in the Workplace

The highest percentage of health advisers worked with one other colleague (24%) [21%]. A significant percentage worked alone (23%) [31%]. Those with two colleagues 13%; with three 9%; and with four or more 9%. The mean is 2.6 health advisers.

The average number of health advisers by size of clinics as defined by the National Gonorrhoea Audit are as follows: Urban small – 2.00; Urban large 3.47; Provincial small – 1.26; Provincial large – 2.86.

Counselling Supervision

The majority of health advisors (57%) have Counselling Supervision. However whether you have counselling supervision is determined by a number of factors. By taking the percentage of those not receiving counselling supervision away from those that do receive the supervision results in a ratio of whether supervision is received. This is as follows:

By size of clinic:		**By contract:**	
Urban small	+6%	Trust	+26%
Urban large	+42%	Whitley	-8%
Provincial small	-20%	**By working hours:**	
Provincial large	+16%	Full-time	+25%
In receipt of London Allowance:		Part-time	-7%
Yes	+74%		

No -7%

Training

The majority of health advisers (not quantifiable) have undertaken one or more training courses in relation to their health adviser role. 26% are currently undergoing training or study. 31% have experienced a problem getting funding, while 55% experience no problem

Issues

Registration

High Level of Qualifications

As well as conforming to the basic requirements for the job, the majority of health advisers had acquired at least one other recognised qualification, ranging from certificates or Diplomas to professional nursing and EMB courses. The evidence is that health advisers are well qualified and many are continuing their education and/or learning new skills. Indeed it can be asserted that health advisers are more qualified than some professions that have registered status.

The problem is that here are no standard pre-requisites for becoming a health adviser that have been agreed by the profession. This is reflected in the wide range of different (over 30 from a base of 253) qualifications that are held by members. This is because of the varying routes of entry into the profession. Although, the fact that 77% of health advisers are RGNs may indicate that de-facto that standard pre-requisite has been established. But is this at level that the profession requires and how will this impinge on attempts to get health advisers more aligned with counsellors or Professions Allied to Medicine occupations? The case for standardisation appears clear but consensus is needed on that standard and the transitional arrangements for practising health advisers whom may not hold this standard.

Pay and Conditions

In Context

The NHS is undergoing major talks on modernising the NHS pay system in the UK. The proposals entitled Agenda for Change have contained some proposals MSF welcomed and others we have expressed serious reservations about.

The following are the issues that SHASTD/MSF members should consider, which are running parallel to our support for professional status for health advisers:

Agenda for Change talks have outlined a definition for extending coverage of the Pay Review Body. From our survey health advisers should certainly qualify for inclusion in this extended coverage. MSF have submitted a paper that calls for coverage of health advisers by the PRB.

The same talks have outlined proposals for the abolition of local trust pay schemes and its replacement by a UK wide job evaluation scheme. The job evaluation joint working group has made good progress in identifying factors for a new NHS-wide scheme, and the levels within factors. Work continues on this, and there will need to be a further round of testing in the NHS when this work is completed. However, health advisers are presently outside this process.

The career and pay progression joint working group is exploring the definitions of competencies, how they may be defined in a consistent way and the practicalities of introducing them into a system of pay progression. There are also several other strands of work in hand – looking at how market forces might be taken into account of, managers pay and how team bonuses might work.

The Joint Working Group on Terms and Conditions is gathering information on how current terms affect total earnings in order to able to assess the impact on staff and employers of any proposals to change terms and conditions. An attempt has made on examining all the present terms and conditions that presently exists in the NHS.

The Joint Working Group on Implementation is exploring the phasing and timing of implementation, and the establishment of a development programme to support NHS Trusts and staff sides in taking this forward.

Large Salary Range

Amongst health advisers the difference in salary was considerable. At the lowest end of the range were those paid on A&C grade, those at the top of the range tended to be paid on nursing grades or were on Trust contracts. This represents no change since the last survey was undertaken. Indeed the difference between the top and the bottom has been accentuated. Whilst we would expect there to be reasonable differentials so as to allow for experience, qualifications, level of responsibility and so, our study has highlighted an unacceptable discrepancy where the highest paid health adviser is receiving twice as much as the lowest paid. The problem is

obviously at the bottom of the range where salaries do not reflect the professional characteristics of the occupation.

Regional Gradings

By cross tabulating the grading data between those who are in receipt of London Allowance we can confirm the findings of the previous survey that health advisers in London tended to be paid on A&C scale whilst those in the Regions tended to be paid on the nursing scale. 58% [66%] of those in receipt of London Allowance were on A&C scale, compared to a response of 28% [34%] for the country as a whole and 21% [20%] are on the nursing scale.

In contrast 17% of those not in receipt of London Allowance are on A&C scale with 61% [80%] on the nursing scale.

Administration and Clerical Grades

Administration and clerical grades are not appropriate for health advisers. Firstly, they make no allowance for clinical expertise. Secondly, it is self-evident that they are applicable to posts of those "undertaking mainly administrative, clerical and some professional duties" which bares little relevance to the role of health adviser. On the contrary the balance of work involved is drastically different.

The 'benchmark' A&C grade 6 has a salary range (1st April 2000 figure) of £18,236 - £21,336. In contrast the 'benchmark' nursing grade G has a salary range (1st April 2000 figure) of £20,830 - £24,090 with discretionary points taking this to £25,350.

Other elements of the overall terms and conditions package for the A&C grades are less preferential.

More importantly, the vast majority of A&C grades are likely to remain outside the Pay Review Body and it is important that the professional profile of health advisers is promoted over the grade on which many have been inappropriately placed.

Nursing and midwifery grades

One advantage is that 77% of respondents were RGN/RMN trained and 51% (many of the 17% on Trust contracts are also linked to nursing grades) already on nursing grades, and in the main covered by the recommendations of the Pay Review Body. However, those health advisers without a primary nursing qualification may not be eligible for a nursing grade. Therefore if professional status is sought with an appropriate grading structure, a separate health adviser

spine needs to be developed. This would be ideally linked to a distinct spine of Professions Allied to Medicine.

Annual Leave

The average basic annual leave of 25 days for health advisers compares with other health professions. The target is for a service-based entitlement, reaching 30 days after a given period of service. This is already in place with 42% of health advisers presently in receipt of over 25 days annual leave. Any approach should both increase the entitlement for those presently receiving below the average and protect the position of some health advisers who enjoy up to 32 days or at least offer compensation for any erosion of this entitlement.

Allowances

Given that health advisers are expected to do home visits in their capacity as contact tracers, and are increasingly involved in outreach work of one form or another, there should be a facility for claiming travel expenses. Therefore, the reduction of the numbers in receipt of the travel allowance is of concern.

Equality

In a female dominated profession it is surprising that there is ample evidence of the need for SHASTD/MSF to pursue an equalities agenda for health advisers.

A greater proportion of women has a nursing qualification, a certificate in counselling, CQSW/DipSW and other qualifications. Men are proportionately more qualified in a Diploma in Counselling and at degree level. This is probably directly linked to the path of entry into the profession has a tendency to differ between men and women. Yet men are more likely to reach the position of senior health adviser. 24% of men are senior health advisers, whilst 18% of women have reached this position. This is also associated with access to training; a woman having to take career breaks to rear children and the effect of working part-time on career development. Although 28% of health advisers work part-time, only 16% of senior health advisers work part-time.

Professionally, men (79% of men answered yes, against 52% of women) are more likely to obtain counselling supervision and whilst roughly the same proportion of men and women have undertaken training in relation to their role, women (32% answered that they had some problem getting funding, against 28% of men) tend to experience slightly greater problems getting funding for this training. This would partly explain the result that a greater proportion of men (30% of men, against 26% of women) are currently undergoing training or study.

Women are 81% of the profession but only 70% of the total number that receive London Allowance are female. This could be because a greater proportion of men work in London than in the rest of the country. Or another explanation may be that some part-time health advisers that live in London are denied London Allowance. 81% of

part-time health advisers do not get London Allowance, compared with 68% of all health advisers that do not. Part-time health advisers are predominantly women.

Women have a greater tendency to get a travel allowance. But men have a greater tendency to get a car rental scheme. Women health advisers have a greater tendency to get the nursing/STD lead allowance that reflects the route of entry

Conversely men are more likely to work on generally considered inferior Trust contracts than Whitley, which may be explained once again by the path of entry into the profession. Women have a greater tendency to be on nursing scales and men on A&C scales. Regardless of what the scale, men tend to be grouped at the top of each respective scale. However, some of base figures for the numbers of each scale point are small and therefore these results should statistically be treated with caution.

But overall the net effect of all these various processes on salaries is clear. 30% of men earn less than £21k, while 45% of women earn less than this amount. The mean gross salary for men is £22,317.40, while for women this is £20,489.60.

Men on average have 25.47 days annual leave, while women have 24.38 days.

Opportunistic screening for Chlamydia trachomatis : local implementation and management of those screened positive.

Lindsey Shone, Community Health Adviser, Wirral Chlamydia Pilot

Abstract

Background

In 1998, an Expert Advisory Group on Chlamydia trachomatis concluded that measures were required to reduce the reproductive mortality associated with untreated infection in England. They recommended testing of all symptomatic individuals and those in high risk groups, in addition to opportunistic screening of sexually active
young people. As a result, the government has funded a pilot study to assess the cost, feasibility and acceptability of opportunistic screening in primary and secondary health care settings, focusing on 16-24 year old women.

Implementation

The pilot was introduced to health professionals during the Spring of 1999. Education of professionals was crucial to the success of the pilot and is being evaluated independently by NOP Research.

Management of those screened positive for Chlamydia

Men and women who test positive receive a letter to the address of their choice, as with any screening programme. They are requested to telephone the pilot office to make an appointment to speak to a community health adviser.

The consultation involves education about chlamydia, discussion about treatment options, referral to GU and partner notification.

(3) Workshop findings

(i) Herpes – My Favourite STD!: Working with Patients Newly Diagnosed with HSV

Rob Houghton, Ambrose King Centre, Royal London Hospital.

The aim of the workshop was to show that while HSV and its impact may require time and patience, it can also be a rare opportunity for health advisers to work at some depth with people, addressing vital concerns, and be an immensely rewarding part of any working day.

The formal aims and objectives were as follows:-

Aims
To allow participants to discuss their difficulties and assist them in identifying resistances to working with people with HSV;

To explore the symbolic reality of HSV for patients, staff and society as a whole;
and
To make explicit the needs of people newly diagnosed with herpes;

To look at how these needs might be met in a single session.

Objectives
By the end of the workshop, participants will feel more at ease with the subject;

They will be able to work in a way that is supportive of the patient and personally more satisfying.

The Participants

The 19 health advisers (and the clinical supervisor and GU physician) attending the workshop had a wide variety of backgrounds, experience and length of service in the field of sexual health. Some had experienced difficulties in working with newly diagnosed while others relished the challenge and wished to share their learning and enthusiasm for the subject. Several participants disclosed their HSV positive status and generously showed how this had informed their work with newly diagnosed patients.

To begin with we looked at why some health advisers, and indeed other members of staff, found herpes interviews a chore. We attempted to identify resistances to working with people with HSV and came up with the following thoughts:-

- Herpes interviews can be lengthy and in a busy clinic can lead to a backlog of work;
- There is a perception that people with HSV can be very needy and emotionally draining;
- Some HA's mentioned that they felt used by doctors and nursing staff if asked to deal with a patient's distress and called upon to 'mop up';
- Many patients feel disempowered and this sense of powerlessness can be experienced by the HA – no cure and huge areas of uncertainty within the information that can be given;
- Some HA's acknowledged the difficulty of spending time with the patient in a 'being' rather than a 'doing' mode, which is often what is required.

Happily, all the participants felt committed to working with patients newly diagnosed with HSV in spite of the areas of difficulty outlined above.

The group as a whole was asked to consider what they thought HSV represents to society as a whole? What follows is a list of truths and misconceptions which often burden patients who are newly diagnosed with herpes. The group reported that many patients felt considerably better when given sound information which countered these beliefs.

Herpes is…….

- Incurable
- Painful
- The result of promiscuity ('nice people don't get it!')
- A punishment – very pop with religious right before HIV
- Visible and to be avoided (oral HSV)
- 'new sexual leprosy' - media hype
- 'Herpes is for life…….not just for Christmas' and other jokes

Several participants understood, from their experience of working closely with patients with Herpes, that the adverse effects on quality of life arise not only from the infection itself, but also from the way in which society regards it and people with HSV.

The group was asked to identify patients' rational and irrational responses, to HSV.

Patients may believe that their infection is:-

- A punishment for indiscriminate sexual behaviour (irrespective of whether this is true or not)
- Result of own inadequacy

- ❑ Due to a behaviour change , either individual or societal, and thus to be expected
- ❑ Simply the result of having come into contact with a virulent pathogen (a matter of fact and no more).

We looked at what might be the immediate feelings of a patient following HSV diagnosis?

- ❑ Shame
- ❑ Embarassment
- ❑ Fear of rejection/condemnation
- ❑ Guilt
- ❑ Poor self-regard/esteem
- ❑ Futility/pointlessness/uselessness/impotence
- ❑ Anxiety about transmission
- ❑ Confusion around contraction
- ❑ Anger towards putative infector
- ❑ Concerns about future fertility
- ❑ Depression
- ❑ Suicidal ideation
- ❑ Grief - some patients may go through the stages of the grieving process.

Some or all of the above may accompany recurrences.

And having identified the needs of someone newly diagnosed, the group proposed concrete steps that could be taken to meet those needs.

- ❑ Space to explore feelings above
- ❑ Recognition and respect for said feelings
- ❑ Space to explore fears/concerns
- ❑ Clear information to meet those concerns either to dispel them or validate them.
- ❑ Coping strategies to foster a sense of empowerment
- ❑ An offer of on-going support

In our work with people diagnosed with herpes, most of us had come across patients who may have been living with the virus for many years but without adequate information or support. Below are some of the on-going emotional difficulties that we identified as presenting problems in such patients.

- ❑ Anxiety generally and about contracting STI's specifically(often leading to dampening of libido)

- Depression (often prompted by a new episode)
- Relationship concerns - Did this come from partner? Is my partner at risk? Will I ever get a partner/have sex again?
- Concerns about the ability to have children
- Bereavement - grieving the loss of good health / body image
- Sexual identity (esp. if HSV is contacted in formative years)

It is important to remember that such responses can re-present any time there is a recurrence and that the force of the response is often a reflection of the severity of the physical symptoms.

Conclusion

I was greatly encouraged by the interest, expertise, enthusiasm and commitment to patients' welfare demonstrated by those who attended the workshop. We covered a great deal of ground in a very short time and really could have done with an afternoon rather than a one hour session.

The discussions did help us to identify the scale of the task confronting us when we work with patients with an initial HSV diagnosis but equally demonstrated that, on the whole, the necessary skills and understanding is present among the body of health advising. The workshop also allowed us to see more clearly the degree of change and empowerment that can be effected in the individual patient given the opportunity to do so.
On the subject of the workshops, some of us wondered if, at the next conference, they could not be held earlier, maybe on the second day, to facilitate continuing informal discussion among delegates.

Thanks to all who supported this workshop beforehand and on the day, and to all those HAs who joined in with such enthusiasm, interest and openness.

(ii) 'Health Advising in a Women's Prison'

Caron del Rio, Health Adviser, HMP Holloway, Marlborough Clinic team at the Royal Free Hospital

The workshop introduced the service and gave some background regarding the prison. We looked at common health advising issues relevant to female prisoners and had time for discussion amongst the group.

The workshop highlighted the fast turnover of women in Holloway and the vulnerable nature of the population. It discussed the high percentage of drug users (around 50% of prisoners undergo drug or alcohol detoxification). The prison also holds young offenders (under 21 years of age) and foreign nationals (30-40% of women from non-European countries).

The breakdown of the health adviser's work shows a bias towards Hepatitis C work, HIV throughcare and abnormal cytology results. HIV throughcare is the most visible to other prison staff, and the health adviser works very closely with Positively Women and specialist HIV centres to ensure that women in prison have access to one to one peer support and specialist medical care.

Within Holloway prison there is a high incidence of women requesting support following sexual assaults, domestic violence and pre and post termination of pregnancy. The health adviser works alongside other prison services such as psychology to provide this support.

Outside of the clinic environment, the health adviser is involved in policy formation with internal and external groups such as the National AIDS in Prison Forum and the HMP Holloway Communicable Diseases Group. She also facilitates relevant prisoner and staff education and awareness events such as World AIDS Day.

Some specific problems relating to health advising in a women's prison that were identified by the group included issues of confidentiality and privacy and how communication with prisoners and staff is often difficult from outside.

(iii) Bringing 'Partner Notification' into focus

Anna Doughty, Clinical Psychologist, Newcastle upon Tyne

The postal Partner Notification Survey (March 2000) conducted of health adviser experiences and attitudes to aspects of partner notification explored the following issues.

- Is a written policy on provider referral available?
- Is consent given in all cases before provider referral goes ahead?
- What details are required before provider referral goes ahead?
- Is a surname required? / Is a full address required?
- Are provider referrals initiated if patient referrals are unsuccessful?
- What does routine follow up mean?
- If a patient refused consent for partner notification but gave full details of a partner, provider referral would be initiated in what circumstances?
- Does provider referral cause short-term distress to index patients and/or partners?
- Is provider referral acceptable to index patients and/or partners?
- What methods of provider referral used in current practice?
- What methods acceptable for provider referral?
- Is partner notification an effective tool for promoting safer sex and /or monitoring the incidence of chlamydia?
- Are problems encountered when dealing with other GUM clinics in relation to provider referrals?
- Which of registers are used for provider referrals, and how easy are these to access?
- Which of registers are acceptable to use to gain information in relation to provider referrals?
- Does your work in relation to partner notification create dilemmas?

Summary of the discussion a 'focus group' of 12 health advisers had when exploring some of the themes that emerged from the survey findings.

Themes arising from discussion

Consent

- Can consent for partner notification be assumed if the patient gives details of a partner?
- Will there always be cases where partner notification goes ahead without consent being given eg if a partner is known to be pregnant?

Confidentiality

- Guidelines remain unclear
- Should information gathering be restricted to the health service system?

Difficulties encountered between clinics

- Not all clinics undertake provider referrals
- Lack of communication eg other clinics failing to return contact slips or informing of patient attendance
- Expectation that all clinics operate in a similar way
- Is this realistic given that services are often very different in nature eg inner London vs rural communities ?

How does this impact on local clinics addressing appropriate provider referrals at the request of another clinic?

(iv) *Male rape*

Richard Pates and Fran Brinn

Introduction

The problem with the workshop was the lack of time in which to develop the themes. The participants were all eager to contribute and as they came from a variety of backgrounds both geographically and demographically and had different experiences in terms of the subject this was useful. This was a useful. There were 14 participants, 4 men and 10 women, plus the facilitators.

Facilitators introduced themselves and asked the participants to do the same saying who they were, where they came from and what their experience of male rape was.

Confidentiality and etiquette were raised with the following as rules for the session:-

- What is discussed stays in the room except from any conclusions from the workshop.
- Every one has the right to say what they want and to be heard.
- Every one has the right to remain silent.
- Every one has the right to challenge but we expect this to be constructive.

The first task was then with the group divided into four groups they were asked to consider the following questions:-

- What are the fundamental differences between the rape of a man and the rape of a woman?
- What are the physical and psychological results you might anticipate from the act of the rape of a male?
- What are the barriers to reporting such a crime?

Response to the questions were as follows:-

If you are raped you are raped (no difference)
Concept of masculinity and strength which makes it more difficult to be acceptable (ie men can't be raped)
More difficulty in discussing the issue
Being the same gender makes it more difficult
There are fewer services and support

Reactions of other people
Powerlessness
Questioning of your sexuality (physiological sexual response)
Question their own strength.
Is passivity unusual in a man?
Whether you are believed.
It is unusual for men to discuss their feelings.
Woman have a risk of pregnancy after rape, do men have higher risk of HIV?

The physical and psychological reactions would be:-

Physical trauma
Issues of sexuality
Loss of sex drive
Fear of infection
Shame
Withdrawal/depression
Denial
Decrease in general health
Damaged relationships
Internalised homophobia
Eating and sleep disorders
Erectile dysfunction and loss of libido
Substance misuse
Suicidal thoughts
Panic attacks and phobias
Abusive relationships
PTSD
Loss of self esteem image and self worth

The barriers to reporting such a crime were:-

Guilt
Shame
Lack of support systems
Ridicule
Not being believed
Internalised homophobia

Lack of police experience
Fear of judgement
Perceptions/assumptions of partner, family and friends
Fear of rejection
Being examined and re-examined
Lack and loss of control

The second set of questions that were raised were discussed in one group because of the lack of time to discuss and report back:-

- Why do men not attend our services in representative numbers for help?
- What are the features of a gold standard service that we should be providing?

The answers to the first question was contained within the responses to the earlier questions (see above).

The sort of service provision we should be offering includes:-

Listening and accepting what is being said and refer on where appropriate. Do not deal with things out of your depth. Give plenty of time, many issues will not come up immediately.

Give good publicity to services so that men know they are there. Have good multi agency working many people have something to offer. Have a named specialist in the clinic so that there is a consistent approach. Educate other professionals. Have a system of fast tracking rape victims. Set up good liaison with the local police. Have rape kits available.

These ideas above could for the basis of guidelines for good practice. Much more time is needed for this and could be the subject of a half day workshop at a future conference.

(v) Young Persons Clinic in Cardiff.

Anita Johansson, Health Adviser, Cardiff

In this workshop I discussed the setting up of a Young Persons Clinic for 18 years and under. This is the first joint clinic in Wales with the family planning services. We discussed how it was advertised by family planning clinics, school nurses, practice nurses and social workers. The open access clinic is held each Monday from 3.00pm to 5.00pm and an assessment is made by the health adviser and nurse and then referred for STI screen, family planning advice and HIV counselling if necessary.

I showed statistics of the pilot project with an age range of 12 to 19 years –
82 patients were seen (63 girls, 19 boys). (See attached chart)

My conclusions were –

1) How do we access more boys?
2) More patients need to see family planning doctor.
3) How do we address the smoking problem? (39 girls smoked and 14 boys).

Workshop findings –

1) London clinics – any patient 16 and under are strongly advised to see the health adviser.
2) London clinics - health advisers in one Young Persons Clinic answers queries by E Mail from local youth group.
3) London clinics – In one Young Persons Clinic a drug worker is in attendance.
4) London clinics - All doctors dual trained in STI and family planning.
5) Within London some Young Persons Clinics are open until 7.00pm.

(4) EVALUATION REPORT

47 forms were completed.

Overall impressions of the conference.

Conference facilities
The delegates rated the venue overwhelmingly as excellent, with good facilities and helpful staff.
Those delegates staying at the Commodore Hotel, unfortunately, were less satisfied with their accommodation, and found it more difficult to integrate as they were on a separate site.

Content
The content was rated from good to excellent.
Delegates found the programme varied and relevant, with a good balance between presentations and informal discussion. Some delegates suggested shorter presentations and more workshops on the Thursday.

Organisation and management
This was rated as excellent by most delegates. They were impressed by the hard work, smooth running and planning of the whole conference, and many gave their thanks to the attentiveness, timekeeping skills and humour of the organisers. They were very much appreciated!

Presentations
The presentations were rated from good to excellent, and almost all delegates found them to be quite or very relevant.
Delegates praised the high standards of the speakers and the fact that they were all health advisers. The power point presentations were admired, and the use of case studies and personal experience along with evidence-based research and practice was commented on as helpful, thought-provoking and relevant.
The main issues highlighted were the importance of supervision, the changing role of the health adviser including professional development, and state registration. It was clearly helpful for many delegates to think about standards, protocols and guidelines, and the profession of health advising within their own clinics.
The talks on Sexual Health on the Web and Munchausens and Rape were particularly singled out by many delegates.

Workshops
Unfortunately, the evaluation sheet omitted to include the workshops specifically, so it is not possible to give many comments on these. However, the feedback from some delegates who mentioned the workshops on their form was positive.

AGM
From the evaluation last year, there was definite improvement on this year's meeting. However, a few delegates were not impressed by the MSF rep., and there is still some confusion as to who and what SHASTD Council is and does. The comments will be taken on board by the Council to try and put across its function and tasks more clearly and any interested members are always welcome to become involved in its activities.

Summary
"Brilliant", "Fantastic", "Best ever", were a few of the comments of the delegates this year. They found the conference highly enjoyable, relaxed, friendly, with a good mix between work and social interaction. Many delegates highlighted the importance of meeting colleagues, sharing ideas and networking, particularly for those working alone.
Delegates were impressed by the high standards and professionalism, and were energised and enthused by the positive direction and clarification of the health adviser role.
There was very positive feedback on the organisation and content of the conference with many saying it just get better and better.

With thanks to the organisers (in particular, David Cox, who stood down from the position of SHASTD Conference Officer this year), the sponsors, the presenters and facilitators, and all the participants who gave such constructive and enlightening feedback!

Sandra Jarrett
SHASTD Conference Officer.